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The Human Face of Mental Health and Mental Illness in Canada 2006



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- **Mood Disorders Society of Canada**
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- **Statistics Canada**
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The Human Face of Mental Health and Mental Illness in Canada is endorsed by the following organizations that believe in its purpose and collectively wish to improve the mental health of all Canadians and the health of those who live with mental illness.

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Canadian Academy of Geriatric Psychiatry
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Canadian Psychiatric Association
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Mood Disorders Society of Canada
National Network for Mental Health
Native Mental Health Association
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Minister of Health



Ministre de la Santé

Canada



Minister's Message

The human suffering associated with mental illness is something that more than one in five Canadians face at some point in their life. Our individual experiences with mental illness vary, but what is clear is Canadians' desire to help those suffering from the illness and to help their families and loved ones. It is only through research and dedication towards understanding more about mental illness and the best ways to cope and treat the illness, that we will make strides towards progress. This report, *The Human Face of Mental Health and Mental Illness in Canada*, does just that.

The report helps outline what each of us can do to improve one's own mental health and the mental health of those around us. It is designed to increase public awareness of mental illness and mental health, and to help Canadians realize the great strides we are making towards the illness and Canada's new Government's commitment to mental health.

Without the commitment of the Public Health Agency of Canada, Health Canada, the Mood Disorder Society of Canada, Statistics Canada, the Canadian Institute of Health Information, and several other supporting organizations, the report would not have been possible. Thank you to them and to their ongoing commitment to the good mental health of all Canadians.

I trust that you will find understanding, meaning and hope, as I did, in the pages of this report. We all look forward to future updates and advances in mental health and illness.

A handwritten signature in black ink, appearing to read 'Tony Clement'.

Tony Clement
Minister of Health
Government of Canada

A WORD TO BEGIN...

Welcome to the report on *The Human Face of Mental Health and Mental Illness in Canada*. Its purpose is to raise awareness and increase knowledge and understanding about mental health and mental illness in Canada.

This report is the culmination of many hours of work by many dedicated people who care about improving the quality of life of people coping with mental illness and their families, and who believe in the power of positive mental health to help people “realize aspirations, satisfy needs and ... cope with a changing environment.”¹

Like its predecessor, *A Report on Mental Illnesses in Canada*, this report includes a general chapter on Mental Illness and chapters on Mood Disorders, Schizophrenia, Anxiety Disorders, Personality Disorders, Eating Disorders, and Suicidal Behaviour. New chapters have been added on mental health, problematic substance use, gambling, hospitalization, and Aboriginal people’s mental health and well-being.

The information in the previous report has been updated and new data has been added from the 2002 Statistics Canada, Canadian Community Health Survey Cycle 1.2: Mental Health and Well-being², the 2002-2003 Hospital Mental Health Database³, and the 2004 Health Behaviours of School Children Survey⁴.

Much confusion exists about the difference between mental health and mental illness in the past because the two words are sometimes used to mean the same thing. In this report, they have two distinct meanings.

Chapter 1 explores **mental health** - the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges that we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity.⁵ Everyone benefits from positive mental health. The determinants of mental health go well beyond individual attitudes, beliefs and behaviours: the family, the community, the school and workplace environments all contribute to mental health. Thus, one could say that every single individual and organization has a role to play in promoting the mental health of Canadians.

Chapter 2 explores **mental illness** – a biological condition of the brain that causes alterations in thinking, mood or behaviour (or some combination thereof) associated with significant distress and impaired functioning. Mental illness affects approximately 20% of Canadians during their lifetime. Most mental illness can be treated, and placing treatment within a recovery model encourages individuals to go beyond symptom reduction to improved quality of life. Supportive community, education and workplace environments facilitate recovery. People with mental illness who have positive mental health are better able to cope with the symptoms of mental illness.

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Phil Upshall of the Mood Disorder Society of Canada facilitated communication and discussions with the professional and consumer communities and led the initial launch of the report.

We encourage everyone to read this report with an inquisitive, open mind. Reducing the stigma associated with mental illness is one of the single most important challenges this country faces to enhance the recovery of persons with mental illness. We all have a part to play in this. Think about what you can do to make a difference and share this report with others.

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CHAPTER 1

MENTAL HEALTH

What Is Mental Health?

For all individuals, mental, physical and social health are vital strands of life that are closely interwoven and deeply interdependent. As understanding of this relationship grows, it becomes ever more apparent that mental health is crucial to the overall well-being of individuals, societies and countries.¹

“**Mental health** is the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity.”²

Mental illnesses are characterized by alterations in thinking, mood or behaviour—or some combination thereof—associated with significant distress and impaired functioning. The symptoms of mental illness vary from mild to severe, depending on the type of mental illness, the individual, the family and the socio-economic environment. Mental illnesses take many forms, including mood disorders, schizophrenia, anxiety disorders, personality disorders, eating disorders and addictions such as substance dependence and gambling.

Conventional notions of mental health and mental illness tend to describe their relationship on a single continuum. Mental illness is represented at one end of the continuum while mental health is at the other end. However, mental health is more than the absence of mental illness.³ In fact, for people with mental illness, promoting mental health as defined above, is a powerful force in aiding the recovery process.

In 1987, *Mental Health for Canadians: Striking a Balance* initially noted many of the advantages of looking at mental health and mental illness as two distinct concepts. Other researchers and policy makers in the field have added their supportive voice over the last decade.^{4,5,6} One of the principal advantages is that it encourages thinking and research about the individual, family, social, cultural, environmental, political and economic factors that influence mental health. This thinking and research guides program, policy and service decisions in all sectors of the community including health, social services, education, justice, recreation and business.

The terms mental health problems, mental illness and mental disorder are often used interchangeably. Whereas the phrase mental health problem can refer to any departure from a state of mental or psychological well-being, the terms illness and disorder suggest clinically recognized condition, and imply either significant distress, dysfunction, or a substantial risk of harmful or adverse outcome. This report uses the term mental illness except where a specific study has used the term mental health problems. For this report, mental disorders as a group include the specific conditions such as psychotic disorders, anxiety disorders, personality disorders, mood disorders that we have collectively called mental illnesses, as well as other brain disorders such as developmental delay and Alzheimer’s disease.

What Is the State of Mental Health in Canada?

Self-perceived Mental Health

Overall self-perceived mental health is a useful indicator of population mental health. Most people have a good sense of their own state of mind and situation. However, people with mental illness who lack insight into their thoughts, feelings and behaviour may not be able to accurately report their true state.

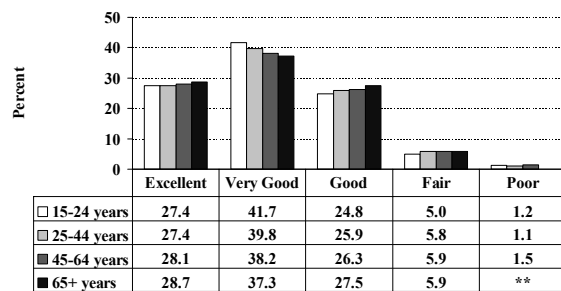
According to Statistics Canada’s 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2), nearly 7 out of 10 (67.1%) Canadians reported that their mental health was excellent or very good. Approximately 2.5 in 10 (26.0%) perceived their mental health to be good. This pattern was similar among all Canadians aged 15 years and over. (Figure 1-1)

Young women aged 15–24 years, were 1.5 times as likely as young men to report fair or poor mental health. (Figure 1-2) Young men

15–24 years of age were less likely than men in all other age groups to report fair or poor mental health. The variation among women across age groups was less than among men.

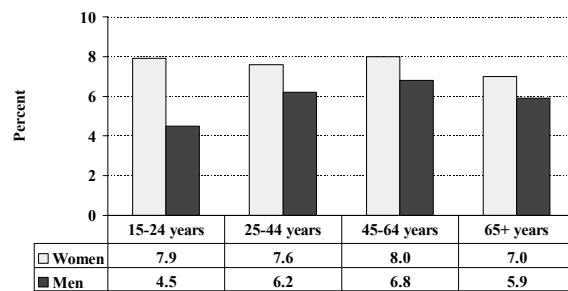
The difference between younger women and men in self-perceived mental health suggests different patterns and outcomes of life experiences. Young men and young women also differ in introspection, or reporting behaviour. Young women are more likely than young men to experience mood, anxiety and eating disorders. This may reflect differences in the social standing of girls and women in Canadian society (including expectations and discrimination), as well as life challenges, such as lower average income. In addition, young men may be unwilling to admit that they experience mood and anxiety disorders or are unable to handle unexpected problems.

Figure 1-1 Self-perceived mental health, by age, Canada, 2002



** Insufficient sample size.
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 1-2 Mental health perceived as fair and poor, by age and sex, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Ability to Handle Day-to-Day Demands

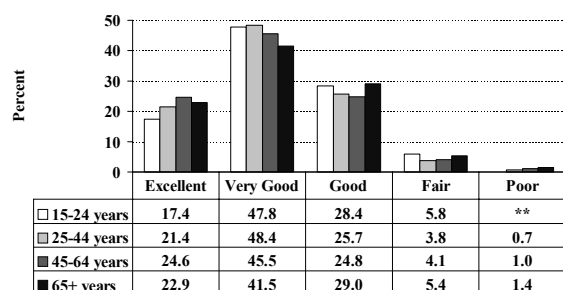
Good mental health provides the foundation for handling the demands and challenges of daily life. These may include learning at school, working productively, forming and maintaining relationships, contributing to the community, and all the practical, routine tasks surrounding personal care, nutrition, physical activity, sleep, recreation and spiritual needs.

In 2002, approximately 7 in 10 Canadians (68.5%) aged 15 years and over reported that their ability to handle day-to-day demands was excellent or very good. (Figure 1-3)

Perceived ability to handle day-to-day demands increased until age 64 years and then dropped in the senior years (65+). (Figure 1-4)

Older people may experience difficulty handling day-to-day demands as they age. With age comes an increased likelihood of illness, disability, sleep and appetite disturbances, reduced energy, and reduced financial and social supports, all of which may restrict or interfere with everyday activities, affecting mood and exacerbating illness.⁷

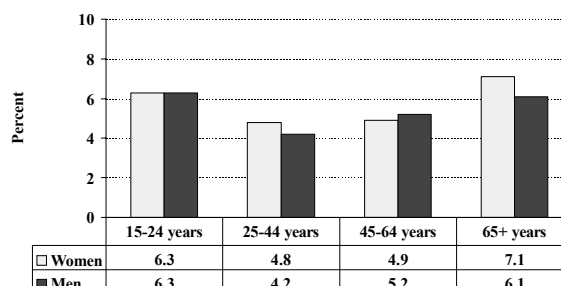
Figure 1-3 Ability to handle day-to-day demands, by age, Canada, 2002



** Insufficient sample size.

Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 1-4 Ability to handle day-to-day demands reported as fair or poor, by age and sex, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Ability to Handle Unexpected Problems

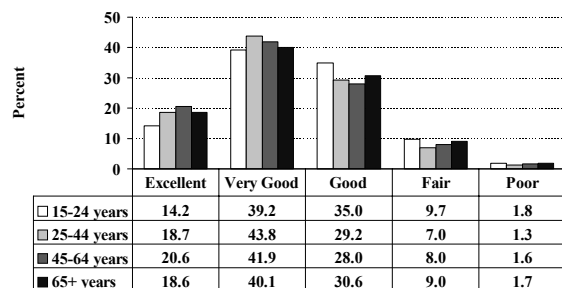
Unexpected problems are part of everyday living. An individual’s ability to handle them is a good indicator of mental health. Healthy people can consider options, reach out to others for support and make decisions in a timely way. However, other determinants of health, such as poverty, may also affect one’s ability to handle unexpected problems by limiting choices and increasing stress.

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), approximately 6 in 10 (60.3%) of all Canadians 15 years of age and over reported that their ability to handle unexpected problems was excellent or very good. (Figure 1-5) The proportion was lower among 15–24 year-olds (53.4%). Young people may lack the life experience and the emotional and social resources that would allow them to cope with unexpected problems.

Higher proportions of women than men aged 15–24 and 25–44 years reported their ability to handle unexpected problems as fair or poor. (Figure 1-6) Men and women do not necessarily experience the same stressors. Interventions to support young women’s problem-solving skills as well as initiatives to improve their sense of self-efficacy might reduce the number of women who perceive their ability to handle unexpected problems as only fair or poor.

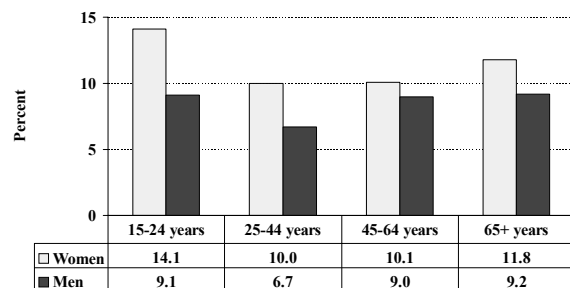
The proportion of women who reported fair or poor ability to handle unexpected problems, increased over the age of 65 years, perhaps because of increasing health problems, and decreasing economic and other resources.

