Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

Prevalence of Mental Illnesses and Related Service Utilization in Canada:

An Analysis of the Canadian Community Health Survey

9

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Prevalence of Mental Illnesses and Related Service Utilization in Canada: An Analysis of the Canadian Community Health Survey

A report for the Canadian Collaborative Mental Health Initiative

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Canadian Collaborative Mental Health Initiative

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O U R G O A L

The Canadian Collaborative Mental Health Initiative (CCMHI) aims to improve the mental health and well-being of Canadians by enhancing the relationships and improving collaboration among health care providers, consumers, families and caregivers; and improving consumer access to prevention, health promotion, treatment/ intervention and rehabilitation services in a primary health care setting.

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EXECUTIVE SUMMARY

To move forward the agenda of collaborative mental health care, it is important to have an understanding of the prevalence of mental illness and related service utilization across the country. How many people seek care providers for mental health reasons? Who do they seek? Do they tend to see more than one person? Of those with a mental disorder, how many will seek care? Are there any noticeable differences across the country? What do these findings indicate in terms of unmet needs? Where should we focus our attention?

In seeking to answer these questions, the Canadian Collaborative Mental Health Initiative (CCMHI), a consortium of 12 national organizations, commissioned this report to analyze the findings from the Canadian Community Health Survey — a survey of 36,984 adult Canadians conducted between May and December 2002 by Statistics Canada.

Key Findings

- In a one-year period, 10% of Canadians used services for their mental health.
- The most widely consulted human resources in descending order are: general practitioners (GP), social workers/counselors/psychotherapists, psychiatrists, psychologists, and self-help groups.
- This trend was different in Quebec, where psychologists were the second group of professionals most often consulted.
- When grouping providers by sector, people most often sought professionals in the general health system, then "other professionals" (e.g., nurses, social workers, religious advisors, acupuncturists, chiropractors, dietitians and others), followed by mental health specialists (i.e., psychiatrists and psychologists) and finally the voluntary sector (i.e., self-help groups, telephone help lines, Internet).
- Half of the time, when a GP was consulted, another professional or mental health specialist was also involved. This is an indicator of potential collaborative mental health care.
- When looking at the prevalence of various mental disorders and substance dependence across the country, there were minor variances but no significant differences.
- Nearly, 40% of Canadians with a self-reported mental health disorder reported using health services for their mental health. There was no statistical difference in the number of Canadians who reported seeking health services for their mental health across provinces.

Conclusion

- Planners, researchers, providers and other stakeholders need to closely examine the reasons why only 40% of Canadians with a self-reported mental disorder seek services for their mental health. For example, a lack of resources, stigma and accessibility to services have all been cited as barriers to care.
- Although Canadians are most likely to seek mental health care from their general practitioner they are also seeking care from other professionals and the voluntary sector. A significant number seek assistance from more than one source. This suggests that a foundation for collaboration in primary health care could be further developed.

INTRODUCTION

The Canadian Collaborative Mental Health Initiative (CCMHI) is a consortium of 12 national organizations, representing community services, consumers, family and self help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers from across Canada. They are working together to improve mental health promotion, mental illness prevention and early detection, and access to the mental health care of Canadians in primary health care. The CCMHI's vision is one of a country where consumers receive the most appropriate service from the most appropriate provider when they need it and in a location that is accessible with the fewest obstacles (CCMHI, 2005).

At the moment, what is known of the mental health and care of Canadians and other citizens in industrialized countries is the "One in five" and "50% rule": mental disorders are prevalent at a rate of one person in five, mainly suffering from anxiety, depression or substance abuse disorders; and less than half of people with mental disorders seek help for their mental health.

The following report provides a Canadian and cross-provincial comparison of:

- service utilization for mental health reasons
- utilization by provider type and sector
- prevalence of mental disorders and unmet needs

For example, a published systematic review and meta-analysis of existing literature showed that only 60% of community-residing individuals who suffer from an affective disorder seek professional assistance, with 76% of these only consulting their general practitioner (GP) (Richards et al., 2004). Finally, the primary medical sector, specifically general practitioners, have been found to be the most often seen for mental health reasons, more than the specialist sector, other professionals, or the voluntary sector in Canada and the USA (Fournier et al., 1997).

The Canadian public health care system should, in principle, be capable of delivering necessary mental health services in a way that is both accessible and effective (Patten & Beck, 2004). Many Canadians, however, as shown above, do not seem to receive the mental health care and support they need. Encouraging more collaboration among primary health care professionals, mental health care providers, consumers, families and community organizations is the goal of the CCMHI, a two-year national initiative being funded by Health Canada's Primary Health Care Transition Fund. The CCMHI will enhance the effectiveness of all health care providers in meeting the mental health needs of Canadians. The Fund encourages reforms in primary health care, to ensure that Canadians have access to the right care, by the right provider, when and where they need it.

To inform its initiative, the CCMHI has commissioned an analysis of the most recent survey of the mental health and care of adult Canadians, conducted in 2002 by Statistics Canada under the name: Canadian Community Health Survey Cycle 1.2 - Mental Health and Well-being. The objectives are to provide the most recent background of the de facto situation in Canada and Canadian provinces. Specifically, the following report will provide Canadian and cross-provincial comparisons of mental health care, the different types of providers with a special attention to primary care providers and potential collaboration among providers, the prevalence of mental disorders, the extent of utilization of services, and the unmet need for care.

METHOD

The Canadian Community Health Survey (CCHS) operates on a two-year collection cycle. The first year of the survey cycle, ".1", features a general population health survey with a large sample designed to provide reliable health-related estimates at the regional level. The second year of the survey cycle, ".2", features a smaller survey designed to provide provincial-level results on specific health topics; here, on mental health and well-being.

Information for the CCHS Cycle 1.2 was collected between May and December 2002 on 36,984 adult Canadians. The primary objectives of the CCHS Cycle 1.2 were to:

1. Provide timely and reliable cross-sectional estimates of mental health determinants, mental health status and mental health system utilization across Canada;
2. Determine prevalence rates of selected mental disorders to assess the burden of illness;
3. Juxtapose access and utilization of mental health services with respect to perceived needs;
4. Assess the disabilities associated with mental health problems.

