

## CANADA'S MENTAL HEALTH TRENDS: PRESCRIPTION FOR PSYCHOLOGY

JOHN RENNER AND VIVIAN RENNER

*Memorial University of Newfoundland*

CANADA

If you're one of the rare, 400 individuals in the world who function as psychologists in one of Canada's 1,423 hospitals, you've probably earned the right to skip over the rest of the following paragraph dealing with the basics of Canada's mental health services. For our non-Canadian readers: Canada has a population of approximately 22 million. The southern portion of this second-largest country in the world is divided into 10 provinces, each with its own government, but ultimately subordinate to the federal government. The northernmost, least populated, part of Canada is divided into the Northwest and Yukon territories and is administered solely by the federal government.

Mental health services in Canada are organized as part of provincial health services. Each province employs a director of mental health services, usually a psychiatrist, and one or more consultants in psychiatric nursing, clinical psychology, social work, occupational therapy or special education and, also, one or more psychiatrists specializing in pediatrics, geriatrics, mental retardation, alcoholism and drug addiction, or related fields. Since the mental health directors are public health officers, they are responsible for the development of programs aimed at prevention of mental disorder and for the general promotion of mental health. In working toward these ends they cooperate with welfare, education, manpower, labour, and justice departments. As psychiatrists, the mental health directors are responsible for development and supervision of the various health facilities for the treatment of people who suffer from mental disorders including disorders of character and behaviour, the mentally retarded, those with damaged nervous systems, alcoholics and drug addicts (Dominion Bureau of Statistics, 1971b).

Mental health services differ in detail and stage of development from province to province; all are being extended and improved to take advantage of the best methods of treatment and prevention. One hundred and seventy-four of Canada's 1,423 hospitals are classified as mental institutions. This includes 47 public mental hospitals, 48 institutions for the mentally retarded, 14 psychiatric hospitals, 17 hospitals for addicts, 42 treatment centres for emotionally disturbed children, 4 homes for the senile, and 2 hospitals for epileptics. In

addition to the above institutions, there are 100 general hospitals which have psychiatric wards (DBS, 1971d). One out of every six Canadians will spend part of his or her life in one of these institutions.

The traditional pattern of long-term care of the mentally disordered in large, isolated mental hospitals is giving way to new patterns of care developed to cure the afflicted, or failing that, to provide for them living and working environments that will enable them to have reasonably normal lives. Thus, in the past 10 years, no more of the large, isolated, general mental hospitals—currently averaging about 1,000 beds each—have been built. The number of patients on books in these hospitals has decreased 41% since 1960. But during this same period the number of small—100 to 300 bed—psychiatric hospitals has doubled. These latter hospitals are designed primarily for short-term intensive treatment. Similarly, the number of psychiatric wards in general hospitals, also designed for short-term intensive treatment, has doubled during the past 10 years. Also, during this period, treatment centres have become problem-specific, as is demonstrated by a doubling in the number of hospitals for retardates (patients on books have increased by 40% in these units since 1960) and a tripling of the number of other specialty hospitals (e.g., for emotionally disturbed children, epileptics, etc.).

The increasing emphasis on treatment rather than custodial care also places a great deal more emphasis on community integration. Thus, the number of clinics and outpatient wards, designed expressly for the mentally disordered, has increased from a totally insignificant number ten years ago to 212 today. Amidst this increase in number and type of treatment units for the mentally disordered, the number of institutionalized patients has decreased, the number of hospital staff has increased, and we have fewer beds for the mentally disordered every year.

The number of institutionalized patients peaked at 80,211 in 1964, but has been decreasing steadily. In the beginning of 1970, for example, there were only 66,934 patients reported. Of the 34,167 admissions during the year 1969, 14,290 were first admissions and 19,877 were readmissions. But there were 35,381 discharges and 2,238 deaths—or a total of 37,619 people leaving the hospitals that year (DBS, 1971a). For the same 67,000 patients institutionalized in 1969, there were almost 51,000 full-time staff. The latter figure has been increasing at a rate of some two to four percent during the past several years. Over 50% of the staff are nurses, 3.3% are medical doctors, the rest are technical, administrative, and "other."