Figure 1-5 Ability to handle unexpected problems, by age, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 1-6 Ability to handle unexpected problems reported as fair or poor, by age and sex, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Children and Youth

The mental health of youth is as important as their physical health: those who suffer from emotional problems are also more likely to manifest both physical and mental health problems. The onset of most mental illnesses occurs during adolescence and young adulthood.

Young people's confidence level has been found to be related to the extent to which they are integrated with their peers and how they feel about their appearance.⁸

The Health Behaviour of School-Aged Children (HBSC) Study is a cross-national study supported by the World Health Organization (WHO). In Canada, the HBSC surveys have been funded by the Public Health Agency of Canada (PHAC).

HBSC makes a unique contribution to the study of young people's health through the collection of cross-national data in surveys conducted every four years using a common survey protocol. This allows the measurement and tracking of aspects of adolescent health and health-related behaviours and their developmental and social contexts.

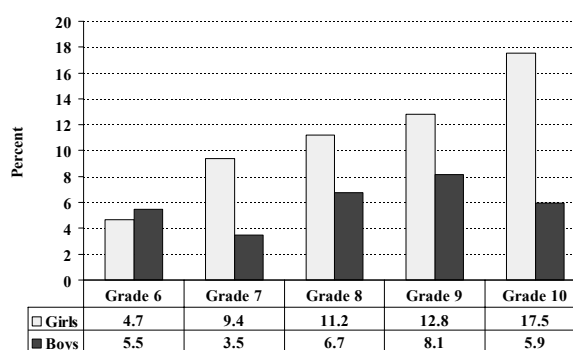
The 2002 HBSC study found 4.7% (or almost 5%) of Grade Six girls did not feel confident, compared to nearly 18% of Grade Ten girls. Across all grades, boys showed less variation than girls in levels of confidence. (Figure 1-7)

In its 1998 study, *Focus on Youth*, the Canadian Council on Social Development reported similar results: while the number of boys who say they "have confidence in themselves" remains relatively stable through adolescence, the numbers for girls dropped steadily from 72% in Grade Six students to 55% in Grade Ten.

Feelings of isolation, hopelessness and lack of a social support network can lead to suicidal thoughts in adolescents. Youth who are well integrated socially are far less likely to experience emotional problems than youth who have few friends and feel isolated.⁹ Adolescents who feel accepted socially and have support at home and at school generally have higher levels of self-confidence and self-esteem.

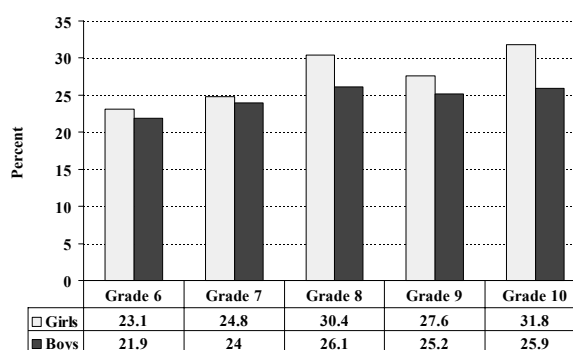
According to the HBSC survey, in Grade Six, approximately 1 in 5 boys and girls reported that they often felt lonely or left out. These feelings of isolation increased with age and were higher for girls than boys. (Figure 1-8)

Figure 1-7 Proportion of students who do not feel confident, by sex and grade, Canada, 2002



Source: Health Behaviour of School-Aged Children Survey, 2002, WHO.

Figure 1-8 Proportion of students who often feel left out or lonely, by sex and grade, Canada, 2002



Source: Health Behaviour of School-Aged Children Survey, 2002, WHO.

For many young people, school is richly satisfying; but for others, school is an unpleasant or threatening place where they feel criticized and excluded.

A higher percentage of boys than girls felt that they did not belong at school. (Figure 1-9) This peaked in Grades Eight and Nine where approximately 23% indicated that they felt that they did not belong at their school.

A variety of symptoms can arise when an individual is under stress. Some of these symptoms can be physical, such as headache, stomach ache, back ache and dizziness; others can be mental or emotional, including feeling low or depressed, irritability, nervousness and

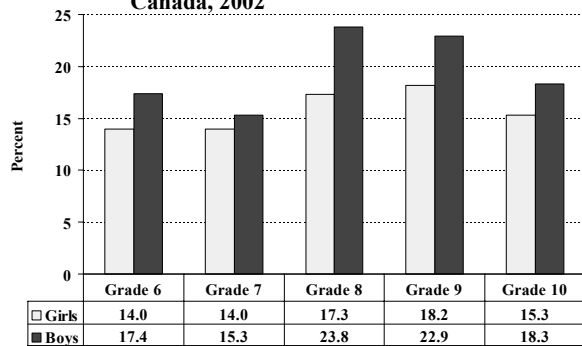
problem sleeping. One in 4 Grade Six students reported having at least one of these symptoms daily, with no difference between girls and boys. (Figure 1-10) Beginning in Grade 7, a greater percentage of girls than boys reported daily symptoms; and by Grade 10, the percentage among girls was 35.7%, or 1 in 3 girls.

Healthy Aging

The majority of seniors describe themselves as at least as happy as when they were younger.¹⁰ Seniors develop skills that help them retain life satisfaction, such as maintaining central values, roles, activities and relationships, modifying aspirations, being flexible about goals and in solving problems, and being able to anticipate and to control emotional responses to situations.¹¹

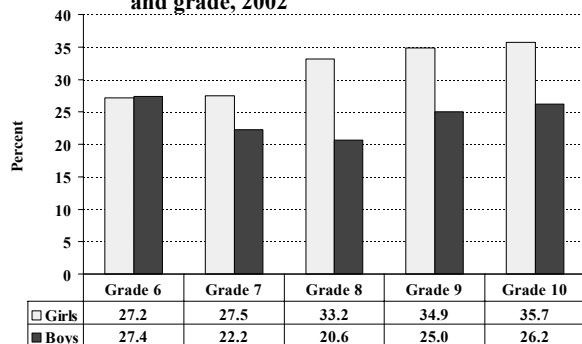
In early adulthood, people begin to selectively reduce their social interactions based on emotional closeness. As these social networks become smaller and relationships are irreplaceably lost to attrition, loneliness becomes a problem affecting well being.¹² Approximately one-half of people over 80 years of age report feeling lonely.¹³

Figure 1-9 Proportion of students who feel they do not belong at their school, by sex and grade, Canada, 2002



Source: Health Behaviour of School-Aged Children Survey, 2002, WHO.

Figure 1-10 Proportion of students reporting daily problems* in the previous six months, by sex and grade, 2002



Source: Health Behaviour of School-Aged Children Survey, 2002, WHO.

What Factors Affect Mental Health?

A variety of factors influence an individual's mental health. Some of these factors—or health determinants—are within the individual; some are within the family; and others are in the broader community. The determinants do not act in isolation from one other: the complex interaction of these determinants has an impact on the health of individuals and communities.

Many of the determinants of mental health lie outside the health and mental health care systems and reflect the influence of other sectors, such as the economy, education and housing. Consequently, strategies to improve mental health and reduce mental illness among Canadians will require the active cooperation of other sectors.

Mental health is an individual resource that develops over the lifespan. Challenges experienced as a child (such as sexual abuse) may create an increased risk for a mental illness in later life. Likewise, personal coping mechanisms developed at an earlier life stage may protect the individual from developing a mental illness in adulthood. A lifespan-development perspective would lead to early identification of psychosocial risks for mental illness and to early intervention, which would

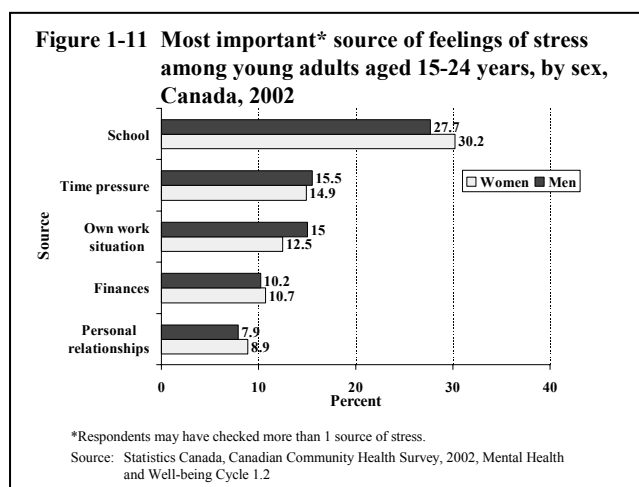
promote optimal mental health over the lifespan.¹⁴

Sources of Feelings of Stress

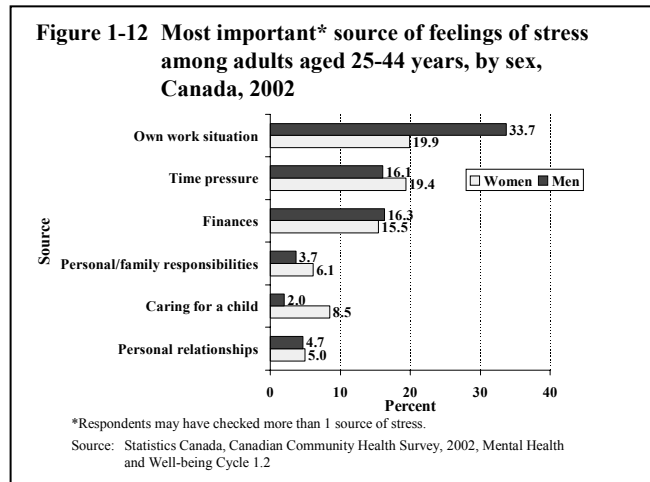
Stress is a major factor influencing mental health. The 2002 Mental Health and Well-being Survey (CCHS 1.2) asked respondents to identify the most important source of their feelings of stress in their lives.

Respondents selected several major sources of stress that they had experienced: own physical problems (11.5%), financial situation (11.0%), time pressure (8.5%), school (8.2%), health of a family member (7.4%), personal or family responsibilities (7.0%), personal relationships (5.0), own work situation (4.3%), caring for a child (4.2%), employment status (4.1%), personal security (2.1%), caring for someone else (1.4%), discrimination (1.0%), or death of a loved one (0.5%).

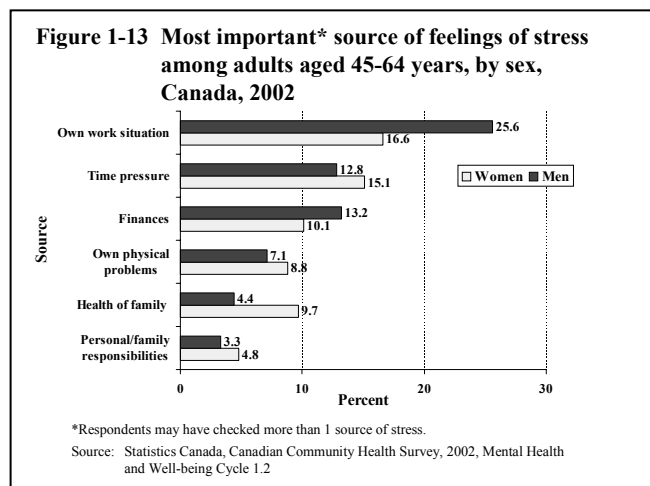
Both young women and young men (15–24 years of age) reported that school, time pressure, work situation, finances and personal relationships were important sources of the stress that they had experienced. (Figure 1-11)



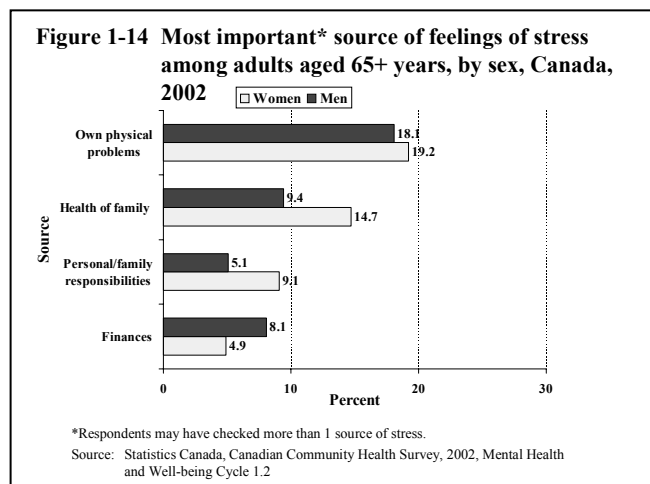
Among individuals 25–44 years of age, the proportion of men that reported their own work situation as a source of stress was 1.7 higher than women. (Figure 1-12) The proportion of women that reported caring for a child as a source of stress was 4 times higher than men; women were also more likely than men to report time pressure and personal/family responsibilities as sources of stress. These differences reflect women’s greater responsibility for child care and family matters. Nearly equal proportions of both men and women reported finances and personal relationships as sources of stress.



Among adults 45–64 years of age, the work situation was most frequently reported as a source of stress by both men and women—and the proportion among men was 1.5 times that of women. (Figure 1-13) Men were also more likely than women to report that finances were a source of stress. The proportion of women to report stress due to family health was twice that of men; women were also more likely to report stress from personal/family responsibilities. These findings reflect women’s greater responsibility for family and greater involvement in managing family health matters.