This report is based on the analysis of the Canadian Community Health Survey – Cycle 1.2. A total of 36,984 Canadians participated in this survey in 2002.

Topics on the survey included lifetime and past 12-month prevalence of various mental disorders (e.g., major depressive episode, manic episode, panic disorder, agoraphobia, social phobia, eating disorders, alcohol and drug dependence), access to and use of mental health care services, and disabilities associated with mental health. The survey also collected information on determinants and correlates of mental health, such as socio-demographic factors, stress, medication use and social support. The content for this study was partly based on a selection of mental disorders from the World Mental Health Survey Initiative (Kessler & Ustun, 2004). The other content areas come from existing sources, such as the CCHS Cycle 1.1 and other special studies. The selection of priority areas in terms of mental disorders and mental well-being was informed by discussions with the Statistics Canada Population Health Surveys Advisory Committee and with a Mental Health Expert Group assembled to advise on the survey. Consultations also included contacts with representatives of the WHO, academia, international, federal, and provincial governments, consumers, and professional associations (Gravel & Béland, 2005).

The CCHS Cycle 1.2 used computer-assisted interviewing and targeted persons aged 15 years and older living in private occupied dwellings in the ten provinces. The survey excludes from its target population those living in the three territories, on Indian Reserves and Crown lands, as well as residents of institutions, full-time members of the Canadian Armed Forces and residents of some remote areas. This survey covers approximately 98% of the population aged 15 or older in the ten provinces. To provide reliable estimates at the provincial level, and given the budget allocated to the Cycle 1.2 component, a sample of 30,000 respondents was desired. Because provinces vary greatly in population size, and that reliable estimates were required both at the national and provincial levels, the sample was allocated among provinces proportionally to

the square root of the estimated population in each province. Prior to the start of the data collection, the provinces of Ontario and Nova Scotia provided extra funds so that a larger sample of dwellings could be selected. The intention of this buy-in was to get sufficient sample size in order to provide reliable estimates for sub-provincial areas. The final sample sizes for Canada and the Canadian provinces are found in the first column of tables 2 and 3.[1]

All descriptive and statistical analyses were carried out at the Montreal Regional Data Centre of Statistics Canada, *Centre interdisciplinaire québécois de statistiques sociales*. The analyses were produced as part of a project financed jointly by Canadian Institutes of Health Research and Statistics Canada, and approved by the Social Sciences and Humanities Research Council of Canada. The research and analysis are based on data from Statistics Canada, but the opinions expressed in this report do not represent those of Statistics Canada. Estimates and 95% Confidence Intervals (95% CI) were obtained from the BOOTVAR programme developed by Statistics Canada (Brisebois & Bédard, 2003). If the number of sampled respondents who contributed to the estimate was less than 30, the weighted estimate was not be released; for weighted estimates based on sample sizes of 30 or more, release depended on the coefficient of variation (CV) of the rounded estimate (i.e., a CV > 33.3 is not releasable). Cross-tabulations were first run on unweighted data to ensure sample sizes were sufficient, and only then were weighted analyses completed.

1 For more information on the questionnaire, sample design, interview training, and data collection procedures, see Gravel and Béland (2005).

RESULTS

Past-year prevalence of provider use for mental health reasons in Canada and in each province

The past-year prevalence of any type of provider use (see side notation for definition of provider) for mental health reasons in Canada was 9.5% (95% CI- 9.1%, 10.0%) (Graph 1). The prevalence rates by province for any type of provider use, with provinces being presented east to west, are as follows:

Newfoundland and Labrador - 6.7% (5.3%, 8.0%);
Prince Edward Island - 7.5% (5.8%, 9.3%);
Nova Scotia - 11.3% (9.6%, 13.0%);
New Brunswick - 9.5% (7.9%, 11.0%);
Quebec - 9.6% (8.4%, 10.7%);
Ontario - 8.7% (8.1%, 9.4%);
Manitoba - 10.5% (8.8%, 12.2%);
Saskatchewan - 9.8% (8.3%, 11.3%);
Alberta – 9.7% (8.4%, 11.1%);
British Columbia - 11.3% (10.1%, 12.6%).

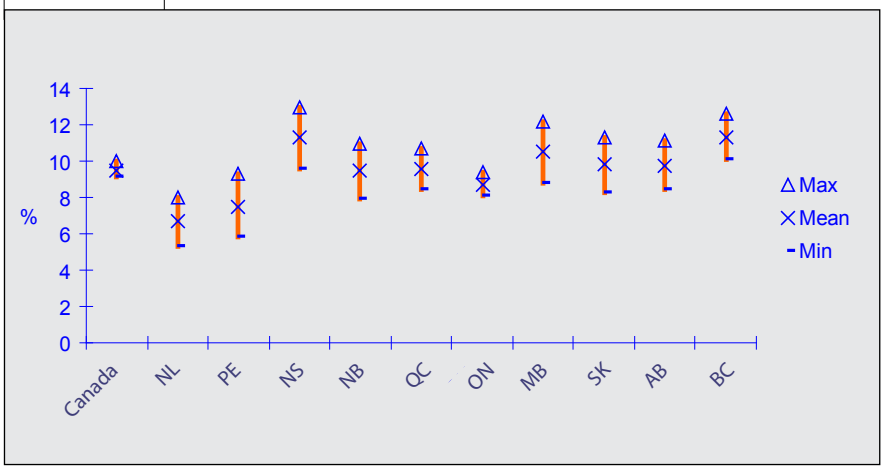
Provider Use:

Have you ever seen, or talked on the telephone to any of the following professionals about your emotions, mental health or use of alcohol or drugs?

Interviewer: read categories to respondents. Mark all that apply.

1. Psychiatrist
2. Family doctor or general practitioner
3. Other medical doctor, such as, cardiologist, gynaecologist, or urologist
4. Psychologist
5. Nurse
6. Social worker, counsellor or psychotherapist
7. Religious or spiritual advisor, such as, priest, chaplain or rabbi
8. Other professional
9. None

graph 1 **Past-year prevalence of any type of resource use for mental health reasons**



NFL: Newfoundland and Labrador; PE: Prince Edward Island; NS: Nova Scotia; NB: New Brunswick; QC: Quebec; ON: Ontario; MB: Manitoba; SK: Saskatchewan; AB: Alberta; BC: British Columbia.