We had a peak of 3.2 beds per 1000 population during 1963, but that has dropped steadily—in accord with new treatment procedures

—2.8 beds per 1000 in 1970. (During the same period, the number of beds per 1000 increased in other hospitals in Canada, to the current figure of some 6 beds per 1000 population.) There were even fewer beds—61,192—during 1969 than there were patients on the books—66,934—because so many patients are encouraged to leave the hospital on probation to live in a foster home or boarding home in the community. These patients are still under medical care, and have access, as does anyone, to the many clinics and outpatient facilities available. Such units are heavily used—dealing, for example, with 204,149 patients during 1969. That figure constitutes about 1% of the total Canadian population (DBS, 1971a). In large urban centres, provincially operated clinics are often supplemented by similar clinics operated by the municipality. In addition, there are privately managed clinics, which are often operated by volunteers who may or may not be mental health professionals. These latter organizations are often funded (i.e., rent, lights, etc.) by small government grants and community donations. They are usually viewed as valuable in providing a casual, non-medical milieu which is useful in handling mild problems and provides an easy point of entry to the therapeutic process for the person who feels too threatened to seek assistance directly from a more formal setting.

In rural areas, the provincial governments provide travelling clinics which usually consist of a psychiatrist, psychologist, social worker, and nurse. In very remote areas, transportation is provided to the nearest treatment facilities. The federal government, incidentally, provides much the same mental health facilities and services for the Yukon and Northwest Territories as do the provinces for their own jurisdictions.

What does all of this cost? For the individual—virtually nothing. All residents of Canada receive necessary medical treatment, and their choice of doctors, as a service of their province or of the federal government. As of 1970, this includes individual psychotherapy given by private psychiatrists.

The cost to the various governments of operating institutions for the mentally disordered across Canada was \$352,168,000 in 1970, approximately 3½ times the cost of \$100,000,000 per year of the early 1960's (DBS, 1971b). This sum does not even include the cost of operating the 110 psychiatric wards of general hospitals. These wards probably handle at least twice as many admissions per year as all mental institutions combined. Cost per patient day in the large, general mental hospitals rose from \$5.33 to \$16.95 between 1960 and the beginning of 1970. The 1969 cost per day is slightly less for retardates—\$13.77—but for patients in psychiatric hospitals the figure is \$43.93 per day (DBS, 1971d).

Improvement in the care of the mentally disordered has been fostered by activities of voluntary organizations such as the Canadian Mental Health Association (CMHA) and the Canadian Association for the Mentally Retarded; by the professional advice of the Canadian Medical Association and the Canadian Psychiatric Association and by the information programs of the Mental Health Division of the Department of National Health and Welfare. A recent example of such improvements has to do with the legal status of the mentally disordered. Under the auspices of the CMHA, three books have been published, during the 1960's, which point out the degree to which provincial and federal procedures for the commitment, review, incarceration, and release of mental patients were based on archaic views—in social as well as scientific terms—of the mentally "ill" (CMHA, 1967). The recommendations made in these volumes have played a major role in the reshaping of provincial and federal laws, and courtroom views, toward the more humane treatment of the disordered and the "suspect" disordered. There is still plenty of room for improvement—but the CMHA is undoubtedly working on that.

In addition to the valuable advice and prodding of professional and lay associations, various provincial and federal projects are underway for the improved treatment of the disordered. For example, special centres have been established for the study and treatment of alcoholism and drug addiction, criminal psychopathology, psychiatric disorder in children, brain injuries and other neurological disorders. The findings from a major survey of residential and in-patient services for emotionally disturbed children, and a Commission of Inquiry into the Non-medical Use of Drugs, have just recently become available (DBS, 1971b).

There are a number of sources of federal and provincial funds for research and demonstration projects available to the mental health professionals in universities, hospitals, and other certain non-profit organizations. In 1970, approximately two million dollars were spent on mental health research by roughly 150 principal research investigators (psychologists or psychiatrists in charge of an independent research project that is supported by some granting agency). Two million dollars seems like a respectable sum, but it actually constitutes only a little over 3% of the 60 million dollars spent on health sciences research during 1970. Also the 150 principal research investigators represent only 2.8% of the 5300 psychologists and psychiatrists in Canada. (Of course, many psychologists—650 of Canada's 3400—are principal investigators on projects not concerned with mental health.)