The sources of stress reported by seniors focused mainly on personal health, family health and personal/family responsibilities. Nearly 1 in 5 reported personal physical problems as a source of stress. (Figure 1-14) A greater proportion of women than men reported family health or personal/family responsibilities as sources of stress. This may reflect the caregiving role that many older women have in the family. More men than women reported finances as a source of stress.



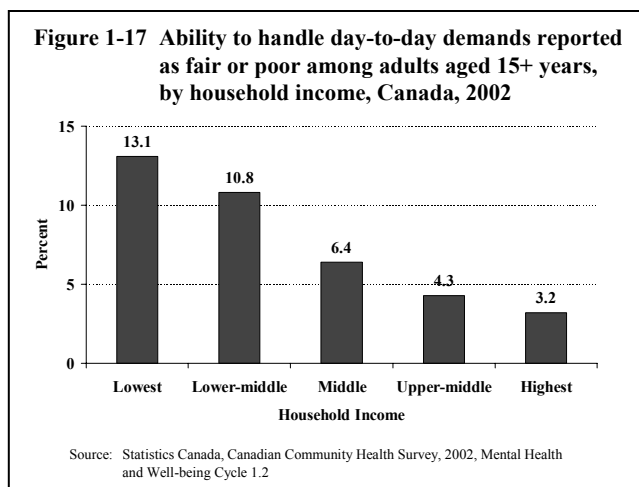
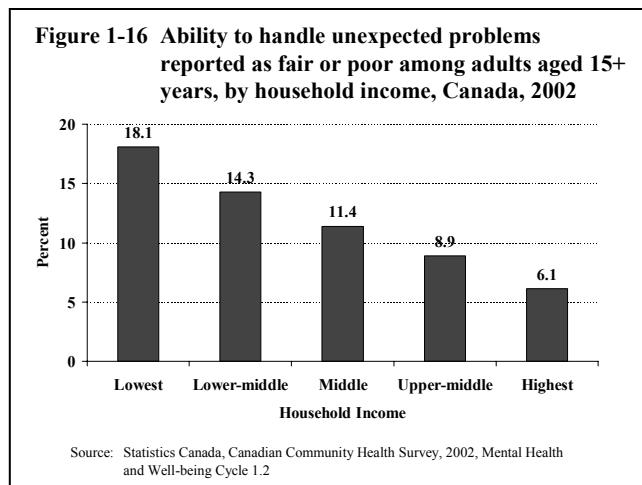
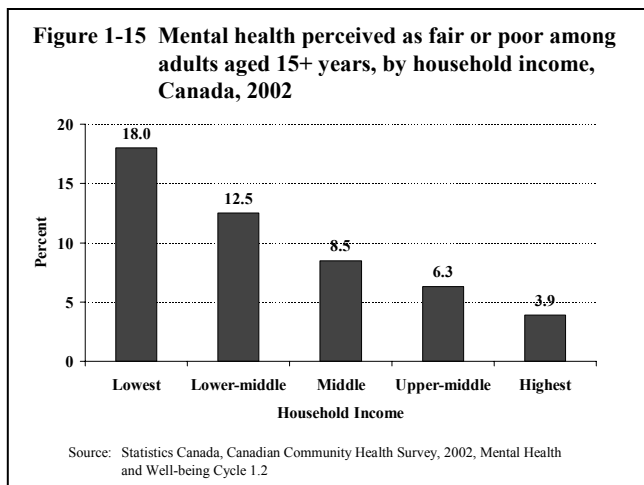
Income

Income can have an impact on mental health because it influences a person's ability to meet basic needs, make choices in life and deal with untoward events.^{15,16,17} Adequate income enables healthy living conditions, such as safe housing and the ability to buy sufficient good food. It also provides options and opportunities that are unavailable to low-income individuals and families. This is particularly important for individuals with mental and physical illness.

The proportions of people in the lowest income adequacy category who reported fair or poor

perceived mental health, ability to handle day-to-day demands, or the ability to handle unexpected problems, were 3 to 4 times higher than those in the highest income adequacy category. (Figures 1-15, 1-16, 1-17)

The relationship between mental health and income is not simple. When people have more money and acquire more material goods, they do not necessarily become more satisfied with their lives or more psychologically healthy.¹⁸



Education

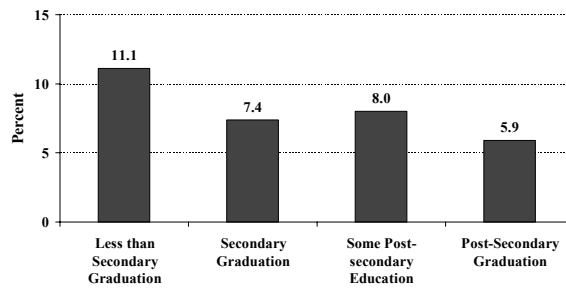
Canadians live in a technologically advanced society. Navigating through it effectively requires knowledge and skill that is learned, to some degree, through formal education. Formal education also helps an individual gain and maintain employment and adequate income.¹⁹

Mental health status improves with each level of education. Education increases opportunities for income and job security and gives people a sense of control over their life circumstances—key factors that influence health.

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), the proportion of Canadians aged 15 years and over who perceived their mental health as fair or poor was highest among those with less than secondary education. (Figure 1-18) This was also the case for reported ability to handle both unexpected problems and day-to-day demands. (Figures 1-19 and 1-20)

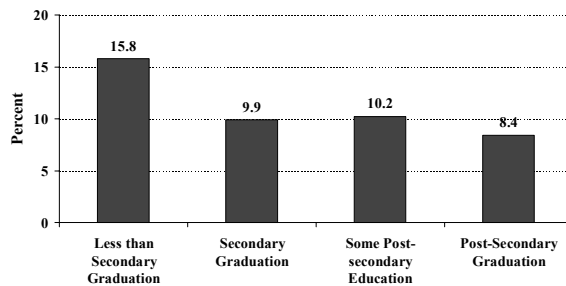
Several research studies have shown that the level of attained education reflects wider economic inequalities. Poor educational attainment reduced the likelihood of finding a good job, leading to mostly negative economic and health consequences. People in low paying jobs were the most disadvantaged materially, were less secure financially, and experienced more unemployment and work injury. They were also less likely to exercise and eat well balanced meals, and more likely to abuse alcohol. Men in low paying jobs tended to be cynical and hostile and feel hopeless about the future. Educational attainment was also a major determinant in the ability of an individual with a mental illness to find work.

Figure 1-18 Mental health perceived as fair or poor among adults aged 15+ years, by education, Canada, 2002



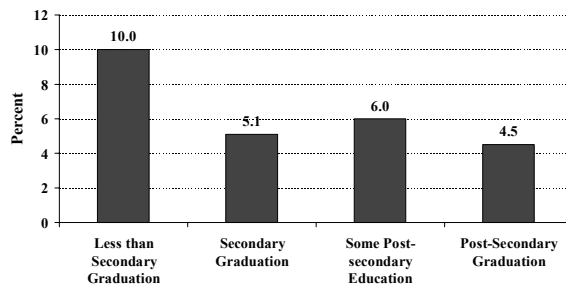
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 1-19 Ability to handle unexpected problems reported as fair or poor among adults aged 15+ years, by education, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 1-20 Ability to handle day-to-day demands reported as fair or poor among adults aged 15+ years, by education, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Social Support

Isolation and loneliness have a profound impact on mental health. The family is usually at the heart of connection to others. A family unit may have various configurations, such as one or more generations, one or more parents, and varied living arrangements.

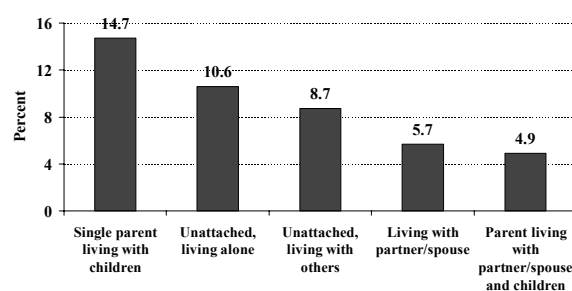
Several studies have shown social connections to be crucial in influencing both mental and physical health. People who volunteered and were involved in social activities—from going to church to a joining a club—were more likely to report better overall health than people who were not involved in regular social activities.²⁰

High levels of social engagement create social conditions that support the development of trust between people, a deeper sense of meaning in life, and an enhanced sense of coherence, control and positive self-regard. These psychosocial factors contribute to improved mental and immunological health.²¹

The 2002 Mental Health and Well-being Survey (CCHS 1.2) found that Canadians aged 15 years and over who were single parents or who were unattached were more likely to report their mental health as fair or poor than those living with a partner/spouse with or without children. (Figure 1-21)

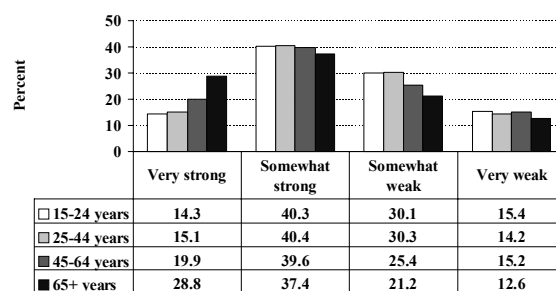
Good mental health and positive self-esteem enable an individual to connect with and embrace a community of people. Belonging to a supportive community contributes to mental health by providing support in times of crisis, grounding in one’s cultural roots and opportunities for creativity. A community could be defined by geography or by characteristics of the individuals, such as religion, language, culture or sexual orientation.

Figure 1-21 Mental health perceived as fair or poor among adults aged 15+ years, by living arrangement, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 1-22 Sense of belonging to community, by age, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

In 2002, 2 in 10 Canadians (18.5%) 15 years of age and over reported a very strong sense of belonging to the community. Another 4 in 10 (39.9%) reported a somewhat strong sense of belonging.

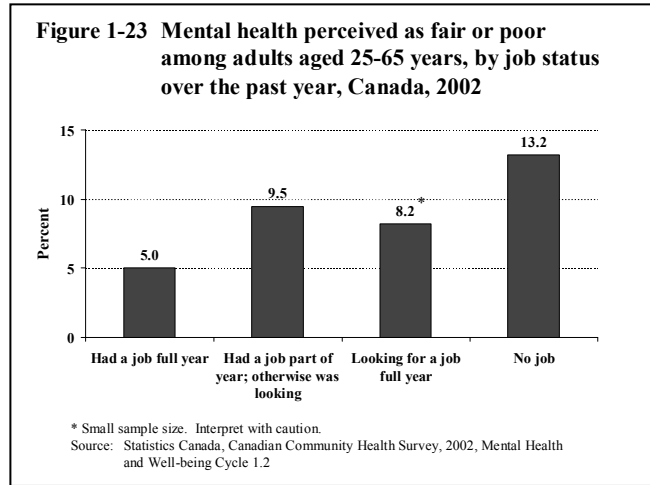
Similar proportions of men and women in all age groups reported a very strong or somewhat strong sense of belonging to community. Individuals less than 45 years of age did not feel as strongly connected as older adults to their communities. (Figure 1-22) This may reflect a change in people’s sense of connection to their community during the second half of the 20th century.

Job Status

Having a job provides income to meet basic needs and gives one a sense of personal achievement and contribution to the community.

Unemployment is associated with poorer health.²² People who are unemployed have difficulties with self-worth and can develop a range of psycho-somatic problems related to the stress of unemployment.²³

Respondents to the 2002 Mental Health and Well-being Survey (CCHS 1.2)-who did not have a job were more likely to report their mental health as being fair or poor compared to those who had a job for all or part of the previous 12 months. (Figure 1-23)



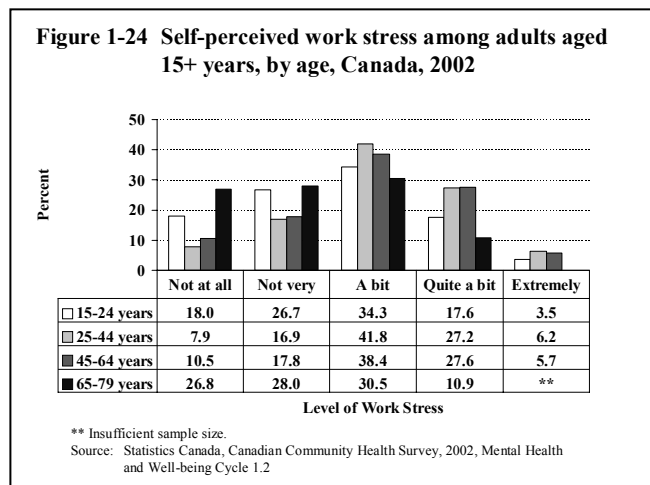
Work Stress

Two-thirds of Canadians (66.9%, or 16 million people) are either employed or actively seeking work.²⁴ With any work comes a certain level of stress associated with the ability to meet demands, the need to feel valued and the loss of control over one’s time and responsibilities.

People who have more control over their work circumstances and fewer stressful job demands are healthier and often live longer than those involved in more stressful or riskier work and activities.