The most widely consulted professional for mental health reasons across the provinces was a general practitioner (Table 1 and Graph 2). An individual respondent may have seen more than one type of provider.[2] Nova Scotia and British Columbia respondents reported seeing more GPs for mental health reasons. Prince Edward Island reported the lowest utilization rate for GPs. The difference was statistically significant and can be seen in Table 1, where the lower bound of the 95% CI for Nova Scotia, 6.2%, does not overlap with the higher bound for Prince Edward Island at 4.0%.

How to read 95% confidence intervals (95% CI):

The difference between two groups is said to be statistically significant when the boundaries of group A CI do not overlap with the boundaries of group B CI.

For example, in Canada (see Table 1), the difference between the GP use (5.3) and SW use (2.3) is statistically significant. While the difference between SW use (2.3) and PSY use (2.0) is not statistically significant.

In Canada, social workers/counselors/psychotherapists were the second most common group consulted. Psychologists and psychiatrists tied for third.

In Quebec, psychologists were the second group of professionals most often consulted in the past year, with more people having reported seeing them than in any other Canadian province.

In Nova Scotia, more people reported having seen a psychiatrist in the past year. Quebec reported the lowest utilization rate for psychiatrists.

Notable among the voluntary sector, self-help groups came fifth for all types of providers, with Prince Edward Island reporting highest use and Newfoundland and Labrador the lowest use of the voluntary sector, self-help groups.

2 The addition of all the providers is greater than the overall utilization reported in the first paragraph, because an individual may have seen more than one provider in the past year.

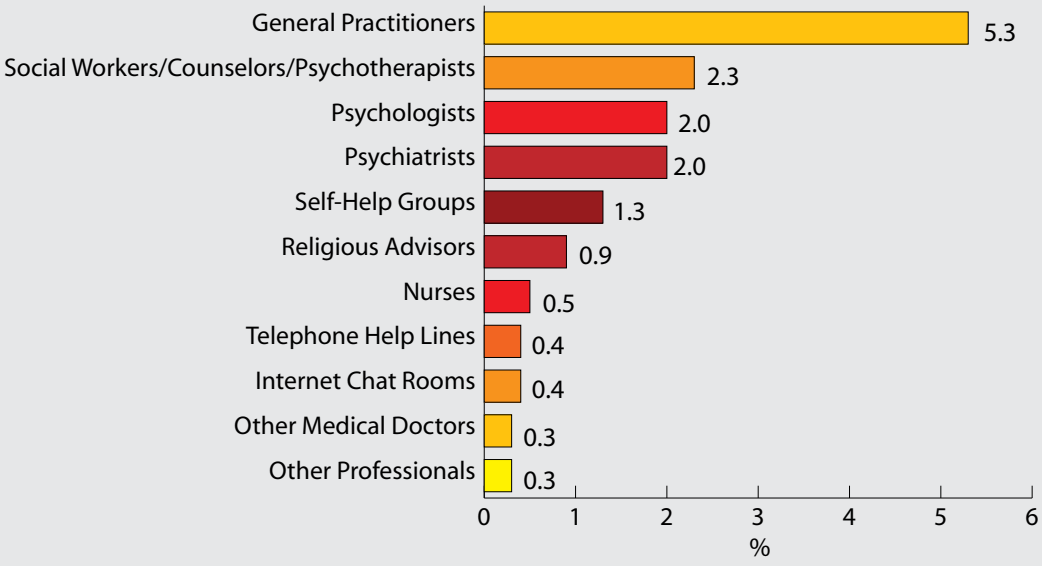
table 1 **Past-year use by type of provider**

	Past-year use by type of provider: Prevalence % (95% CI)										
	GP	**SW**	**PSY**	**Ψ**	**SHG**	**RA**	**NUR**	**TEL**	**INT**	**MD**	**OTH**
CAN	5.3 (5.0-5.7)	2.3 (2.0-2.5)	2.0 (1.8-2.2)	2.0 (1.8-2.2)	1.3 (1.2-1.5)	0.9 (0.8-1.1)	0.5 (0.4-0.6)	0.4 (0.4-0.5)	0.4 (0.3-0.5)	0.3 (0.2-0.4)	0.3 (0.2-0.4)
NL	4.8 (3.5-6.0)	1.9 (1.0-2.8)	0.7 (0.2-1.2)	1.5 (0.8-2.2)	0.4 (0.1-0.8)	0.8 (0.2-1.4)	-	-	0.3 (0.03-0.6)	-	-
PE	2.9 (1.9-4.0)	2.3 (1.2-3.3)	0.8 (0.2-1.3)	1.5 (0.7-2.4)	2.4 (1.3-3.6)	0.4 (0.03-0.8)	-	-	0.5 (-0.03-1.0)	-	-
NS	7.4 (6.2-8.6)	1.7 (1.2-2.2)	1.7 (1.0-2.5)	2.6 (1.8-3.4)	1.4 (0.8-1.9)	1.1 (0.5-1.6)	0.5 (0.2-0.8)	0.3 (0.02-0.6)	0.2 (0.01-0.4)	0.4 (0.1-0.7)	0.2 (0.1-0.4)
NB	5.0 (3.8-6.2)	1.6 (1.0-2.2)	2.0 (1.3-2.7)	2.2 (1.5-3.0)	0.9 (0.5-1.4)	0.6 (0.3-1.0)	0.6 (0.2-0.9)	0.2 (-0.01-0.5)	0.3 (0.03-0.5)	0.4 (0.1-0.7)	-
QC	4.9 (4.1-5.6)	1.8 (1.1-2.5)	3.9 (3.2-4.6)	1.3 (0.9-1.6)	1.2 (0.8-1.6)	0.4 (0.2-0.7)	0.4 (0.2-0.5)	0.5 (0.3-0.6)	0.3 (0.1-0.4)	0.2 (0.1-0.3)	0.4 (0.2-0.7)
ON	5.3 (4.8-5.8)	2.2 (1.9-2.5)	1.1 (0.9-1.3)	2.3 (2.0-2.7)	1.0 (0.8-1.2)	0.9 (0.7-1.1)	0.5 (0.4-0.7)	0.4 (0.3-0.5)	0.4 (0.3-0.5)	0.4 (0.2-0.5)	0.3 (0.2-0.40)
MB	5.1 (3.9-6.4)	2.4 (1.5-3.3)	1.2 (0.6-1.8)	2.5 (1.5-3.5)	1.5 (0.8-2.2)	1.3 (0.8-1.9)	0.9 (0.3-1.4)	0.4 (0.1-0.6)	0.6 (0.2-0.9)	0.5 (0.1-0.9)	-
SK	4.5 (3.5-5.5)	3.1 (2.2-4.0)	1.0 (0.4-1.5)	1.7 (1.1-2.4)	2.5 (1.6-3.5)	1.7 (1.0-2.4)	0.5 (0.2-0.9)	0.4 (0.1-0.7)	0.2 (0.01-0.4)	0.2 (0.05-0.4)	0.4 (0.1-0.7)
AB	5.1 (4.2-6.1)	2.0 (1.5-2.5)	2.0 (1.4-2.7)	2.0 (1.4-2.7)	2.1 (1.5-2.8)	1.4 (0.9-1.8)	0.4 (0.2-0.6)	0.4 (0.2-0.7)	0.7 (0.4-1.1)	0.2 (0.03-0.30)	0.1 (0.02-0.3)
BC	6.6 (5.6-7.6)	3.5 (2.8-4.2)	1.7 (1.2-2.2)	2.0 (1.4-2.5)	1.7 (1.2-2.1)	1.5 (1.0-2.0)	0.7 (0.4-1.0)	0.7 (0.4-1.0)	0.3 (0.1-0.5)	0.3 (0.2-0.5)	0.5 (0.3-0.8)

