A Case for an Investigation by the Saskatchewan Human Rights Commission into Systemic Discrimination of the Mental Health System in Saskatchewan

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History and Background

Saskatchewan has had a very checkered history regarding the provision of mental health services.

While we took a leadership role in “decanting” the two large institutions in Weyburn and North Battleford, there were at least two major misunderstandings which prevented adequate community-based services to be put in place and reinvest savings made by deinstitutionalization.

These misunderstandings were:

1. that new psychotropic medications that provided dramatic increases in ability to control certain aspects of mental illness would provide a “magic bullet” and eventually control virtually all symptoms.
2. that large institutions, by their inherent nature, cause many symptoms and that being “in the bosom of the community” would in itself reduce symptoms dramatically.

We know now, of course, that while psychotropic medications are needed and beneficial, neither they nor simply being in the community are a substitute for adequate and timely access to quality mental health services when needed.

Since deinstitutionalization in the early 1960s, there have been many, many reports and studies outlining the dramatic underfunding of mental health services which has been occurring so long that it has certainly institutionalized poor access and long timelines to services.

A list of recommendations has been made by several professional and government agencies throughout the past few decades. For further reading on some of the more prominent and noteworthy reports please refer to the following articles: Canadian Mental Health Association (CMHA), 1983; CMHA, 1990; Government of Saskatchewan, 2000; Romanow, 2002; Government of Saskatchewan, 2004; and Government of Canada, 2006. Anyone who looks at the recommendations of these and other reports can see that they could have been recently dated as the problems and issues have not changed substantially over the years.

For example, The Canadian Mental Health Association (CMHA,1983) made the case for additional funding for mental health in the document, *The Forgotten Constituents*:

> Suggestions that health programmes are underfunded usually elicit what has become almost a reflex response from government. It is generally put forth that the question is not the need for <u>additional</u> funding but more efficient use of existing funds. It is suggested that by tightening up organizational structures, thus reducing wasteful duplication and overlap, that major economies can be effected.

> The Task Force does not question that duplication and overlap exists within our current mental health system. This point was made in a number of briefs, however it is inconceivable that reorganization alone will free up enough funds to meet existing programme needs let alone those we have recommended for the future.
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> The evidence indicates that the demands for services will continue to increase. In 1980, Psychiatric Services Branch statistics indicate that some 9.6% of the total population in Saskatchewan received help for a psychiatric problem. This is projected to increase to 10.1% of the population by year 2001. These figures related only to services delivered, not to identified needs. We were informed that at least an equivalent number of people have identified themselves as in need of professional assistance but for a variety of reasons have not received it. Clearly, any programme directed at increasing self-awareness could produce an additional service burden which existing programmes could not accommodate. (Figure reference omitted.)

The old saying that "those that do not pay attention to history are doomed to repeat it" seems particularly pertinent when we look at the results of virtually all these reports and what is happening with the latest report, *Working Together for Change: A 10-Year Mental Health and Addictions Action Plan for Saskatchewan* (Winder, 2014).

To put the long and consistent discrimination in a systemic basis into perspective, a look at some historic facts and figures is in order.

As an example of the list of concerns, circa 1966, Dr. Colin Smith, Director of Psychiatric Services Branch, outlined eight issues:

1. There were many more patients with psychotic symptoms in the community than formerly, who posed problems to themselves or relatives and to the community.
2. Good follow-up is essential to ensure that they are adequately cared for and that drugs are taken as recommended.
3. More nurses and other community personnel must be trained and used in this field, and their training adapted to enable them to deal with emerging problems.
4. The community workers must be sensitive to the social stresses which result from the patient's placement in the community. Neither the patients nor those associated with them should be allowed to suffer unnecessarily.
5. A truly therapeutic environment must be created for these patients with all that this implies in terms of sheltered employment, recreational therapy and so on. Homes in which the patients are placed must not become small and inferior institutions.
6. Psychiatric facilities must be prepared to readmit these patients if and when circumstances are warranted. They must take account of social, psychological and biological factors in determining whether or not admission is necessary.

7. The decline in hospital population and increase in community patients presents difficulties to professionals and the community alike. The problems must be tackled imaginatively and backed by a good public education program.
8. Research studies are urgently needed of the problems connected with maintaining patients in the community and of the effectiveness of various measures to diminish these problems.