Working conditions can be a risk factor for mental health problems and illnesses. Authoritarian management systems, health and safety violations, poor labour-management relations, and underemployment or over-employment can lead to mental health problems.²⁵

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), 1 in 2 Canadians perceived work as stressful to some degree. (Figure 1-24) One in 3 adults aged 25–44 years and 45–64 years reported work to be quite a bit or extremely stressful—higher than among young adults and seniors. Only 1 in 5 young adults (15–24 years) found work to be quite a bit or extremely stressful.

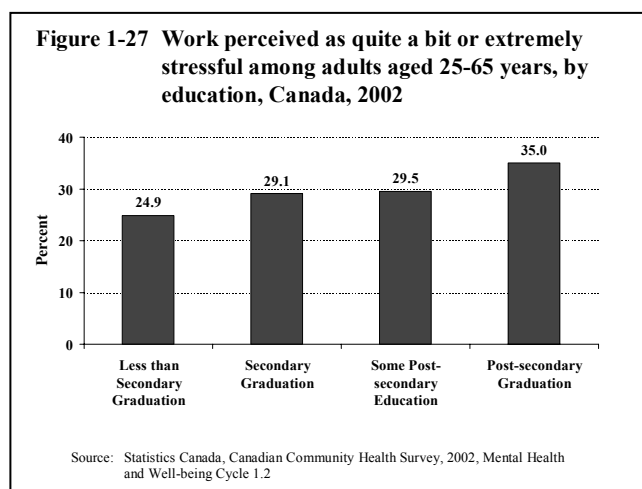
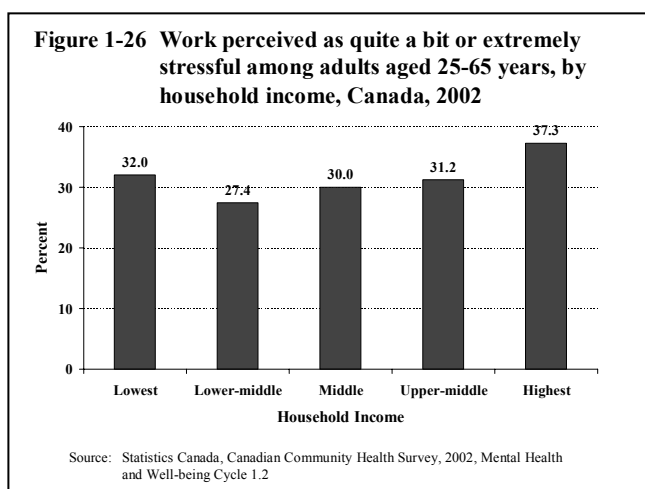
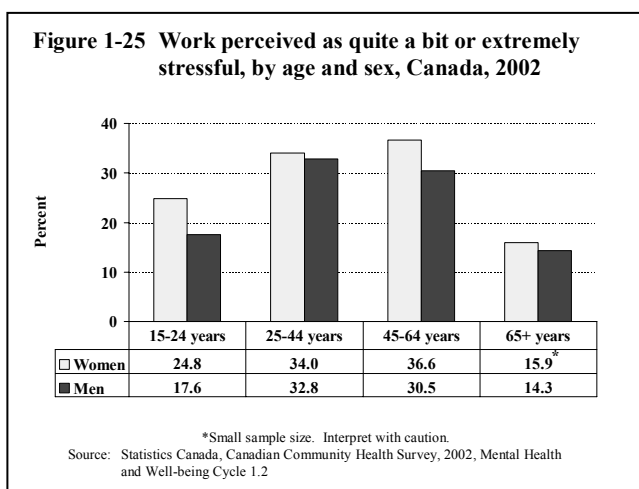


The perception of work as being quite a bit or extremely stressful was higher among women than men in the youngest (15–24 years) and mid-life (45–64 years) age groups. (Figure 1-25)

The survey did not investigate what makes work stressful, the nature of labour force activities (that is, the greater likelihood of women to be employed part-time, and in sales, clerical or service positions) and the demands of balancing work with family care.

Individuals in the highest income group were more likely than those in other income groups to perceive work as more quite a bit or extremely stressful, possibly reflecting the greater responsibility and longer hours. (Figure 1-26)

Individuals with post-secondary education were more likely than those in other education groups to perceive work as being quite a bit or extremely stressful. (Figure 1-27)



Personal Health Practices and Coping Skills

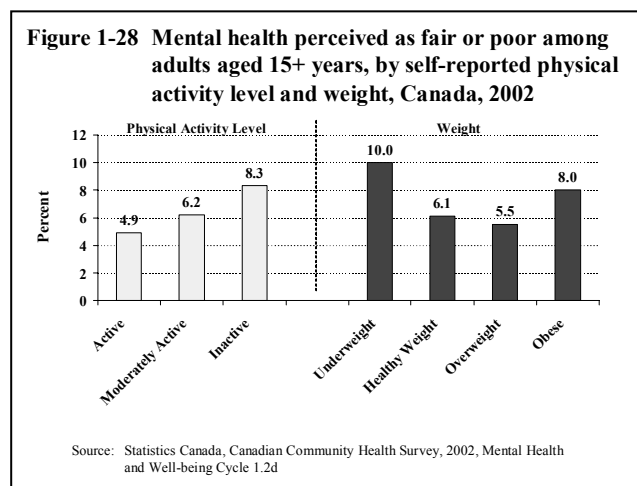
Individuals can reflect on their situation and make deliberate decisions as to how they will act. However, the organizational, institutional, cultural and societal contexts of their lives both enable and constrain their options. Ideally, social environments enable and support healthy choices and lifestyles.

Regular physical activity has a powerful impact on mental health. It releases brain chemicals that help stabilize emotions and reduce anxiety. Regular physical activity also helps people achieve and maintain a healthy weight.

Many people cope with stress in their lives by overeating. Unfortunately, being overweight or obese makes matters worse because it puts the individual at increased risk for physical health problems such as heart disease, stroke, diabetes and osteoarthritis.

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), physically inactive Canadians were more likely than those who were active to perceive their mental health as fair or poor. (Figure 1-28) (Individuals were considered physically inactive or 'sedentary' if they reported a usual daily leisure-time energy expenditure of <math><1.5\text{ kcal/kg/day}</math>.)

Canadians who were underweight or obese were more likely than those of healthy weight or overweight to perceive their mental health as fair or poor. People who are underweight may have an underlying chronic health problem. (Body Mass Index [BMI] = weight in kilograms divided by the square of the height in metres. This report defines underweight as BMI <math><18.5</math>, overweight as BMI = 25.0–29.9, and obese as BMI ≥ 30 .)

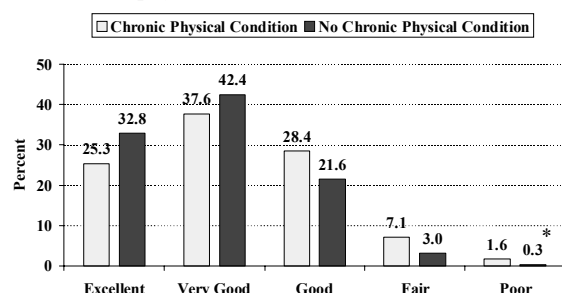


Chronic Physical Conditions

Mental health and physical health are intricately linked. People who are under significant stress are more likely to develop infections and stress can exacerbate chronic health problems such as asthma, Chronic Obstructive Pulmonary Disease (COPD), angina, hypertension and arthritis. People with chronic physical health problems such as diabetes, COPD, heart disease are at high risk for developing depression.²⁶

The link between physical and mental health was also found among the participants in the CCHS Mental Health and Well-being Survey, 2002. People who reported having chronic physical health problems had a less positive perception of their mental health than those without chronic physical conditions. (Figure 1-29) Three-quarters (75.2%) of people without chronic physical disease conditions perceive their mental health as excellent or very good compared to 62.9% of those with a chronic physical condition.

Figure 1-29 Self-perceived mental health among adults aged 15+ years, by existence of a chronic physical condition, Canada, 2002



* Small sample size. Interpret with caution.

Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Cultural/Racial Origin

Canada is a country rich in cultural diversity. People who were born outside of Canada now represent about 16% of the population. Immigrants face the challenge of integrating their way of life into the different values of the Canadian context—often facing social isolation.

Identification with a specific race or an ethnic or cultural group can influence mental health. Coping styles and social supports tend to be culturally determined. A person's mental health may also be linked to broader social issues such as racism, discrimination and poverty.

Aboriginal Well-being

Given the great diversity of Aboriginal Peoples in Canada, one might expect to find a corresponding diversity in concepts of mental health and well-being. While there are important cultural and regional differences, corresponding to different histories, ways of life, and social structures, Aboriginal Peoples also share commonalities in ways of understanding health and illness.

Traditional ideas of health did not separate mental health from other aspects of well-being. Aboriginal Peoples lived in close connection to the land and everyday activities needed for survival included a spiritual dimension that maintained harmonious relations with the animals, the environment, and, indeed, the universe as a whole.

In contrast to the emphasis on the individual in much of Euro-Canadian society, the concept of the healthy person common to most Aboriginal cultures emphasizes relations and connections to others. The person is seen as embedded in a web of sustaining relations. These connections extend to those who have come before, the ancestors, who may be present in memory, stories and ceremonial practices. These

ancestors, sometimes referred to personally as “grandfather” or “grandmother”, also require attention and honour and, in return, provide a sense of connectedness across time. This sense of connection includes others within the family, clan or community.

Health is obtained when there is a morally and spiritually correct relationship with others in the family and community, with ancestors and with the larger web of relations that make up the world and that can insure well-being for future generations.

Most Aboriginal people have multiple models available for thinking about mental health and illness. They bring these to bear, depending on the aspects of the problem that they are addressing. Because of the pervasive effects of cultural oppression and historical trauma, many Aboriginal people see their situation as requiring an ongoing process of individual and collective healing.²⁷

Chapter 12 discusses Aboriginal mental health in more detail.

Biology and Genetic Endowment

The basic biology and organic makeup of the human body are fundamental determinants of health. Genetic endowment provides an inherited predisposition to a wide range of individual responses to developmental stages, life events and challenges. Using genetics to explain mental illness must be balanced with an understanding of the roles of culture, social structure and social interaction in shaping genetic expression.

Healthy Child Development

The development of the resilience required for good mental health begins in childhood. It is crucial, therefore, that children have positive experiences. Healthy parenting, unconditional love, respect for individuality, healthy relationships within the family and healthy peer relationships all contribute to a strong sense of self and connectedness to others.²⁸

Antisocial role models, family violence, marital discord, neglect and abuse in childhood, parental substance abuse, parental mental illness and social isolation contribute to higher risk for mental health problems and mental illness.²⁹

Gender

“Gender” refers to the socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to one or the other of the two sexes. “Sex”, on the other hand, refers to biological differences, such as hormonal, physiological, endocrine and reproductive differences between males and females.

With respect to mental health, gendered norms and expectations may contribute both to what is defined as normal for one sex or the other, as well as to an individual’s comfort with fulfilling those norms. Women and men are commonly viewed differently with respect to their roles, responsibilities and opportunities. For example, women who are mothering and substance users may be regarded differently than men who are fathering and who are substance users. Similarly, women who are violent are viewed differently from men who are violent; men who are depressed are viewed differently from women who are depressed.

Falling outside gendered expectations may have different consequences for women and men,

depending upon the rigidity of sex- and gender-based expectations. Moreover, the stigma attached to falling outside of such expectations may vary over time, between age groups and among cultural groups. These consequences and stigma may have a different impact on women's and men's mental health.

Spirituality

In the first chapter of his book, *Becoming Human*, Jean Vanier wrote:

“This book is about the liberation of the human heart from the tentacles of chaos and loneliness, and from those fears that provoke us to exclude and reject others. It is a liberation that opens us up and leads to the discovery of our common humanity. I want to show that this discovery is a journey from loneliness to a love that transforms, a love that grows in and through belonging, a belonging that can include as well as exclude. The discovery of our common humanity liberates us from self-centred compulsion and inner hurt; it is the discovery that ultimately finds its fulfillment in forgiveness and in loving those who are our enemies. It is the process of truly becoming human.”

This paragraph points to the need for all humans to connect to something beyond themselves, something that transcends individual concerns and allows concern for humanity as a whole to emerge. People find and nurture this connection

in many ways—organized religion, books, music, art, nature or service to others.

For many people, a spiritual connection supports mental health. Without it, the self can be turned inward, losing perspective and resilience. It is hard to reach beyond oneself and either openly receive help or to give help to others. Those who are caught in the trap of addictions exemplify this lack of connection. One of the twelve steps in the Alcoholics Anonymous process to recovery is to acknowledge a higher power, a process that has been used by millions of people recovering from addictions.

Physical Environment

Physical factors in the natural environment (such as air and water quality) are key influences on health. Factors in the human-built environment (such as housing, workplace safety, and road design) are also important influences.

The physical environment can either facilitate or inhibit trust and cooperation and the development of social cohesion in the community—all factors in mental health.