GP: General Practitioners; SW: Social Workers/Counselors/Psychotherapists; PSY: Psychologists; Ψ: Psychiatrists; SHG: Self-Help Groups; RA: Religious Advisors; NUR: Nurses; TEL: Telephone Help Lines INT: Internet Chat Rooms; MD: Other Medical Doctors; OTH: Other Professionals.

CAN: Canada; NL: Newfoundland and Labrador; PE: Prince Edward Island; NS: Nova Scotia; NB: New Brunswick; QC: Quebec; ON: Ontario; MB: Manitoba; SK: Saskatchewan; AB: Alberta; BC: British Columbia.

graph 2 **Past-year use by type of provider in Canada**



Utilization grouped by sector

Providers can be grouped into four sectors: specialty mental health services, the general medical system, other professionals and the voluntary support network (Table 2 and Graph 3).[3] An individual respondent may have seen more than one type of provider and received care from more than one sector.[4] The general medical system is the most often frequented for mental health reasons, more than the other three sectors in Canada. It remains true for all Canadian provinces, but with differences in the magnitude of the disparity because of the relative importance of specific sectors. The use of specialty mental health services were higher in Quebec and New Brunswick than in Prince Edward Island and Newfoundland and Labrador, the two provinces with the lowest use of specialty mental health services. Other professionals were more frequently used in British Columbia and Saskatchewan, and lowest in the four Maritime Provinces. The use of the voluntary support network is most notable in the western provinces and Prince Edward Island, but lower in Newfoundland and Labrador, New Brunswick, Ontario, and Quebec.

In the past year, more Canadians reported consulting a physician for mental health reasons, than professionals in the specialty mental health services, other professionals or the voluntary support network sectors.

3 Table 2 also provides the sample sizes in Canada and in each province.

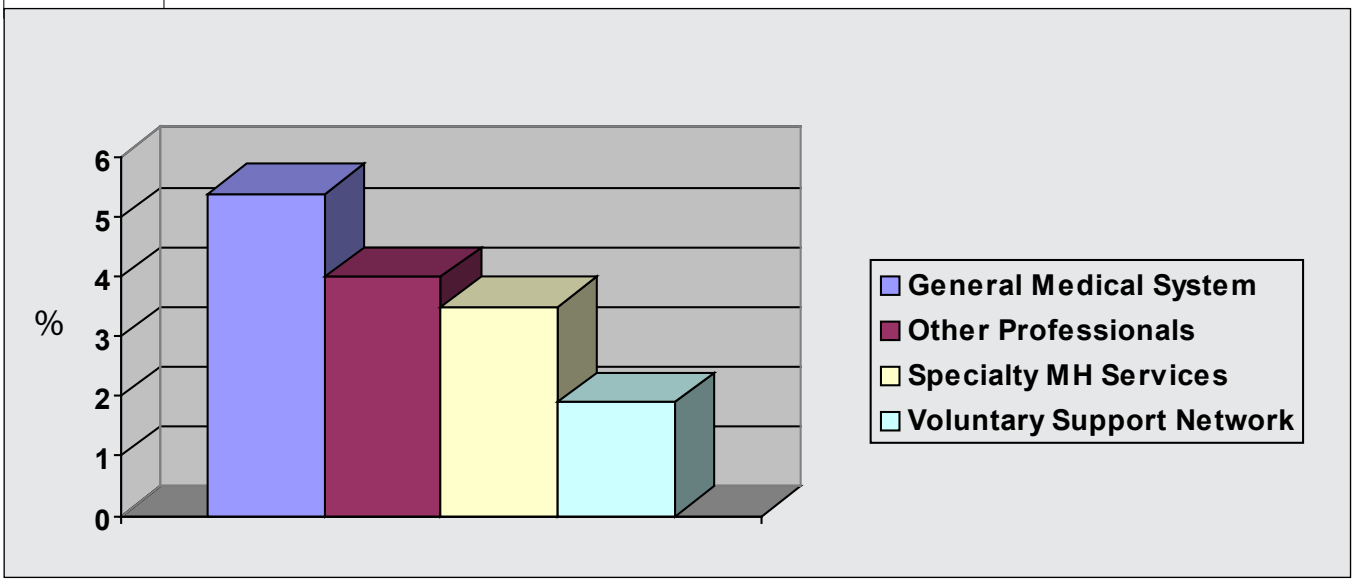
4 The addition of the four sectors is greater than the overall utilization because individuals may have consulted more than one type of services provider.