(CMHA, 1983, p. 20)

In 1967:

> Dr. Frazier pointed out, however, that "neither the original 'Saskatchewan Plan' nor any modification has ever been fully implemented. Instead, he noted that there had been a "gradual financial squeeze" on the Psychiatric Services Branch. This financial squeeze had resulted in unsatisfactory salaries and working conditions and an exodus of key professionals. He described the situation as follows:
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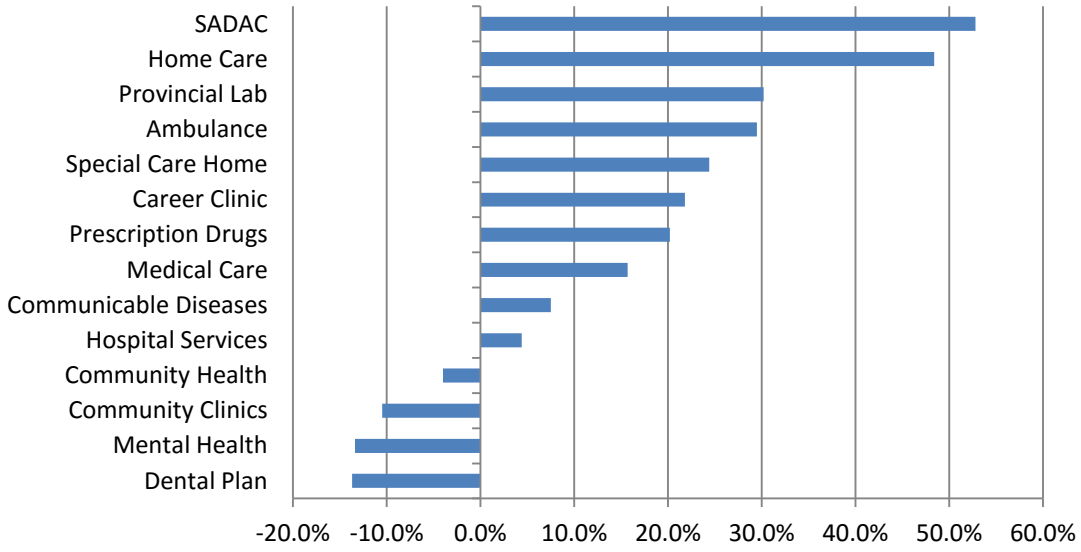
> > *The province has gradually drifted into a situation in which it is trying to run a first-rate program on a second-rate budget, and this simply will not work. As a result, quality of care is slipping, duties are being reassigned to less qualified personnel, caseloads are increasing, and work days are becoming longer, all contributing to demoralization. (Footnotes omitted.)*
>
> (CMHA, 1983, p. 21)

For a dramatic demonstration of the systemic discrimination of mental health services as compared to other health areas, see the following:

> A common thread that permeates each of the above concerns related to the inadequacy of mental health system funding. Spending on the Mental Health Services Branch has been constrained over the past decade – especially in comparison to other health departmental branches. In real dollar terms, branch spending dropped by 13.4% between 1982/83 and 1987/88. Interestingly, this occurred after the 1983 Task Force identified this as a serious system threatening concern. (Figure 7)

Dental Plan	-13.7%	
Mental Health	-13.4%	
Community Clinics	-10.5%	
Community Health	-4.0%	
Hospital Services		4.4%
Communicable Diseases		7.8%
Medical Care		15.7%
Prescription Drugs		20.2%
Career Clinic		21.8%
Special Care Home		24.4%
Ambulance		29.5%
Provincial Lab		30.2%
Home Care		48.4%
SADAC		52.8%



(...)

While there is some room to debate the relative "poverty" of mental health spending within Saskatchewan compared to other provinces, it is beyond question that mental health spending has lagged seriously behind other forms of health spending, and has received less and less of the expanding health care budget. (Figure 8)

Year	1958/59	1983/84	1986/87	1987/88	1988/89
Branch Budget	$8,829,000	$29,518,861	$30,916,491	$29,702,016	$30,353,30
% of Health Budget	32.5%	3.13%	2.6%	2.51%	2.45%

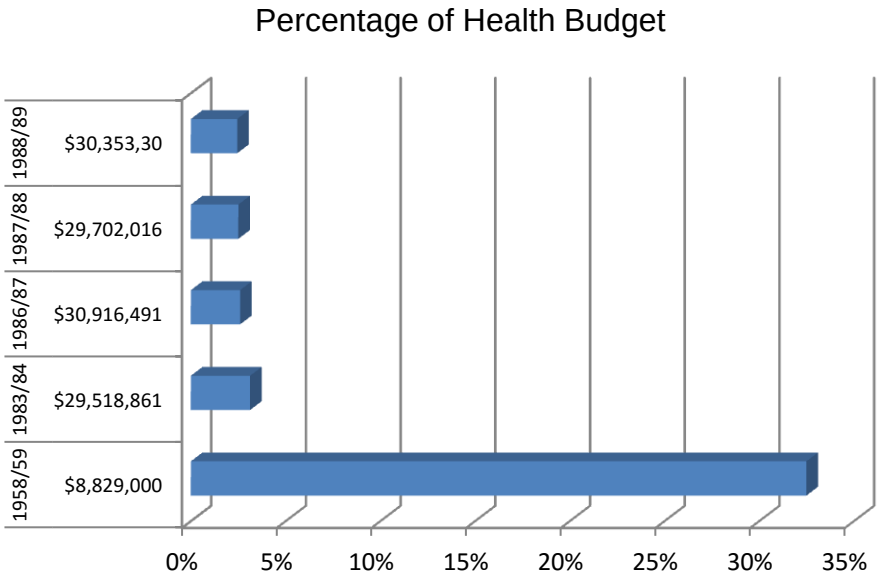


Figure 8 depicts MHSB spending as a percentage of departmental spending 1958 - 1988.