Neighbourhoods with physical characteristics such as prolific graffiti, boarded windows, and abandoned houses, stores and apartment units may reflect the prevalence of vandalism, muggings, gangs—activities that discourage social relationships. Growing up in such a neighbourhood can lead to fear, loneliness and unhappiness.³⁰

Summary

The determinants of mental health demonstrate a complex picture about what makes an individual mentally healthy or unhealthy. (Table 1-1 and 1-2) They provide a perspective on mental health (and mental illness) with implications for policy and program development

at all levels of government and across many sectors of Canadian society.

The inter-sectoral links between the determinants further highlight the interwoven themes of the importance of equality and social justice, holism, relationships or interconnectedness, and community.

Table 1-1 Protective factors potentially influencing the development of mental health problems and mental disorders in individuals.				
Individual Factors	Family Factors	School Context	Life Events and Situations	Community and Cultural Factors
<ul style="list-style-type: none"> • Easy temperament • Adequate nutrition • Attachment to family • Above-average intelligence • School achievement • Problem-solving skills • Internal locus of control • Social competence • Social skills • Good coping style • Optimism • Moral beliefs • Values • Positive self-related cognitions 	<ul style="list-style-type: none"> • Supportive caring parents • Family harmony • Secure and stable family • Small family size • More than two years between siblings • Responsibility within the family (for child or adult) • Supportive relationship with other adult (for a child or adult) • Strong family norms and morality 	<ul style="list-style-type: none"> • Sense of belonging • Positive school climate • Prosocial peer group • Required responsibility and helpfulness • Opportunities for some success and recognition of achievement • School norms against violence 	<ul style="list-style-type: none"> • Involvement with significant other person (partner/mentor) • Availability of opportunities at critical turning points or major life transitions • Economic security • Good physical health 	<ul style="list-style-type: none"> • Sense of connectedness • Attachment to and networks within the community • Participation in church or other community group • Strong cultural identity and ethnic pride • Access to support services • Community/cultural norms against violence
<p>Source: Australia. Promotion, prevention and early intervention for mental health [monograph on the Internet] [cited 2005 Sept 23]. Available from: http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mentalhealth-mhinfo-ppei-monograph.htm.</p> <p>* Many of these factors are specific to particular stages of the lifespan, particularly childhood; others have an impact across the lifespan, for example, socioeconomic disadvantage.</p>				

Table 1-2 Risk factors potentially influencing the development of mental health problems and mental disorders in individuals.				
Individual factors	Family/social factors	School context	Life events and situations	Community and cultural factors
<ul style="list-style-type: none"> • Prenatal brain damage • Prematurity • Birth injury • Low birth weight, birth complications • Physical and intellectual disability • Poor health in infancy • Insecure attachment in infant/child • Low intelligence • Difficult temperament • Chronic illness • Poor social skills • Low self-esteem • Alienation • Impulsivity • 	<ul style="list-style-type: none"> • Having a teenage mother • Having a single parent • Absence of father in childhood • Large family size • Antisocial role models (in childhood) • Family violence and disharmony • Marital discord in parents • Poor supervision and monitoring of child • Low parental involvement in child's activities • Neglect in childhood • Long-term parent unemployment • Criminality in parent • Parent substance misuse • Parental mental disorder • Harsh or inconsistent discipline style • Social isolation • Experiencing rejection • Lack of warmth and affection 	<ul style="list-style-type: none"> • Bullying • Peer rejection • Poor attachment to school • Inadequate behaviour management • Deviant peer group • School failure 	<ul style="list-style-type: none"> • Physical, sexual and emotional abuse • School transitions • Divorce and family breakup • Death of family member • Physical illness/impairment • Unemployment, homelessness • Incarceration • Poverty/economic insecurity • Job insecurity • Unsatisfactory workplace relationships • Workplace accident/injury • Caring for someone with an illness/disability • Living in nursing home or aged care hostel • War or natural disasters 	<ul style="list-style-type: none"> • Socioeconomic disadvantage • Social or cultural discrimination • Isolation • Neighbourhood violence and crime • Population density and housing conditions • Lack of support services including transport, shopping recreational facilities
<p>Source: Australia. Promotion, prevention and early intervention for mental health [monograph on the Internet] [cited 2005 Sept 23]. Available from: http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mentalhealth-mhinfo-ppei-monograph.htm.</p> <p>* Many of these factors are specific to particular stages of the lifespan, particularly childhood; others have an impact across the lifespan, for example, socioeconomic disadvantage.</p>				

Mental Health Promotion

Mental health promotion is the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health.³¹ By working to increase self-esteem, coping skills, social support and well-being in all individuals and communities, mental health promotion empowers people and communities to interact with their environments in ways that enhance emotional and spiritual strength. It fosters individual resilience and promotes socially supportive environments.

Mental health promotion also works to challenge discrimination against those with mental illness. Respect for culture, equity, social justice, interconnections and personal dignity is essential for promoting mental health for everyone.

Mental health promotion benefits the entire population. Everyone needs positive mental health to cope with daily living and major life events. In addition, positive mental health helps those with chronic illness and disability to cope effectively with their illness or disability.

Mental Health Promotion Strategies

Mental health promotion is rooted within a population health approach to decisions about policies, programs and services. A population health approach aims to improve the health of the entire population and to reduce health inequities among population groups. It recognizes the range of social, economic and physical environmental factors that contribute to health.³²

A population health approach for mental health promotion includes:

1. Focusing on the needs of the population as a whole as well as sub-populations with particular needs;
2. Addressing the determinants of mental health and their interactions (See previous section in this chapter for discussion of these determinants);
3. Basing decisions on evidence of need and the effectiveness of interventions;
4. Increasing investments on the social and economic determinants of health;
5. Applying multiple strategies in multiple settings and sectors based on the *Ottawa Charter for Health Promotion 1986* (developing personal skills, encouraging community action, creating supportive environments, developing healthy public policy and re-orienting the health system);
6. Collaborating across sectors and levels of government;
7. Employing mechanisms for meaningful public involvement; and
8. Demonstrating accountability for health outcomes.

Healthy Children and Youth Strategies

Human Resources and Social Development Canada's Community Programs for Children³³ recognizes that children and youth are particularly vulnerable to events and conditions in their family, social, education and community environments. These events and conditions can either help to develop strong, resilient young people who contribute in a positive way to their family and community, or they can have detrimental effects that last for a lifetime. The following are the essential components of an overall program to improve the health, including the mental health of children:

- **Child and Family Friendly Policies** – Governments, industry, workplaces and others need to consider how their policies will impact on children and families.
- **Parenting Programs** – Parents benefit from support from family, friends and community programs that teach parenting skills and provide a social support network. The love and affection that parents give their children has a profound impact on their sense of self, their ability to form attachments with others and their ability to learn.
- **Early Child Development Programs** – Accessible early learning and quality daycare programs based on principles of inclusion, affordability, accessibility, quality and parent choice can provide the stimulation and nurturing for the early years.
- **Family Income Adequacy** – Programs to assist families in finding employment, finding affordable housing, accessing health care and pursuing learning opportunities can change the poverty cycle. The consequences of growing up in poverty can follow children throughout their lives. It can contribute to poor development, learning delays and social exclusion.

- **Family Justice System** – A child-friendly justice system that considers the views of the child as appropriate for age and development, can lead to a less adversarial and more child-centred process. Providing support and tools to parents can help them reach parenting arrangements that serve the best interest of children.
- **Social Inclusion and Diversity: Building Community** – Programs to sensitize people about unintended barriers, and the creation of processes and partnerships between those who are affected by decisions and those who make them. Some children experience barriers to full participation in society because they have disabilities, are immigrants, have certain religious beliefs, live in the north or rural areas.

School-based Programs

Comprehensive School Health³⁴ (CSH) is an integrated approach to health promotion that gives students numerous opportunities to observe and learn positive mental health attitudes and behaviours.

“CSH views health as a resource for daily living. It recognizes that many different factors affect the health and well-being of students, including the physical condition of the home, school and community; the availability and quality of health services; economic and social conditions; and the quality and impact of health promotion. CSH encourages and depends on active partnerships between everyone who can and should contribute to the well-being of students, including teachers, parents, peers, health professionals and the community.”

The CSH Framework combines four main elements:

- **Instruction** is the way students receive information about health and wellness, health risks and health issues. This includes curriculum, physical health education and varied learning strategies. It fosters life skills, such as problem solving and communications, and promotes a sense of personal competency and self-efficacy.
- **Support services** are essential for the early identification and treatment of children with mental disorders that can affect lifelong learning. These supports include health, social and psychological services. The school can be a convenient access point for services based in schools or in the community, including those provided by public health units, health service providers, social service organizations and non-government health agencies.
- The **psycho-social environment** is comprised of the psychological and social support available within the school and in relation to the home and community. The support can be informal (friends, peers and teachers) or formal (school policies, rules, clubs or support groups). This component also takes into account how the school operates and what policies are in place.
- A **healthy physical environment** attends to clean air, good lighting, sound control, measures for preventing overcrowding, healthy food services and minimizing exposure to toxic substances. These can all create stress leading to physical symptoms and difficulty learning.

Workplace Health Programs

The workplace is an important place to promote mental health and to help people recover from mental illness. Both employers and employees benefit from mental health promotion programs. Productivity, collegiality and creativity all benefit from employees who are coping well with life and with workplace demands.

Successful workplace health programs are based on management support and participation, involvement and support of others in the organization and a committee that is willing to work. The Corporate Health Model³⁵ developed by Health Canada and the Addiction Research Foundation of Ontario identifies the following guiding principles for workplace health programs:

- Meet the needs of all employees regardless of their current level of health;
- Recognize the needs, preferences and attitudes of different groups of participants;
- Recognize that an individual's lifestyle is made up of an interdependent set of health habits;
- Adapt to the special features of each workplace environment; and
- Support the development of a strong overall health policy in the workplace.

Within all workplace health promotion programs, it is important to address the three avenues of influence: environment, personal resources and health practices.

Within the environment, consider:

- Physical environment—noise, toxic substances, air quality, lighting and workplace design;
- Social environment—work schedules, coordinating home and work responsibilities, deadlines, work organization and available training and support; and

- Interpersonal relationships—peer communication, respect for difference and diversity and fostering a sense of belonging in the workplace.

Within personal resources, consider supporting self-efficacy and social support.

Within health practices, consider supporting healthy weight, non-smoking, physical activity, healthy sleep and avoidance of problematic substance use.

Seniors' Mental Health Promotion

It is never too late to promote mental health. The experience of growing older is influenced by a number of factors, including income, adaptability and health status. All seniors could benefit from physical, mental and social activity in order to maximize their functioning, regardless of age or illness-related limitations. In fact, positive mental health can help seniors cope with the challenges that arise with aging, such as chronic illness, the loss of partners and friends, and retirement. Increased awareness of the range of normal functioning in seniors could prevent the medicalization of normal aging.

Supportive Communities

Mental health promotion applies to the whole population in the context of everyday life.³⁶ It benefits everyone. By identifying and activating the personal and social strengths that support positive mental health, people can work together to develop healthier communities.

Much of the work of community mental health promotion has to do with shifting attitudes—emphasizing the importance of maintaining positive mental health instead of dealing with only individual distress, and dealing with mental illness in a balanced and humane way that will dismantle stigma and encourage recovery.

One of the most powerful factors supporting mental health is informal relationships with family, friends and others. Mental health promotion initiatives build on these social support networks, and create new relationships that enhance a sense of belonging. They can take many forms and depend on the nature of and resources within a community.

Mental health promotion includes policies to reduce inequities that contribute to poor mental health, such as power imbalance, violence, living in poverty, lack of education, racial discrimination, stigma, lack of housing and employment opportunities. (See Chapter 2 for more discussion.)

A central aspect is the involvement of the community itself in deciding what its needs are and what can be done to respond to those needs. The desired outcomes are increased sense of personal control, empowerment, self-determination and resilience.

For some Canadians, their community may be a long-term care facility. It is estimated that 80% of long-term care facility residents have a mental disorder that co-exists with cognitive or physical impairment.³⁷ The environment (psychosocial and physical) in long-term care facilities can either promote or undermine mental health among residents. Factors in the psychosocial environment (such as philosophy of care, how care is provided, relational and social opportunities, activity, staff communication) and in the physical environment (such as space, noise, geography, activity level) form the environmental milieu. Modifying some environmental factors, such as decreasing noise by eliminating overhead paging and call bells, can help promote the mental health of all residents. Other modifications, such as peer support for a depressed resident, can address individual issues.³⁸

Individual Strategies

The Canadian Mental Health Association (CMHA) promotes personal mental health fitness.³⁹ This includes:

- **Thinking about one's emotional well-being** – Assess one's ability to cope with life's demands, unexpected problems and whether one is enjoying life. Consider the particular stresses being faced and their effect on one's life.
- **Practicing mental fitness** everyday.
Suggestions include:
 - ⇒ Daydreaming;
 - ⇒ Learning ways to cope with negative thoughts;
 - ⇒ Exercising (see below);
 - ⇒ Enjoying hobbies;

- ⇒ Keeping a journal;
- ⇒ Sharing humour;
- ⇒ Volunteering and connecting with others; and
- ⇒ Treating oneself well.

Participating in **regular physical activity**.