A Canadian medical research survey (1968) lamented the fact that Canadian psychiatrists are outstanding for their lack of involve-

ment in clinical research. Most of Canada's mental health researchers have university positions. Mental health professionals working in hospital settings usually lack either the time, the interest, the competence—or all three—to conduct research. This raises the question as to how well the training programs and the working roles of mental health professionals fulfill the treatment needs of the mentally disordered.

Psychiatrists in Canada are trained to be practitioners. They are consumers, not producers of research. The training procedures consist of considerable "on-the-job" activities which primarily involve face-to-face treatment. Training in community consultation, or a general orientation toward primary, as well as secondary, prevention activities, is still somewhat infrequent, but is very much on the increase. It has been noted though that Canadian psychiatrists, in attempting to absorb not only their medicine and psychiatry, but also psychology, sociology and anthropology, may be overextending themselves (Stokes, 1969). Perhaps this is one reason why, for the last few years, 60% of the psychiatrists who take the qualifying examinations in their specialty fail. But, as more than one psychiatrist has told us, "who else is going to try to learn and use the stuff?"

They have a point. Since 1950, when federal funds for the training of clinical psychologists were stopped, Canadian psychology has become predominantly a theoretical, basic science discipline. Professors hope not to "lose" good students to the area of clinical. Those interested in clinical are often steered into "experimental psychopathology." Those students who managed to maintain their interest in the application of psychological principles usually must submit to the United States' "scientist-practitioner" model of clinical training. The discipline's distaste for applied psychology extends beyond the realm of clinical. In Canada, there is no university which grants a Ph.D. in either industrial or community psychology. Furthermore, in many universities, graduate work in educational psychology and counseling is offered by education, rather than psychology, departments. However, changes in these restrictive training policies are imminent as indicated by the attitudes of younger faculty members, by the expressed interest in "mission-oriented" research by granting agencies, and by numerous articles in Canadian journals which disparage the "scientist-practitioner" model (e.g., Albee and Loeffler, 1971; Arthur, 1971; Davidson, 1970).

The point is that the Ph.D. working in hospitals today has very limited skills. He can test and treat patients—activities which an M.A. psychologist often can do just as effectively, and a lot more cheaply. Meanwhile, researchers have been demonstrating that one

needn't have a Ph.D. or even an M.A., to become an effective psychotherapist. Furthermore, psychologists have known for years that the test reports they write (brain damage cases excepted) seldom serve any important function in classifying or treating a patient. As the budget squeeze forces more hospitals to engage in frequent cost-benefit analyses, the role of the psychologist will have to change. With developments in the areas of organizational and community psychology, clinicians could be engaging in the design, implementation, and evaluation of not only treatment, but also general preventive health programs. In this capacity, it would make little sense for the psychologist to remain inextricably subordinate to the Department of Psychiatry. Many of his activities would involve the study and development of over-all institutional effectiveness which may often have little direct bearing on treatment per se. It's important to note that this role of the psychologist would effectively take him out of direct competition with the psychiatrist in the latter's role as chief therapist. It makes much more sense, in terms of their interests and their academic background, for clinical psychologists to branch into the areas of primary prevention and systems research and for psychiatrists to specialize in secondary prevention. The current charade of psychiatrists trying to learn psychology to satisfy the growing social concern with preventive mental health, while psychologists aim for major responsibility in the therapeutic arena—even though they cannot administer drugs and are working in a medical establishment—will cease as our training programs recover from the science-practitioner phase.

A problem of no small significance right now, however, is that hospitals are full of psychologists who know about therapy. Their training in theoretical research has generally provided them with few of the skills of the action-oriented, or solution-oriented systems researcher. They know little about computers, the various multiple correlation techniques, or how to design a survey, or, in general, how to conduct applied field research. Furthermore, there are virtually no provisions in Canada for post-graduate training in their areas for the working professionals. Therapy workshops we have—as if that is what we need. The truly intrepid professional may be able to enroll in regular graduate courses in statistics or social intervention techniques—but such courses are usually designed for the full-time graduate student and are often designed as much, or more, for evaluation purposes as for educational purposes. Indeed, the problem right now is not so much one of education as communication.