(Keegan, Beach, Broten, Skinner, & Elintsky, 1990, pp. 30–31)

Perhaps even more distressing than the dramatic loss of resources to mental health services between 1958 and 1989 is the consensus about the lack of direction and vision regarding what the delivery system should look like and how it should be funded in the future as follows:

> Officials of the Mental Health Services Branch seem beleaguered. There is a lack of clarity as to goals and objectives of the organization. Branch staff are clearly caught up in a crisis management quandary and are having difficulty in developing future directions in mental health in the absence of political commitment. Policy decisions appear to be made in direct response to external or internal government pressures with insufficient thought, either encouraged or allowed, to see through some of the implications of such decisions (e.g. formation of NGOs in the absence of a province-wide future-oriented master plan).
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> Some observers term this the “Lord Ronald Syndrome” after a Stephen Leacock character who “flung himself upon his horse and rode madly off in all directions”.

By way of example, the following "planning and policy" problems persist:

- a lack of clear policy regarding who is to be served and how services are to be provided;
- a lack of long-term planning;
- little coordination;
- disparities in the availability of services across the province;
- gaps in service;
- lack program evaluation and quality control;
- reduced human resources without reducing the workload;
- new directions are mandated from Health without new resources to Mental Health Service Branch, nor appreciation of the negative effects of these mandates and no tradeoffs are allowed.

(Keegan, Beach, Broten, Skinner, & Elintsky, 1990, p. 31)

The list of "planning and policy" problems is particularly telling; it is our Association's opinion it could easily be a list in a report dated 2016.

A summary comment in the DOHMS report regarding the progress on recommendations from *The Forgotten Constituents* has set the tone, which is still in effect until the latest report, *A 10-Year Action Plan*, completed in 2014:

> The 1983 Task Force Report, commissioned by the Mental Health Association of Saskatchewan under the chairmanship of Ian McDonald, now Dean of the College of Medicine, was a milestone document. It provided an up-to-date review of the mental health system and relevant impinging human systems that provide services to individuals with mental health problems and mental disorders.
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> (...)
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> The government has addressed a small number of the recommendations, some through its own initiatives, others through the initiatives of interested professionals, consumers and families. However, it would have to be stated that seven years, later, the government has generally failed in successive years, and has accumulative failing status by 1990. In fact, no identified plan of attack has ever been presented publicly to the constituencies interested in mental health and it can only be assumed that a plan of attack, subsequent to the 1983 Task Force, does not exist.
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> (Keegan, Beach, Broten, Skinner, & Elintsky, 1990, Appendix I)

Normally, in most other reports, spending this much time and space on the history of funding and priority issues might seem overdone. In the case of Saskatchewan's mental health system, it is critical in the argument of systemic discrimination to see the decades-long problem this has been and the effect this history has to this day on the current lack of resources.

The Current Situation

Today, Saskatchewan lags far behind the average expenditures mental health receives as a percentage of the health budget. Mental health in Saskatchewan is approximately 5%, while the national average is 7%, and the recommendation of the Mental Health Commission of Canada is 9%. The very discouraging part of this situation is that the 2014 Report, *Working Together for Change: A 10-Year Mental Health and Addictions Action Plan for Saskatchewan* by Dr. Fern Stockdale-Winder, is an excellent overview of the needs and has the following attributes:

1. It is a 10-year plan, which recognizes the decades-long problem of underfunding and, if done properly, could add resources over a decade to get at where we need to be. Where do we need to be? We have a $5.4 billion dollar health budget, so being 2% down on average compared to other provinces, we are $108 million dollars short per year on average expenditures. The 10-year plan would mean a targeted, planned amount of $10.8 million dollars more accumulated year upon year until we got to the average of other provinces instead of being dead last as we are now.

2. The plan is inter-ministerial, so planning and spending across key ministries could and should be happening. The very frustrating part of the *10-Year Action Plan* is that **no** extra resources are being attached to it. This plan took a year and a half to complete and has now been in place for two years without any appreciable or realistic new monies available. Perhaps the most wasteful aspect of this lack of response is the squandering of the potential; there are hard-working and dedicated staff from each ministry who share a vision but virtually no extra resources with which to see it through. This results in very small, no-cost changes as opposed to being given a reasonable overall budget and meaningful plans made within that budget.