table 2 **Type of sector use for mental health reasons in the past year**

	Past-year use by type of sector: Prevalence % (95% CI)			
	*General Medical System	*Other Professionals	*Specialty MH Services	*Voluntary Support Network
Canada (N=36,984)	5.4 (5.1 – 5.8)	4.0 (3.7 – 4.3)	3.5 (3.2 – 3.8)	1.9 (1.7 – 2.1)
NL (N=649)	4.8 (3.5 – 6.0)	2.8 (1.7 – 3.8)	1.8 (1.0 – 2.5)	0.8 (0.3 – 1.3)
PE (N=166)	3.1 (2.1 – 4.1)	3.3 (2.2 – 4.5)	1.7 (0.9 – 2.6)	3.2 (1.9 – 4.4)
NS (N=1,119)	7.6 (6.4 – 8.9)	3.4 (2.7 – 4.2)	3.8 (2.8 – 4.9)	1.7 (1.1 – 2.4)
NB (N=900)	5.2 (4.0 – 6.5)	2.8 (2.0 – 3.6)	3.9 (3.0 – 4.8)	1.3 (0.7 – 1.8)
QC (N=8,938)	4.9 (4.2 – 5.7)	3.7 (2.8 – 4.5)	4.6 (3.9 – 5.3)	1.6 (1.2 – 2.1)
ON (N=14,286)	5.4 (4.9 – 5.9)	3.7 (3.3 – 4.1)	3.1 (2.7 – 3.5)	1.6 (1.4 – 1.9)
MB (N=1,280)	5.3 (4.0 – 6.6)	4.7 (3.6 – 5.9)	3.4 (2.3 – 4.5)	2.3 (1.4 – 3.1)
SK (N=1,123)	4.5 (3.5 – 5.5)	5.0 (3.8 – 6.1)	2.5 (1.7 – 3.4)	2.9 (1.9 – 3.9)
AB (N=3,594)	5.1 (4.1 – 6.1)	3.8 (3.1 – 4.5)	3.4 (2.6 – 4.3)	2.9 (2.1 – 3.6)
BC (N=4,930)	6.6 (5.6 – 7.6)	5.7 (4.8 – 6.6)	3.3 (2.6 – 4.0)	2.5 (1.9 – 3.0)

* Definitions adapted from Fournier et al. (1997)
Specialty MH Services: Psychiatrists and psychologists
General Medical System: General practitioners and other medical specialists
Other Professionals: Nurses, social workers, religious advisors, acupuncturists, chiropractors, dietitians, etc.
Voluntary Support Network: Internet support groups/chat rooms, self-help groups, telephone help lines
NL: Newfoundland and Labrador; PE: Prince Edward Island; NS: Nova Scotia; NB: New Brunswick; QC: Quebec; ON: Ontario; MB: Manitoba; SK: Saskatchewan; AB: Alberta; BC: British Columbia.

graph 3 **Type of sector use for mental health reasons in the past year in Canada**



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Other Professionals: Nurses, social workers, religious advisors, acupuncturists, chiropractors, dietitians, etc.
Voluntary Support Network: Internet support groups/chat rooms, self-help groups, telephone help lines

Estimating potential collaboration with primary care providers

CCMHI has searched for data that would report on the level of collaboration among health and mental health care professionals. At this time, there is no systematically collected data that provides a measure of collaboration among providers. Data that may inform the discussion on collaboration is the number of people who consulted one or more professionals for their mental health.

Of the three categories of professionals, Canadians reported most often seeking care for mental health reasons from a GP.

Three mutually exclusive categories were created: those who consulted a GP only, a GP and another health professional, and, any professional other than a GP (Table 3 and Graph 4).[5] For those who visited GP, one half saw only the GP, while the other half also received care from another health professional. GPs were the single most frequently seen health providers. However the number of people who visited any professional other than a GP was remarkably higher than those who sought assistance from a GP only.

5 Their addition is slightly lower than the overall utilization because it does not include the voluntary sector in this specific analysis.

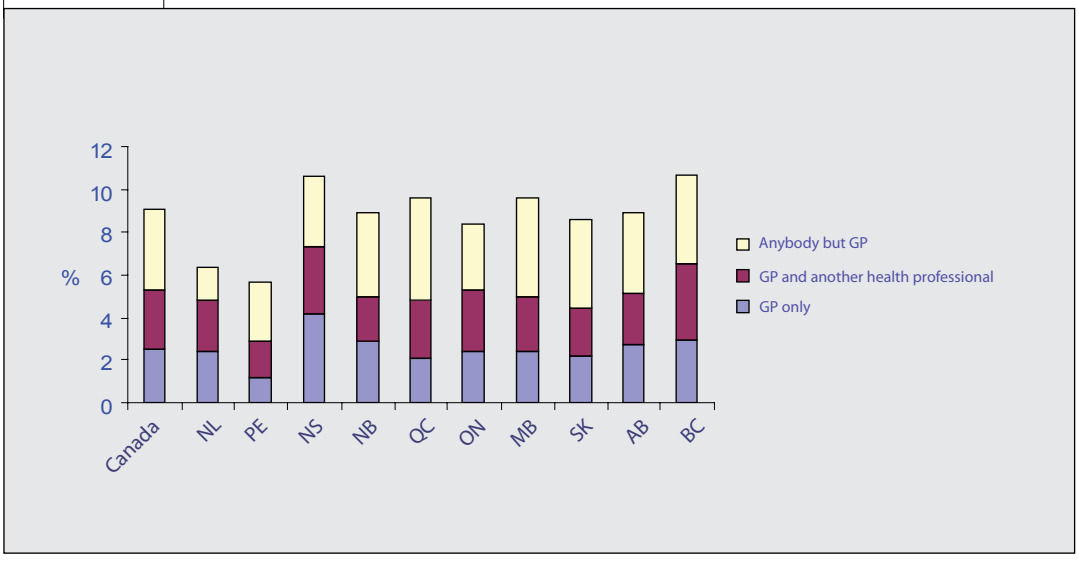
table 3 **Prevalence of type of provider use combinations for mental health reasons in the past year**