Psychologists must certainly be the most unprofessional (organizationally speaking) of the mental health professions. Psychiatrists, nurses, and social workers have national organizations, as well

as provincial organizations, which are primarily concerned with protecting and extending the rights and responsibilities of their members who are working in applied settings. Representatives of such organizations work together on all levels, and in conjunction with the Canadian Council of Hospital Accreditation, in defining their inter-relationships and in justifying their professional criteria for what does or does not constitute expertise in their respective fields. The Canadian Psychological Association (CPA) has proved to be a relatively powerful and useful integrating force for the academic discipline of psychology in its role as national representative to governmental policy-making and research-granting committees. But, although some two-thirds of its members are professional, rather than academic psychologists, CPA does not, in any significant sense, function as a professional organization. The Advisory Council, Provincial Associations of Psychologists, was formed in 1968 in an attempt to nationalize professional standards and licensing. If they are functioning at all, they've certainly maintained a very low profile.

Thus, while the medical profession moves toward a greater use of paraprofessionals—and one can expect them to modify their training programs and qualifications accordingly—psychology is really still struggling on the sidelines at the provincial, rather than the national level. For years, Canadian social workers have been trained in therapy—especially group therapy. As outpatient treatment has begun to overshadow the inpatient approach, there is little doubt that social workers will incorporate these activities as a major area of their professional responsibilities. On an inpatient basis, there are few recently graduated Canadian nurses working in mental institutions who are not familiar with the theory and practice of behaviour modification. The medical profession and hospital administrators are in constant touch with what social workers and nurses can do, and are trained to do. But psychologists are still working on a provincial, or even a hospital-by-hospital level, in trying to define their roles to others. At our present rate, we'll soon be competing with social workers rather than psychiatrists. Everyone knows that, in organizations, power vacuums—arising here from the absence of a strong voice for professional psychology—are soon filled. But here we are, graduating about 100 Ph.D.'s a year in clinical psychology—while other mental health professionals know that the training of these Ph.D.'s has been concerned with the furtherance of psychology as a scholarly discipline rather than with solving the problems of treating the mentally disordered.

But changes are in the air: Bindra (1971) has suggested that new professional training programs be designed in consultation with medical faculties and public service agencies. Arthur (1971) has

outlined a curriculum for a school of professional psychology. And a report prepared by the CPA for the Science Council of Canada, titled "The Future of Canadian Psychology" (1971), includes a compendium of various models which may emerge for the training of applied psychologists.

For the first time, Canada is producing far more Ph.D.'s in psychology than there are academic openings in universities. Thus, the ranks of professional psychology will swell enormously during the next couple of years. This will surely mean that we shall finally have a national accreditation examination, as do all other mental health professions in Canada. It will mean the development of a national professional organization which can carry some weight in influencing university training programs and relevant governmental policy, while maintaining a continuing dialogue with other professions. And finally, it will demand a program for continuing education, and periodic re-accreditation, as befits any profession which is developing and changing as rapidly as psychology.

In summary, mental health services in Canada have been moving toward more preventive health care and outpatient treatment. There has also been a greater concern with being able to account for the efficacy of all such public service activities. The Canadian federal and provincial governments have been generous in providing the necessary funds and encouragement for the development of the necessary physical facilities. Health service professionals, for their part, have generally been coping successfully with the problems of new training demands and the sharing of professional responsibilities. However, the field of psychology, being, in Canada, more academically than professionally oriented, has responded to these changes much too slowly. As a result, psychiatry, social work, and nursing are training their own students to move into areas which, by virtue of interests and field of specialization, should have been incorporated by psychology. Psychology is adapting—but slowly. After all, unlike other health service professions with which it competes, it has no national organization exclusively for the licensing of psychologists. It does not even have national standards as to what constitutes an adequate internship program. It does however have more and more people—nationwide—who have a personal interest in strengthening their professional position. Feelings and communications are sufficiently strong for us to see major improvements in these areas as early as 1973.

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