How does the *Mental Health and Addictions Plan* compare to other health reports and how they have been handled?

- The 2006–2007 *Working Together: Saskatchewan's Health Workforce Action Plan* was released in December 2005 and by September 2006 had $25 million dollars allocated.

- *A Recruitment and Retention Plan for Health Workers* was released in December 2007 and by February 2008 had $60 million dollars attached to fund it.

- *The Saskatchewan Surgical Initiative* released in March 2010 had $50.9 million dollars targeted within 12 months of release of report.

- *Working Together for Change: Mental Health and Addictions Action Plan* was released in November 2014 with no mention of funding upon announcement. There was mention only of teams to create dialogue with no dollar amount attached and now, 24 months after release, there are still no dollars announced.

(Ministry of Health Annual Reports, 2006–2007; 2007–2008; 2009–2010; 2010–2011; 2014–2015)

The Human Face to All the Stats and Budget Issues

The human impact of the underfunding is dramatic and growing each decade.

Not only is the person who has a mental health/illness issue affected by lack of access and timely treatment, but family, friends, and employers are all impacted negatively. There are very cogent and moving stories in the Kirby Report and Saskatchewan's 10-year action plan, which speaks to the results of institutionalized underfunding on the population of our province.

The Final Analysis

In the final analysis of this many decades-long problem, we believe very strongly that there is a clear and consistent path of negative, systemic discrimination towards the handling of improvements and resources in mental health as opposed to other areas of the health system.

We believe the basic "tools" to adequately plan and resource a proper mental health system are basically in place, i.e., the 10-year plan and inter-ministerial planning systems, however; the "fuel" or resources needed to do meaningful and targeted implementation of recommendations made in the action plan are not forthcoming.

We have consistently heard from government that "there is enough money in the system, it just needs to be used more effectively." While this may or may not be true, in the overall health system, it most certainly is not true in the mental health area. This argument has been consistent through decades of underfunding.

We are therefore respectfully asking that the Saskatchewan Human Rights Commission initiate an investigation into systemic discrimination of the mental health system in our province to help break the decades-long funding "drought" mental health has suffered.

We are very aware of the current financial situation of the province but would emphasize that the decision to discriminate against the mental health funding of the *10-Year Action Plan* was made prior to the downturn in commodities and follows the long and, in our eyes, shameful history of lack of funding for mental health over the decades.

We have suggested to government that, as other levels of government have done, they announce dollars available after a period of planning to finance priority expenditures, but to no avail. As quoted from *The Forgotten Constituents*:

> **The real test of any government's commitment to a programme is what recognition they give it through the budgetary process. Budgetary allocations over the past 10–15 years would certainly suggest this commitment to be minimal.**
> (CMHA,1983, p.157)

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EXECUTIVE SUMMARY

In *A Case for an Investigation by the Saskatchewan Human Rights Commission into Systemic Discrimination of the Mental Health System in Saskatchewan*, the authors illustrate that there has been a long history of ignoring and underfunding mental health and wellness in Saskatchewan.

In 1966, the Director of Psychiatric Services outlined a Saskatchewan Plan that highlighted eight issues that required attention for mental health and wellness. In 1967, it was noted that there had been financial pressure to disregard mental health issues (The Forgotten Constituent, 1983).

In 1983, the Task Force Report was a milestone document that provided an up-to-date review of the mental health system and relevant impinging human systems that provide services to individuals with mental health problems and mental disorders. Seven years later, in 1990, the government still presented no identified plan of attack publicly to the constituencies interested in mental health (DOMHS Report, 1990).

Today, the government's spending on mental health in Saskatchewan is approximately 5% of the total health budget, while the national average is 7%, and the recommendation of the Mental Health Commission of Canada is 9%. Being 2% down on average compared to other provinces, we are $108 million dollars short per year on average expenditures. The 10-year plan would mean a targeted, planned amount of $10.8 million dollars more, accumulated annually until Saskatchewan meets the National average. *Working Together for Change: The Mental Health and Addictions Action Plan*, created in 2014, is a ten-year plan which outlines seven recommendations as system goals to improve mental health and addictions services in Saskatchewan.

Other recent action plans and initiatives to provide health improvements have been granted funding (as much as $60 million) in a timely way (as short as three months) with pride. *The Mental Health and Addictions Action Plan*, however; has seen no funding over the past two years and would have cost less over these last two years than these other plans (Ministry of Health Annual Reports). This is much needed funding to accomplish an adequate level of mental health services.

We are therefore respectfully asking that the Saskatchewan Human Rights Commission initiate an investigation into systemic discrimination against mental health service consumers in Saskatchewan. Consumers do not need plans to be made and then forgotten, they need the plans to come to fruition so that there can be recovery, healing, and mental wellness.