	Past-year use by type of provider: Prevalence % (95% CI)		
	GP only	**GP and another health professional ***	**Anybody but GP**
Canada (N=36,984)	2.5 (2.3 – 2.7)	2.8 (2.6 – 3.1)	3.8 (3.5 – 4.1)
NL (N=649)	2.4 (1.5 – 3.2)	2.4 (1.4 – 3.4)	1.6 (0.8 – 2.4)
PE (N=166)	1.2 (0.6 – 1.9)	1.7 (0.9 – 2.4)	2.8 (1.7 – 3.9)
NS (N=1,119)	4.2 (3.3 – 5.1)	3.1 (2.4 – 3.9)	3.3 (2.3 – 4.2)
NB (N=900)	2.9 (2.0 – 3.9)	2.1 (1.4 – 2.7)	3.9 (2.9 – 4.8)
QC (N=8,938)	2.1 (1.6 – 2.6)	2.7 (2.1 – 3.3)	4.8 (3.9 – 5.7)
ON (N=14,286)	2.4 (2.1 – 2.7)	2.9 (2.5 – 3.2)	3.1 (2.7 – 3.4)
MB (N=1,280)	2.4 (1.7 – 3.2)	2.6 (1.6 – 3.6)	4.6 (3.5 – 5.7)
SK (N=1,123)	2.2 (1.5 – 2.9)	2.2 (1.4 – 3.0)	4.2 (3.2 – 5.2)
AB (N=3,594)	2.7 (2.0 – 3.4)	2.4 (1.8 – 3.0)	3.8 (3.0 – 4.5)
BC (N=4,930)	3.0 (2.3 – 3.6)	3.5 (2.8 – 4.3)	4.2 (3.4 – 5.1)

* GP and another health professional: GP and any one of specialty mental health services, general medical system, and other professionals (definition adapted from Fournier et al., 1997)

NL: Newfoundland and Labrador; PE: Prince Edward Island; NS: Nova Scotia; NB: New Brunswick; QC: Quebec; ON: Ontario; MB: Manitoba; SK: Saskatchewan; AB: Alberta; BC: British Columbia.

graph 4 **Prevalence of type of provider use combinations for mental health reasons in the past year**



Prevalence of mental disorders in the past year

The previous results summarized the health service utilization for mental health, including the number of people who sought services, and from which profession and sector they sought these services. The next two sections consider the need and thus potential unmet need for mental health services.

The presence of a mental disorder in the past year is an indicator of need, even though other dimensions like distress, disability, suicidal ideation could also be seen as indicators of need (Vasiliadis et al., 2005). Table 4 shows the prevalence of past-year self-reported disorders as defined by Statistics Canada (Gravel and Béland, 2005). Slightly higher rates were found in British Columbia and Alberta, associated with higher rates of mania and alcohol dependence. Alcohol dependence was similarly high in Saskatchewan and Manitoba. Depression, at 4.8% in Canada, did not differ significantly, with lower rates noted in Prince Edward Island and in New Brunswick; panic disorder followed the same pattern. Otherwise, no significant differences were noted across provinces for other disorders.

table 4 **Past-year prevalence rate of a mental disorder**

	Past-year prevalence rate % (95% CI)							
	Any disorder	**Depression**	**Social phobia**	**Alcohol dep.**	**Panic disorder**	**Mania**	**Drug dep.**	**Agora-phobia**
Canada	10.9 (10.5-11.4)	4.8 (4.5-5.1)	3.0 (2.8-3.3)	2.6 (2.4-2.8)	1.5 (1.4-1.7)	1.0 (0.8-1.1)	0.8 (0.6-0.9)	0.7 (0.6-0.9)
NL	9.2 (7.5-10.9)	3.7 (2.8-4.7)	2.7 (1.8-3.6)	3.2 (2.0-4.4)	1.9 (0.8-2.9)	0.8 (0.3-1.2)	0.6 (0.2-1.0)	0.4 (0.1-0.8)
PE	7.9 (6.1-9.7)	2.6 (1.6-3.6)	2.3 (1.5-3.1)	2.8 (1.7-4.0)	0.4 (0.02-0.7)	-	-	-
NS	11.6 (9.9-13.3)	4.6 (3.6-5.5)	4.3 (3.1-5.4)	3.2 (2.2-4.2)	1.5 (1.0-2.1)	0.8 (0.4-1.1)	0.6 (0.3-0.9)	1.1 (0.6-1.5)
NB	9.5 (8.1-11.0)	3.5 (2.6-4.4)	2.7 (2.0-3.5)	2.0 (1.3-2.7)	2.2 (1.3-3.1)	0.7 (0.3-1.2)	0.8 (0.3-1.3)	0.8 (0.3-1.3)
QC	10.2 (9.1-11.3)	4.9 (4.1-5.6)	2.0 (1.6-2.4)	1.9 (1.4-2.4)	1.4 (1.0-1.8)	0.8 (0.5-1.0)	0.9 (0.6-1.3)	1.0 (0.6-1.4)
ON	10.7 (10.0-11.4)	4.8 (4.3-5.3)	3.3 (2.8-3.7)	2.1 (1.8-2.4)	1.5 (1.2-1.7)	0.9 (0.7-1.0)	0.6 (0.4-0.7)	0.6 (0.5-0.8)
MB	11.3 (9.7-12.8)	4.7 (3.6-5.8)	3.5 (2.6-4.4)	3.6 (2.7-4.4)	1.4 (0.8-2.0)	0.7 (0.3-1.1)	0.6 (0.3-0.9)	0.2 (0.01-0.4)
SK	11.9 (10.2-13.6)	4.1 (3.1-5.0)	3.5 (2.6-4.5)	4.0 (3.1-5.0)	2.0 (1.2-2.7)	0.7 (0.3-1.1)	0.8 (0.4-1.2)	0.6 (0.1-1.0)
AB	12.1 (10.6-13.6)	5.7 (4.6-6.7)	3.1 (2.4-3.9)	3.5 (2.8-4.2)	1.7 (1.1-2.3)	1.5 (1.0-1.9)	1.0 (0.6-1.4)	0.7 (0.4-1.1)
BC	12.4 (10.9-13.8)	4.9 (4.1-5.6)	3.6 (2.8-4.3)	3.6 (2.9-4.4)	1.6 (1.1-2.1)	1.5 (1.1-2.0)	1.1 (0.6-1.6)	0.7 (0.4-0.9)

NL: Newfoundland and Labrador; PE: Prince Edward Island; NS: Nova Scotia; NB: New Brunswick; QC: Quebec; ON: Ontario; MB: Manitoba; SK: Saskatchewan; AB: Alberta; BC: British Columbia.