Exercise stimulates the production of endorphins, chemicals produced in the brain that make one feel good and provide relief from stress and pain. It reduces anxiety and relieves tension, fatigue and anger. Physical exercise helps to counteract both withdrawal and feelings of hopelessness that are associated with depression; it also promotes interaction with other people in a positive environment. Even five minutes of aerobic exercise (such as swimming, walking) can be beneficial.

Partners in Mental Health Promotion

Given the broad range of determinants of mental health, every individual, service provider, agency, organization and government in Canada needs to be involved in mental health promotion.

Friends and families form the basis of any individual's mental health promotion system by providing

- Meaningful relationships;
- Opportunities and support for growth; and
- Development and support in times of conflict, stress or difficult life events.

Governments at all levels create policies that influence employment, poverty, social assistance, education opportunities, and the justice and legal systems.

Non-government organizations (NGOs)

- Create public awareness;
- Provide self-help and mutual aid; and
- Lead and support community action and advocacy for supportive policies and environments.

Health service providers and community organizations, including religious organizations:

- Support personal knowledge and skill development;
- Assist individuals to identify and respond to stressors in their lives, both through counselling and referral to other organizations; and
- Participate in community coalitions.

Researchers, academia, and professional organizations

- Train service providers;
- Provide the research base for effective interventions; and
- Participate in coalitions and community action.

Childcare, schools and workplaces in the public and private sector are settings in which children, youth and adults spend a large proportion of time on a daily basis. Thus, they are prime locations for mental health promotion programs.

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CHAPTER 2

MENTAL ILLNESS IN CANADA: AN OVERVIEW

What Is Mental Illness?

Mental illnesses are characterized by alterations in thinking, mood or behaviour—or some combination thereof—associated with significant distress and impaired functioning. The symptoms of mental illness vary from mild to severe, depending on the type of mental illness, the individual, the family and the socio-economic environment. Mental illnesses take many forms, including mood disorders, schizophrenia, anxiety disorders, personality disorders, eating disorders, and addictions such as substance dependence and gambling.

During his or her lifetime, every individual experiences feelings of isolation, loneliness or disconnection—some of the symptoms of mental illnesses. If these symptoms begin to interfere with everyday functioning, however, the

individual may need help to regain balance and restore optimal functioning.

Mental and physical illnesses are often intertwined. Individuals with physical health problems often experience anxiety or depression, which affects their response to the physical illness. Individuals with mental illnesses can develop physical symptoms and illnesses, such as weight loss and the biological disturbances associated with eating disorders, or depression contributing to diabetes or a heart attack.

Mental illnesses often occur together. An individual may experience both depression and an anxiety disorder, for example. Some individuals may attempt to manage symptoms through alcohol or drugs, leading to problematic substance use.

How Common Are Mental Illnesses in Canada?

Several research projects in the past 15 years in Canada and the United States have estimated the prevalence of mental illness.^{1,2,3,4} In 2002, Statistics Canada conducted the 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2), which provided for the first time national and provincial level data on mental illness in Canada.⁵

According to the survey, at some time during the twelve months prior to the interview (Table 2-1):

- 1 out of every 10 Canadians aged 15 and over, or about 2.7 million people, reported symptoms consistent with a mood or anxiety disorder, or alcohol or illicit drug dependence.
- 1 in 20 met the criteria for a mood disorder, either major depression or bipolar 1 disorder (see Chapter 2);
- 1 in 20 met the criteria for an anxiety disorder, either panic disorder, agoraphobia or social phobia (see Chapter 5);
- 1 in 50 met the criteria for moderate-risk or problem gambling (see Chapter 9); and
- 1 in 30 met the criteria for substance dependence associated with either alcohol or illicit drug use (see Chapter 10).

Other than those who met the criteria for a mood or anxiety disorder or substance dependence, 5.3% of the Canadian population either sought help for mental health problems or felt a need for help but did not receive it.

One in 5 participants (20.6%) in the 2002 Mental Health and Well-being Survey (CCHS 1.2) met the criteria for a mood or anxiety disorder or substance dependence at some point during their lifetime—24.1% of women and 17.0% of men.

Mental Disorder or Substance Dependence	Total**		Men		Women	
	Number	%	Number	%	Number	%
Any measured mood disorder, anxiety disorder or substance dependence*	2,660,000	11.0	1,220,000	10.2	1,440,000	11.7
<u>Any mood</u>	1,310,000	5.3	510,000	4.2	800,000	6.3
• Major depression	1,200,000	4.8	450,000	3.7	740,000	5.9
• Bipolar disorder	240,000	1.0	120,000	1.0	120,000	1.0
<u>Any anxiety</u>	1,160,000	4.8	430,000	3.6	730,000	5.9
• Panic disorder	380,000	1.5	130,000	1.0	250,000	2.0
• Agoraphobia	180,000	0.7	40,000	0.4	140,000	1.1
• Social anxiety disorder (Social phobia)	750,000	3.0	310,000	2.6	430,000	3.4
<u>Any substance dependence</u>	760,000	3.1	550,000	4.5	210,000	1.7
• Alcohol dependence	640,000	2.6	470,000	3.9	170,000	1.3
• Illicit drug dependence	190,000	0.8	130,000	1.1	60,000	0.5
<u>Eating Attitude Problems</u>	430,000	1.7	60,000	0.5	360,000	2.9
<u>Moderate Risk for / or Problem Gambling</u>	490,000	2.0	320,000	2.6	170,000	0.5
• Problem Gambling	120,000	0.5	70,000	0.6	50,000	0.4
• Moderate Risk for Problem Gambling	370,000	1.5	250,000	2.0	130,000	0.1

* Respondents could have reported symptoms that met the criteria for more than one condition.
 ** Numbers have been rounded to the nearest 10,000.
 Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being, Cycle 1.2

Respondents to the survey were also asked to report whether they had dysthymic disorder, schizophrenia or an eating disorder that had been diagnosed by a health professional and lasting six months or more.

- 0.3% of survey participants reported that they had a dysthymic disorder or suffered from dysthymia (0.3% of men and 0.4% of women) (see Chapter 3);
- 0.3% reported schizophrenia (0.3% of men and 0.2% of women) (see Chapter 4); and

- 0.5% reported an eating disorder (0.2% of men and 0.8% of women) (see Chapter 7).
- These self-reported estimates may under-represent the true picture in the population since many people with mental illness remain undiagnosed. In addition, people with severe mental illness were likely missed by the study.
- Other studies have reported a prevalence of approximately 1% for schizophrenia in contrast to the 0.3% found in this survey.

Impact of Mental Illnesses

Who Is Affected by Mental Illnesses?

Mental illnesses affect people in all occupations, education levels, socio-economic conditions and cultures. At some point in their lives, mental illness will affect most Canadians through a family member, friend or colleague.

Men and Women

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), 10.2% of men and 11.7% of women met the criteria for a mood or anxiety disorder or substance dependence during the previous 12 months. (Table 2-1) While the overall proportions are similar, women were 1.5 times more likely than men to meet the criteria for a mood or anxiety disorder, while men were 2.6 times more likely than women to

meet the criteria for substance dependence. For some specific disorders gender differences were even more evident: eating disorders and agoraphobia were 6 times and 3 times more common among women than men.

These gender differences may reflect biological differences between men and women or cultural and social differences, such as norms of expressing or framing health problems, and life experiences.^{6,7} Societal attitudes encourage stoicism and an illusion of immunity from mental illness. As a result, men may focus on physical symptoms and disregard an underlying mental illness or they may use drugs and alcohol to cope with anxiety or depression.

Age

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), between 1 in 4 and 1 in 5 adults in the age groups between 15–64 years reported symptoms that met the criteria for a mood or anxiety disorder or substance dependence during their lifetime: 19.8% of those 15–24 years of age, 22.7% of those 25–44 years of age, 23.4% of those 45–64 years of age. (Figure 2-1)

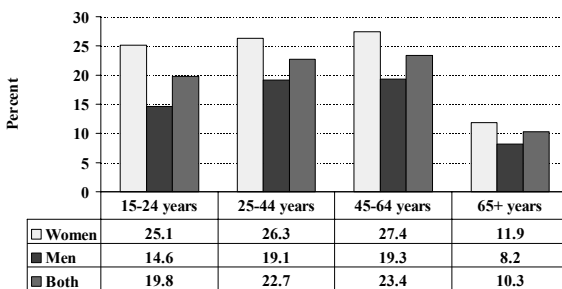
Seniors were less likely than other age groups to report symptoms consistent with a mood or anxiety disorder or substance dependence during their lifetime. This may be an underestimate of mental illness, because the survey did not include those individuals living in nursing homes, retirement homes or chronic care hospitals where depression is common. It is estimated that 80%–90% of residents of long-term care facilities have a mental disorder.⁸ In addition, seniors may not have remembered past episodes or the questions may not have been sensitive enough to identify symptoms of mental illness specific to seniors.

Seniors do, however, have a high prevalence of dementia. The Canadian Study of Health and Aging found that 8% of individuals over age 65 years and 34.5% of those over age 85 years had dementia.⁹ Depression was higher among individuals with dementia than among those without (9.5% versus 2.1%).¹⁰ This combination of neurodegenerative and mental illness is very challenging to diagnose and treat. However, anti-depressants have been found to be effective for treating depression among seniors living with Alzheimer’s disease.¹¹

The highest prevalence of a mood or anxiety disorder or substance dependence in the previous 12 months was among young adults aged between 15 and 24 years: 19.8% of women and 17.5% of men. (Figure 2-2)

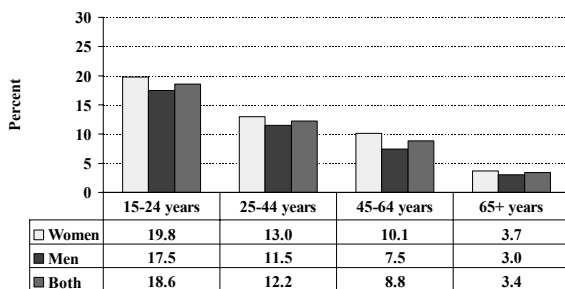
Among adults aged 25–44 years, more than 1 in 10 (12.2%) reported symptoms that met the criteria for one of these conditions in the previous 12 months. The twelve-month prevalence was slightly lower among individuals aged between 45 and 64 years (8.8%).

Figure 2-1 Proportion of population with a measured disorder¹ during lifetime, by age and sex, Canada, 2002



¹Individuals met criteria for mood disorder or anxiety disorder
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 2-2 Proportion of population with a measured disorder in past 12 months, by age and sex, Canada, 2002

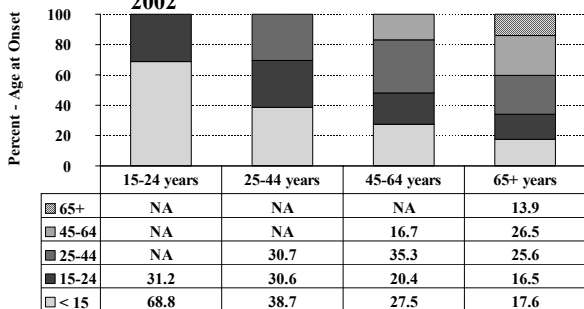


¹Individuals met criteria for mood disorder, anxiety disorder or substance dependence
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Mental illnesses often develop during adolescence and young adulthood. According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), two-thirds (68.8%) of young adults aged 15–24 years with a mood or anxiety disorder reported that their symptoms had started before the age of 15. (Figure 2-3) Almost one-half of those aged 45–64 years (47.9%) and one-third of seniors (34.1%) stated that their mental illness started before the age of 25 years.

Mood or anxiety disorders continue to develop during each life stage: 30.7% of individuals aged 25–44 years; 16.7% of 45–64 year-olds, 13.9% of seniors developed their disorder while in that age group. Patterns were similar among both men and women.

Figure 2-3 Age at onset of symptoms among individuals with a measured disorder¹, by age, Canada, 2002



¹Individuals met criteria for mood disorder or anxiety disorder
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Immigrants

Eighteen percent of people living in Canada were born elsewhere—many have been here for years. Some come to Canada through the formal immigration system that assesses their potential to contribute to the economic productivity of the country. Others—about 10%—are refugees in need of refuge and protection.¹²

In general, immigrants are very healthy because the pre-entry process screens out individuals with health problems. The 2002 Mental Health and Well-being Survey (CCHS 1.2) found that immigrants had lower rates of depression and alcohol dependence than those born in Canada (6.2% versus 8.3% for depression; and 0.5% versus 2.5% for alcohol dependence).¹³

This difference may reflect either the influence of the new country or the change in origin of immigrants over time, or both. While in the past, immigrants came from Europe or North America, more recently they have arrived from Asia and Africa, from countries with low reported rates of depression and alcohol dependence.

All immigrants face resettlement stress, or the challenge of settling in a new country. Possible stressors include unemployment, poverty, isolation, language barriers, differing societal values, racism and, in general, knowing how various systems—such as credentialing, employment, workplace, education and health—function. Whether or not these stressors lead to mental illness is likely the result of the interaction between vulnerabilities, stressors, social resources and personal strengths.

Pre-immigration trauma, such as internship in refugee camps, torture or witnessing violence, increases the risk of mental illness, particularly post-traumatic stress disorder and depression, in the first six months after arrival in Canada.¹⁴ (See Chapter 5 – Anxiety Disorders). The higher the degree of trauma, the more likely a mental illness will develop. The diagnosis of post-traumatic stress disorder can be a challenge. Programs for assisting refugees need to recognize this reality and provide the necessary support.

Immigrants show a strong desire to be productive and independent—it is a motivation for coming to Canada.¹⁵ However, more than 30% of immigrant families live below the poverty level during their first ten years in Canada. Mental illness such as depression can arise when immigrants are unable to find meaningful and economically sustaining employment.

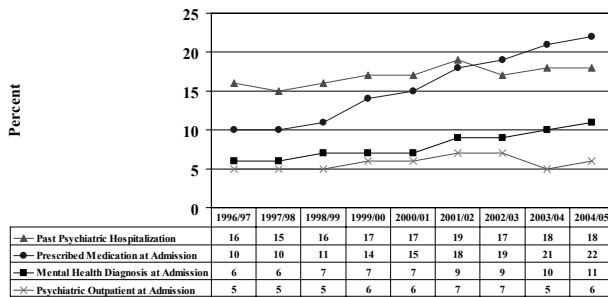
Preventing mental illness among immigrants requires societal, community and individual interventions.

Inmates in Correctional Facilities

Inmates in correctional facilities are more likely than the community population to have present or past mental illness. This is, in part, because the nature of some mental illnesses, such as bipolar disorder, personality disorders or problematic substance use, is highly associated with participation in illegal acts such as theft and violence. Another health condition, foetal alcohol syndrome caused by heavy alcohol intake during pregnancy, contributes to behaviour problems in adolescents and adults that can result in conflict with the law. A correctional facility is by definition a restrictive, coercive environment that could contribute to anxiety and depression.

An analysis of offender intake assessments to the federal corrections system between 1996/97 and 2004/05 showed an increase in the proportion of individuals who were diagnosed as having a current mental disorder and who were prescribed medication for a current mental disorder. (Figure 2-4)

Figure 2-4 Proportion of admissions to federal corrections system with current or history of mental health diagnosis, Canada, 1996/97-2004/05



Source: Reprinted with permission from 2005 Corrections and Conditional Release Statistical Overview <http://www.psepc-sppcc.gc.ca/res/cor/rep/2005/ccrs05-en.asp>

A 2004 review of mental health and illness in federal correctional facilities (where sentences were of two years or more) summarized Canadian literature and studies.¹⁶

- Most inmates in Canadian federal correctional facilities are male (97%) and under 50 years of age (86.1%).
- About 1–2% of inmates have an intellectual disability and a high proportion of these individuals also have a mental illness.
- In 2002, about one-third (31%) of female inmates and 15% of male inmates reported emotional or mental health problems at the time of intake.
- In 1999, more than 4 out of 5 inmates entering prisons in British Columbia (84%) reported symptoms that met the criteria for at least one current or lifetime diagnosis of a mental disorder, including problematic substance use. Forty-three percent met the criteria for one lifetime mental disorder: 18.3% for an anxiety disorder, 30.2% for a mood disorder and 1.5% for schizophrenia. Over 90% of inmates diagnosed with either a mood, anxiety or psychotic disorder had at least one other disorder, including substance abuse. Almost one-half of those with substance abuse had another mental disorder.
- In 2002, substance abuse was identified as a problem among a high proportion of inmates at the time of intake. Among men, 34.3% in minimum- 45.8% in medium- and

42.1% in maximum-security facilities had an alcohol problem. The proportion was even higher for drug problems: 36.4% in minimum-, 51.2% in medium- and 51.4% in maximum-security facilities. Among women, the proportions were 29.3%, 49.4% and 69.6%, for alcohol, and 40.1%, 67.5% and 78.3% for drugs in minimum-, medium- and maximum-security facilities, respectively.

- In 2000/01 the suicide rate in correctional facilities was 3.7 times higher than in the general public for similar age groups.
- A 1995 survey of federal inmates reported stresses associated with relationships among inmates and staff, getting parole, getting transferred, release dates, double bunking, getting enough tobacco, and physical safety.
- A survey of women conducted at a psychiatric hospital in British Columbia found that 58% had been sexually abused as children.¹⁷ Another study found that 83% of women in an inpatient setting had experienced physical or sexual abuse.¹⁸

The high prevalence of mental illnesses and problematic substance use underscores the need for effective assessment and treatment services within correctional services. It also points to the importance of policies, programs and services directed at the prevention and early recognition of mental illness and problematic substance use, particularly among youth, to reduce the risk of criminal activity.

Armed Forces Personnel

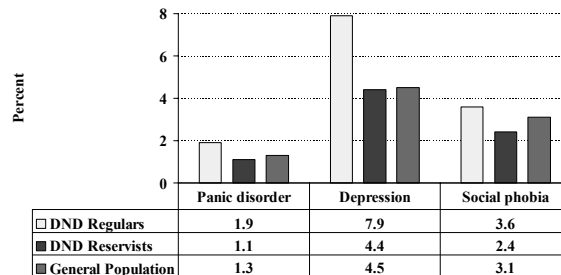
Mental health has special significance in the military. Service is demanding both physically and emotionally, and mental illness may be a consequence of military service. In addition, poor mental health may put both the individual and others at risk.

Mental illnesses among Regular Force service members, particularly depression and post-traumatic stress disorder (PTSD) contribute heavily to long-term sick leave medical releases. PTSD has been an important cause of service-related disabilities following peacekeeping and other deployments since the Persian Gulf conflict of 1990/91.

At the request of the Canadian Forces, Statistics Canada administered a slightly modified version of the 2002 Mental Health and Well-being Survey. Survey respondents who were in the Regular Forces were more likely than the general population of similar age and sex to meet the criteria for panic disorder and depression, but not for social phobia. (Figure 2-5) The prevalence of these conditions in the Reserve Forces was very similar to those of the general population.

Whether the difference in prevalence of mental disorders is due to practices associated with military service, recruitment and selection practices, or other factors is unknown.

Figure 2-5 Proportion of DND* Regulars and Reservists and general population with and without selected disorders in the previous 12 months, age- and sex-adjusted, Canada, 2002



*DND – Department of National Defence.
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2 and Canadian Forces Supplement

How Do Mental Illnesses Affect People?

Quality of Life

Mental illness affects every aspect of an individual's life—personal and family relationships, education, work and community involvement. Too often, life closes in and the individual's world becomes narrow and limited.

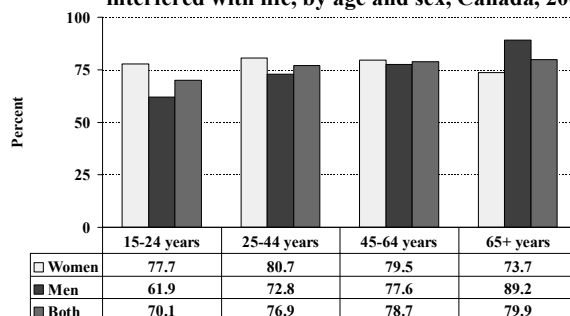
The greater the number of episodes of illness experienced by an individual, the greater the degree of lasting disability. Receiving and complying with effective treatment and the security of strong social supports, adequate income, housing and educational opportunities are essential elements in minimizing the impact of mental illness.

Worldwide, mental illnesses (major depression, bipolar disorder, schizophrenia, alcohol use, PTSD, obsessive-compulsive disorder, and panic disorder) accounted for 9.4% of the disability-adjusted life years (DALYs) in 2002.¹⁹ This is comparable to 9.9% for cardiovascular disease and almost twice as high as DALYs attributed to cancer (5.1%).

According to the 2002 Mental Health and Well-being Survey, 75.5% of individuals with a mood or anxiety disorder or substance dependence in the previous 12 months, reported that the condition interfered with their lives (71.2% of men and 79.2% of women). Nearly 1 in 3 individuals (32.7%) reported that they had to reduce activities at home. One in 6 (18.4%) reported that they had “often” or “sometimes” found it necessary to reduce their activities at work. This percentage does not include people who had to leave the workplace because of their mental illness.

Under the age of 45 years, more women than men reported that their condition interfered with their lives, but this pattern was reversed among seniors. (Figure 2-6) The greater impact among women than men under the age of 45 years could reflect their wider range of responsibilities (work, family, school) and caregiving burdens. For men, the loss of structure and role after retirement may contribute to the impact of mental illness on their life.

Figure 2-6 Proportion of population with a measured disorder¹ in past 12 months who stated it interfered with life, by age and sex, Canada, 2002



¹Individuals met criteria for mood disorder, anxiety disorder or substance dependence
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Young Adults

Adolescence and early adulthood involve important developmental changes, including completing school and developing a career, developing self-confidence and finding their place within the community. The enormity of the changes associated with this life stage likely contributes to the development of mental illness and substance dependence among young adults who are predisposed to mental illness.

Young adults with a mental illness face greater developmental challenges compared to their peers who do not have a mental health or substance dependence problem. Few other health problems affect so many people in this age group. Without help, young adults with a mental illness may not develop the life skills, independence and self-confidence that they need for not only at this point in their lives, but also in the future.

Seniors

It may be difficult to diagnose mental illness among seniors because they have multiple physical problems that may be confused with or masked by an underlying mental illness. Symptoms of mental illness in seniors may differ from those experienced by younger people, which can make accurate diagnosis and treatment difficult.²⁰ In addition, symptoms of anxiety or depression may be incorrectly considered part of the aging process and not be recognized as a treatable condition. Dementia also makes it difficult to identify underlying mental illness. Health care providers without specialized training in seniors' mental health may not be able to effectively diagnose or treat seniors' problems.

Family

Mental illnesses have a major impact on the family, in part because the symptoms of mental illness have a major impact on interpersonal relationships. For example, undiagnosed and untreated depression among men may contribute to hostility, irritability, verbal abuse and violence, or excessive drinking that affects the family.

Families may face difficult decisions about treatment, hospitalization, housing, and contact with and support of family members. Both the

individuals and their families face the anxiety of an uncertain future and the stress of a potentially severe and limiting disability. Families sometimes live with the unnecessary, self-induced guilt that they caused the illness.

The cost of medication, time off work and extra support can create a severe financial burden for families. With these burdens, along with the stigma attached to mental illness, family members often become isolated from the community and their social support network. This isolation may even contribute to the suicide of a family member.

A 2004 caregiver survey²¹ commissioned jointly by the Women's Health Bureau and the Primary and Continuing Health Care Division of Health Canada found that 70% of those caring for individuals with mental illness are women. Almost one-half (47%) of all caregivers are between the ages of 45 and 64 years. About one-third juggled full-time work with caregiving. Most lived with their care recipient (69%).

For most caregivers, caregiving was a family responsibility (86%) and they chose to provide the care (81%). In more than one-half of the situations (58%), no one else was available to provide the care—the lack of adequate mental health (58%) or home care services (42%) had thrust them into the role of caregiver. The heavy demands of care may lead to burnout. Caregiving for people with dementia is particularly challenging. While it can be rewarding, it may also cause significant stress.

The caregivers responding to the survey expressed a need for more home and community services, including access to psychologists, social workers, nutritionists and psychiatrists, homemaking, support programs and groups, nursing visits, personal care workers, occupational therapy and psychiatric day programs.

Chronic Conditions

Depression often accompanies chronic illnesses such as heart disease, stroke, Alzheimer’s disease, Parkinson’s disease, epilepsy, diabetes, cancer and HIV/AIDS.²² This is a particular problem among seniors where chronic disease is very common. Detecting and treating the depression is as important as treating the physical illness for maintaining quality of life and helping the individual cope with and manage the physical illness.

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), an individual with a chronic physical condition was more likely than an individual without such a condition to have met the criteria for one of the mental illnesses during the previous 12 months. (Figure 2-7) Individuals with a chronic physical condition were twice as likely as those without such a condition to have a mood disorder and almost twice as likely to have an anxiety disorder.

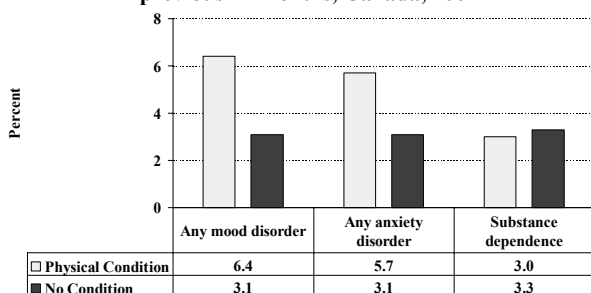
Suicide

Suicide is a major risk for individuals with schizophrenia. With other mental illnesses, such as major depression, bipolar disorder, and borderline personality disorder, the risk of suicide is also higher than in the general population. (See also Chapter 7 – Suicidal Behaviour.)