Resource use for mental health reasons among respondents with a disorder

Need is but one determinant of utilization, but the most constant one (Vasiliadis et al., 2005). Table 5 shows the extent of utilization of services for mental health reasons when at least one disorder is present. Just over a third of individuals with a mental disorder or substance dependence consulted for mental health reasons in the past year. A difference appears across provinces but is not statistically significant [consider that the highest bound of the 95% CI for the P.E.I. estimate at 45.4% overlap with British Columbia's (38.3% - 49.2%)].

Nearly 40% of Canadians with a self-reported mental disorder reported using health services for their mental health.

table 5

Prevalence of any type of resource use for mental health reasons among respondents with a disorder and/or substance dependence

	Prevalence rate % (95% CI)
Canada	38.5% (36.2% - 40.7%)
Newfoundland & Labrador	38.2% (27.5% - 48.8%)
Prince Edward Island	34.4% (23.5% - 45.4%)
Nova Scotia	42.3% (35.6% - 49.0%)
New Brunswick	41.9% (32.8% - 50.9%)
Quebec	38.5% (33.0% - 43.9%)
Ontario	35.7% (32.2% - 39.3%)
Manitoba	34.7% (26.5% - 42.9%)
Saskatchewan	37.8% (29.6% - 46.1%)
Alberta	40.7% (34.4% - 47.0%)
British Columbia	43.7% (38.3% - 49.2%)

DISCUSSION

As reviewed in the introduction, the literature frequently reports that one in five people will have a mental disorder and that 50% of these individuals will seek help for their mental health. Are the results of the most recent and comprehensive mental health survey of adult Canadians consistent with these findings?

The exact figures relating to the prevalence of mental disorders are lower than in previous studies, but this can be explained by fewer mental disorders being included in the analysis so that the "1 in 5" would likely still be applicable. Past-year prevalence of mental disorders reported in an earlier Ontario Mental Health Survey (17.8%), Edmonton survey (17.1%), US Epidemiologic Catchment Area study in the 80s (20%), and the recent national co-morbidity survey in the US (29.5%) (Fournier et al., 1997), were based on a larger coverage of mental disorders. For example, they covered generalized anxiety disorder and specific phobias. A brief recalculation of the rates obtained in the Ontario Mental Health Survey, including only the disorders that were covered by the CCHS1.2, produced lower rates than those reported in the former and similar rates to the latter (personal communication from Betty E. Lin). Specific disorders that were measured in the CCHS1.2, such as major depression, had very similar rates than in a systematic literature review conducted by Waraich et al. (2003), in which the best one-year and lifetime estimates for major depression were 4.1% and 6.7% respectively.

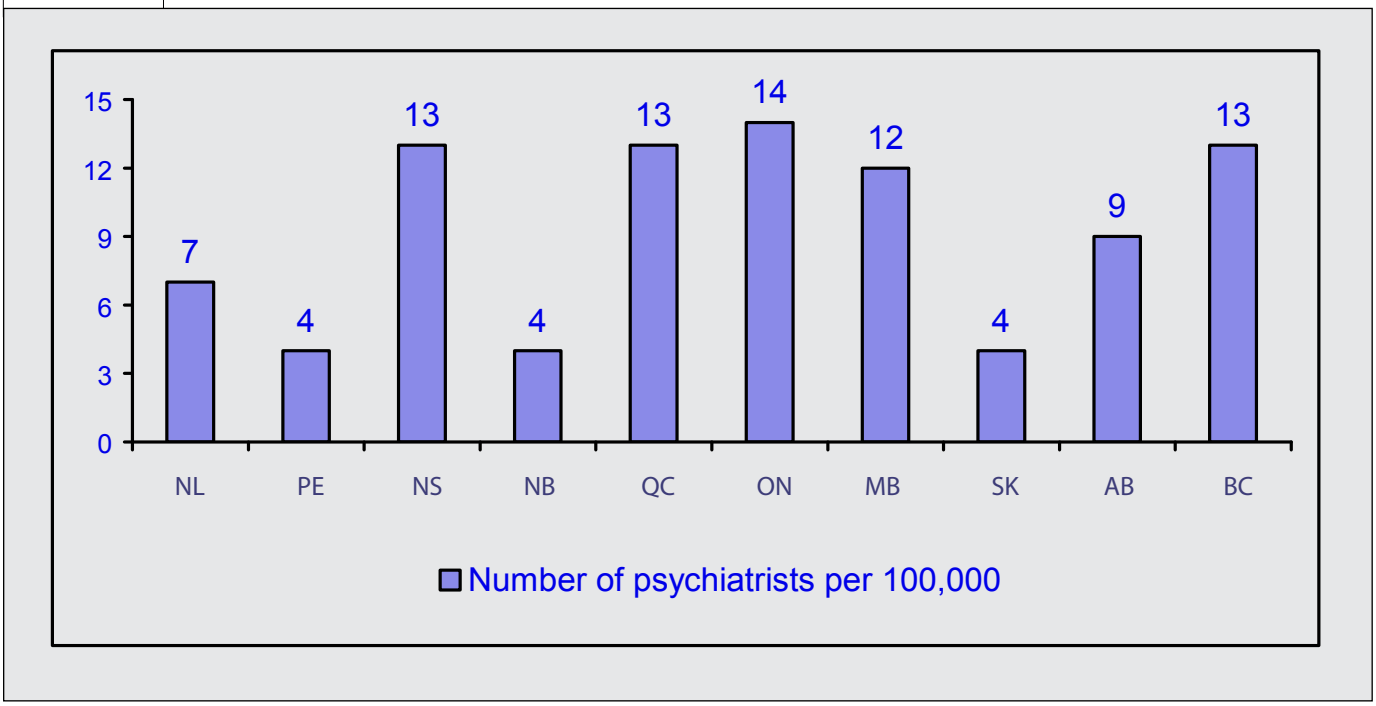
Less than 40% of Canadians with a self-identified mental disorder, including substance dependence, consulted at least one type of public, private or voluntary provider in the past year, which is lower than the 50% rule. However, by encompassing substance dependence in the definition of mental disorders, which has been reported to be less associated with the likelihood of consulting (Vasiliadis et al., 2005), we lower the overall rate of consultation. It could also be argued that the identification of a mental disorder does not equate with a need for care — research instruments may yield false positive, but also false negative. On the other hand, receiving services does not mean that needs are met. The few studies that have relied on intensive clinical appraisal of needs for care have found rates of needs for care at least similar to the one-year prevalence of disorders in the survey. For example, Fournier et al., found that nearly 18% of the Montreal adults were in need of mental health care and less than one in six had their needs for care met (Fournier et al., 2002).

There are more similarities than differences across provinces in the utilization of services for mental health reasons, especially with regards to consulting or not. Differences are found in the types of providers that are seen. The result of the examination of the different types of providers, included in this survey, that are seen for mental health reasons reveal that general practitioners are the single provider most often seen for mental health reasons; social workers/counselors/psychotherapists are the second group most frequently consulted; while psychologists and psychiatrists tied for third across the country. Differences are noted across provinces with Nova Scotians reporting having seen their general practitioner more often for mental health reasons. In a similar vein, Quebecers reported seeing psychiatrists less often than was reported in the other provinces, while reports about seeing a psychologist were almost two times more likely in Quebec than in Canada.

In explaining these differences, Canadian and provincial planners, decision makers and stakeholders need to consider two important factors, namely the number of providers and the

mode of practice of these providers. Consider for example the population ratio of psychiatrists across Canadian provinces, available from the Canadian Institute of Health Information (Graph5). The number of psychiatrists is two to three times lower in several Canadian provinces such as New Brunswick and Prince Edward Island than in Ontario, Quebec, British Columbia and Nova Scotia. Despite similar ratios, there are other variables to be considered that explain some of the observed differences, for example, why Nova Scotians are twice more likely to see a psychiatrist than Quebecers (Table 1). Since the number of providers is similar, a difference in practice or geographical barriers could be part of the explanation. Perhaps, Quebec psychiatrists may be less available as consultants to primary care and concentrate more exclusively on treating more intensively a smaller number of mentally ill people than their provincial counterparts.

graph 5 **Number of psychiatrists per 100,000 per province**



NL: Newfoundland and Labrador; PE: Prince Edward Island; NS: Nova Scotia; NB: New Brunswick; QC: Quebec; ON: Ontario; MB: Manitoba; SK: Saskatchewan; AB: Alberta; BC: British Columbia.

The differences in the number of providers available in each province may however explain some of the differences in services utilization for other professionals. For example, examining the ratio of psychologists in Quebec, psychiatric nurses in Manitoba and social workers in British Columbia may reveal higher numbers than in other provinces, pointing to this type of explanation for higher prevalence of consultation with this type of provider. The present report's results could therefore serve as a catalyst in each jurisdiction to examine the reasons for these differences and the best direction to be taken in order to improve mental health care and the potential of collaborative care.

Collaborative care involves communication between providers concerning the patient, but this could not be assessed in this respondent-based survey. The data did reveal that Canadians will seek a GP for mental health reasons and that half the patients seen by a primary medical care provider for mental health reasons will see another type of provider. If Canadians consult their GPs for their mental health needs, they also seek out other health resources at about the same rate, sometimes with and sometimes without also seeing a GP. This indicates that there is likely to be tremendous opportunity for health professionals to work collaboratively to improve the care and services of people seeking mental health treatment and support.

The data also revealed differences between provinces in the types of providers seen as indicated above, but the different combinations gave a similar rate of potential collaboration with different providers. For example, psychologists play a greater role in Quebec; nurses, in Manitoba; and social workers/counselors/psychotherapists and self-help groups in Saskatchewan, British Columbia, and Prince Edward Island. The varying utilization rates of the different provider groups in each province may indicate to planners which provider groups have been engaged in collaborative mental health care and could participate in the development and implementation of collaborative mental health care. Due to the limitations of this survey, a number of resources may currently be accessed by Canadians and not be reported in this report. A number of provider groups were not offered as optional responses in the survey (e.g., occupational therapists and pharmacists); social workers, counselors and psychotherapists were considered together. Yet we know that these groups offer necessary services to patients with a mental disorder. For example, in a Canadian study of patients prescribed antidepressants, 50% of this group indicated that their initial concerns about being prescribed medications were resolved by pharmacists (Gardner et al., 2001). The CCHS 1.2 did not reach individuals in institutions and homeless shelters, many of which have mental disorders - often serious mental illnesses with special needs for services. Planners should pay close attention to the utilized and underutilized resources in their community and invite all stakeholders to collaborate.

We know that approximately 40 per cent of Canadians reported seeking services for their mental health — why don't the others? We have discussed the availability of providers and mode of practice of providers as one set of explanations. What are the reasons that Canadians do not consult for mental health reasons? Are there individual factors that prevent people from seeking services? These individual factors that bring people to seek care or prevent people from seeking care were not explored in the present report, but reported elsewhere in terms of the factors that favour or hinder utilization (Bergeron et al., 2005; Starkes, Poulin & Kisely, 2005; Vasiliadis et

al., 2005). Vasiliadis et al. (2005) reported that the presence of mental disorders, including depression and anxiety disorders but not substance abuse, was consistently associated with the utilization of services for mental health reasons. Predisposing factors were also systematically identified, with younger and older Canadian less likely to consult. Women are more likely to consult; and being single or separated or divorced, less educated, and born in Canada increases the likelihood of consulting. Among the barriers, income was remarkably absent, but social support, accessibility, acceptability, and availability were identified. Among these barriers, the most important and frequent one was related to acceptability, with more than half of Canadians reporting not receiving care when needed because either they preferred to manage by themselves or felt that nothing would help.

The Canadian Alliance on Mental Illness and Mental Health recognizes combating the stigma of mental disorders and dependencies as one of the most pressing priorities for enhancing the mental health of Canadians (Health Canada, 2002). The high response rates for acceptability reasons may be an indication of the lack of understanding among some Canadians regarding mental disorders and how to treat them. These findings also echoed other studies and highlight the importance of continuously educating both the public and health care professionals regarding early recognition of a problem and encouraging individuals to seek care (Health Canada, 2002).

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