Hospitalizations

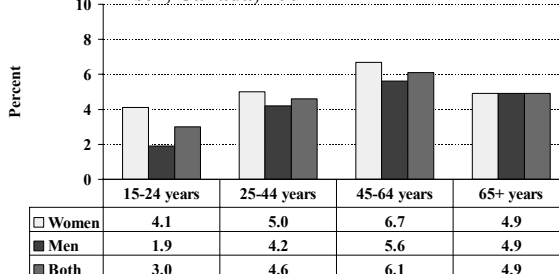
In the 2002 Mental Health and Well-being Survey (CCHS 1.2), 4.9% of individuals (4.3% of men and 5.4% of women) reported that they had been hospitalized for a mental health problem or substance abuse during their lifetime. The proportion increased with age until 65 years. (Figure 2-8) The proportions of men and women who reported being hospitalized were similar in all age groups, except among those aged 15–24 years, where women were twice as likely as men to report being hospitalized. (See also Chapter 11 – Hospitalization and Mental Illness)

Figure 2-7 Proportion of among adults aged 15+ years with and without a chronic physical condition who met the criteria for a mental illness in the previous 12 months, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 2-8 Hospitalization during lifetime for self-reported problems related to emotions, mental health or use of alcohol or drugs, by age and sex, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Economic Impact

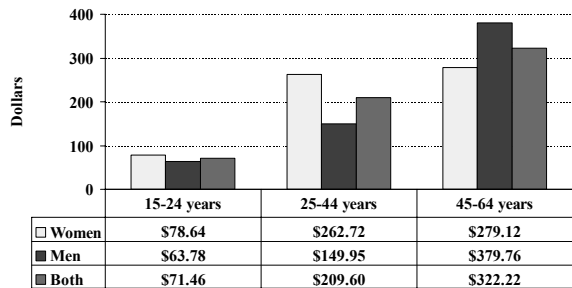
Mental illnesses have a major impact on the Canadian economy in terms of both lost productivity and health care costs. Measuring the economic impact of mental illnesses in Canada is hampered by a lack of comprehensive data, not only on the use and cost of services, but also on the economic impact of lost productivity through, for example, absence from work.

Health Canada’s 2002 report, *Economic Burden of Illness in Canada*,²³ using 1998 data, identified \$4.7 billion dollars in direct costs associated with hospital costs (\$2.7 billion), drug use (\$1.1 billion) and physician care (\$0.9 billion), and \$3.2 billion in indirect costs associated with short (\$0.5 billion) and long term disability (\$2.2 billion) and premature mortality (\$0.5 billion) for mental disorders. This represents only a small part of the economic burden: it does not include workplace costs, third-party insurance costs or the cost of all the mental health professionals who are not covered by the health insurance plans.

The impact of mental illness on the workplace comes from both lost productivity and disability claims.²⁴ In 2003, mental illness accounted for 30% of disability claims and 70% of the total costs—\$15 billion to \$33 billion annually.²⁵

Participants in the 2002 Mental Health and Well-being Survey (CCHS 1.2) reported that on average they had spent \$202.63 on mental health services and products in the previous 12 months. Among individuals 25–44 years of age, women spent more than men. (Figure 2-9) This pattern was reversed among adults aged 45–64 years. Given women’s lower wages and less access to economic resources, this represents a significant additional financial pressure due to mental illness.

Figure 2-9 Average amount spent on mental health services and products in past 12 months, by age and sex, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Stigma Associated with Mental Illnesses

Stigma... is externally imposed by society for an unacceptable act and internally imposed by oneself for unacceptable feelings.²⁶

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), many people were embarrassed about and faced discrimination because of their mental illness or mental health problem. Of respondents who met the criteria for a mood or anxiety disorder or substance dependence in the previous 12 months and reported some activity restriction:

- 53.5% felt embarrassed about their mental health problems (58.5% of men and 53.4% of women); and
- 54.3% reported facing discrimination due to mental health problems (55.9% of men and 52.8% of women).

The serious stigma attached to mental illnesses is one of the most tragic realities of mental illness in Canada. Arising from superstition, belief systems and lack of knowledge, this stigma has existed throughout history and results in stereotyping, fear and discrimination. Symptoms of mental illness remain strongly connected with public fears about potential violence and with a desire for limited social

interaction.²⁷ Yet very few people with mental illness are violent.

Stigma also results in anger and avoidance behaviours among those with a mental illness. By forcing people to remain quiet about their mental illnesses, stigma often causes them to delay seeking health care, avoid following through with recommended treatment, and avoid sharing their concerns with family, friends, co-workers, employers, health service providers and others in the community.

Stigma in the workplace has a profound impact on people with serious mental illnesses. This includes

“... diminished employability, lack of career advancement, and poor quality of working life. People with serious mental illnesses are more likely to be unemployed or to be under-employed in inferior positions that are incommensurate with their skills or training. If they return to work following an illness, they often face hostility and reduced responsibilities. The results may be self-stigma and increased disability.”²⁸

A high degree of stigmatization of pregnant women and mothers who are substance users, mothers who are abused by their partners, and mothers with mental illnesses is created by

media and public discourse. Mothers who use substances experience greater stigma than mothers with mental illness. Stigma also has a great impact on mothers who are marginalized by poverty and racism.²⁹

Seniors with mental illness carry a double burden stemming from the stigma associated with both mental illness and old age. As a result, seniors mental health problems are under diagnosed and under treated. Stigma also affects seniors suffering from dementia, sometimes causing alienation from their familiar supports.

Addressing stigma about mental illnesses is one of the most pressing priorities for improving the mental health of Canadians. Educating the public and the media about mental illness is a first step toward reducing stigma and encouraging greater acceptance and understanding. Developing and enforcing policies that address discrimination and human rights violations provide incentives for change.

In May 2006, the Standing Senate Committee on Social Affairs, Science and Technology released the final report of their consultations called “Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada”.³⁰

Causes of Mental Illnesses

Mental illnesses are the result of a complex interaction of genetic, biological, personality and environmental factors with the brain as the final common pathway for the control of behaviour, cognition, mood and anxiety. At this time, the links between specific brain dysfunction and specific mental illnesses are not fully understood.³¹

Most mental illnesses are found to be more common among close family members, suggesting a genetic basis to the disorders. Personal factors such as age, sex, lifestyle and life events can contribute to the onset of mental illnesses.

Environmental factors, such as family situation, workplace and socio-economic status of the individual, can precipitate the onset or recurrence of a mental illness.

Depression can contribute to or have a common pathway with physical illnesses such as cancer, heart disease and diabetes.³²

Genetics

Current research suggests that the risk of developing a mental illness may be related to defects in multiple genes rather than in any single gene. The development of a mental illness is likely the result of an interaction between genetic and environmental factors. This offers hope that in the future modifiable environmental risk factors will be identified and become targets of prevention.³³

Poverty and Mental Illnesses

The relationship between poverty and mental illnesses is complicated. Many studies have found that socio-economic status is inversely related to the development of mental illnesses. Two frameworks³⁴ have been proposed to explain this relationship.

Indirect Association: Selection and Drift

The concept of selection proposes that certain individuals may be predisposed both to a mental illness and to lower expectations and ambition, which in turn result in lower levels of educational and occupational achievement. On the other hand, a milder undiagnosed mental illness makes it difficult for individuals to achieve success in the complex post-industrial society. Poverty is associated with a lower level of achievement in formal education. In this situation, then, there is an indirect association between poverty and mental illnesses.

“Drift” refers to the likelihood that those with a mental illness may drift into poverty as they have difficulty achieving and maintaining regular employment. This indirect association between poverty and mental illness may be mitigated by the “class” effect, whereby the networks of support around people in higher socio-economic classes prevent their drift into poverty.

Direct Association: Social Causation

Direct association between poverty and mental illnesses implies that the social experience of individuals who are poor increases the likelihood of developing a mental illness. For example, living in poverty may lead to a lack of opportunity and consequently to hopelessness, anger and despair. When combined with a genetic predisposition, poverty can contribute to the development of mental illnesses. Most people

who are poor do not have mental illnesses, however.

Violence Contributing to Mental Illness

Childhood Maltreatment

Childhood maltreatment refers to “the harm, or risk of harm, that a child or youth may experience while in the care of an adult whom they trust or depend on, including a parent, sibling, other relative, teacher, caregiver or guardian. Harm may occur through actions by the adult (an act of commission) or through the adult’s neglect to provide a component of care necessary for healthy child growth and development (an act of omission)”³⁵

According to the Canadian Incidence Study of Reported Child Abuse and Neglect 2003, the estimated incidence of substantiated child maltreatment was 21.7 cases for every 1,000 children. Of the over 100,000 substantiated cases in this study, 30 % involved child neglect, 28% exposure to domestic violence, 24% physical abuse, 15% emotional maltreatment, and 3% sexual abuse.³⁶

A unique set of symptoms, such as feelings of powerlessness, dissociative symptoms and self-blame, arises from early and chronic sexual abuse. Early childhood trauma has been linked to later depression, borderline personality disorder, multiple personality disorder, problematic substance use, and post-traumatic stress disorder.^{37,38,39,40}

In one long-term study, almost 80% of young adults who had been abused as children met the diagnostic criteria for at least one psychiatric disorder at age 21. These young adults exhibited numerous conditions including depression, anxiety, eating disorders, and suicide attempts.⁴¹

A survey of women conducted at a psychiatric hospital in British Columbia found that 58% had been sexually abused as children.⁴² Another study found that 83% of women in an inpatient setting had experienced physical or sexual abuse.⁴³

The powerful impact of childhood maltreatment emphasizes the need for early intervention and prevention strategies to prevent or minimize serious consequences.

Bullying

“Bullying is a relationship problem—it is the assertion of interpersonal power through aggression. Bullying has been defined as negative physical or verbal actions that have hostile intent, cause distress to victims, are repeated over time, and involve a power differential between bullies and their victims.”⁴⁴

According to the Health Behaviour of School-Aged Children Survey (HBSC), 2002,⁴⁵ 39% of boys and 37% of girls in Grades 6–10 reported being bullied at school at least once in the previous term. Between 7% and 10% of students in each grade reported being bullied once a week or more. Overall, the prevalence of being bullied was highest in Grades 7 and 8.

All young people involved in bullying—the bully, the victim and the witnesses—are affected by it. It most frequently occurs at school and at places where there is little adult supervision. Children and youth who bully are more likely to engage in other forms of aggression, including sexual harassment and dating violence in adolescence. They are also more likely to engage in school delinquency and substance use. Childhood bullying is also associated with adult anti-social behaviour.

Victims of bullying are more likely to experience depression and anxiety and, in extreme cases, to commit suicide. Some express their anger about the abuse by becoming aggressive and bullying others themselves.

Violence against Women

Violence against women encompasses a wide range of abuses and harms, including, but not limited to

“... physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation: physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in education institutions and elsewhere, trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the state wherever it occurs.”⁴⁶

The health care costs of violence against women have been estimated at over \$1.5 billion annually.⁴⁷

Many women’s psychological and physical problems are responses to multiple traumas over their lifetime.⁴⁸ The impact associated with violence is compounded if a woman is socially marginalized, is living in poverty, or has serious mental illness.

All women are vulnerable to violence, regardless of their race, ethnicity, culture, physical and

mental ability, age, sexuality or economic status. Canadian statistics suggest that 50% of women have experienced at least one incident of sexual or physical violence.⁴⁹ Over one-quarter (29%) of women ever married have been sexually or physically assaulted by a current or former partner since the age of 16 years.^{50,51}

The estimates of abuse during pregnancy vary.⁵² The Society of Obstetricians and Gynecologists states that the incidence may range from 4% to 17%. The problem is most likely underestimated because most women do not report it, likely for a variety of reasons, including fear that their child will be removed. For many women the abuse begins during pregnancy.

A minimum of 1 million Canadian children have witnessed violence against their mothers either by their fathers or their father-figures.⁵³

Severe and chronic mental illness also puts women at risk for violence and abuse. This increased risk can be a direct result of a woman’s illness and/or the medications she takes for her illness which may impair her judgment, making it difficult for her to protect herself against sexual assault.

At the most extreme end, violence results in serious physical injury and death.⁵⁴ Many other mental and physical health problems—including anxiety, depression, central nervous system damage, sleep disorders, migraines, respiratory-related problems, cardiovascular system problems, endocrine problems, gastrointestinal and genito-urinary problems, reproductive and sexual problems—have been linked to experiences of abuse and trauma. Women may use substances to self-medicate the psychological symptoms arising from trauma.

Any treatment and program planning requires an understanding of the interconnection between violence, mental health and substance use problems. Promising models for treatment include the application of techniques such as trauma-focused cognitive behavioural treatment,

as well as psycho-education and work to help women establish secure attachments.

The manner in which services are provided to trauma survivors with a mental illness needs to be carefully planned. The use of physical and chemical restraints, for example, can trigger feelings of powerlessness.

Prevention and Recovery

Prevention

Addressing the psychological and social determinants of mental health can not only promote mental health but may also prevent some mental illnesses. For the individual, such factors as secure attachment, good parenting, friendship and social support, meaningful employment and social roles, adequate income, physical activity and an internal locus of control will strengthen mental health and help to reduce the impact or incidence of some mental health problems. (See Chapter 1 – Mental Health for more detail.)

Strategies that create supportive environments, strengthen community action, develop personal skills and reorient health services can give the population some control over the psychological and social determinants of mental health.

Primary prevention of most mental illness is still in the early stages of development. Early teaching of cognitive-behavioural strategies may prevent or reduce the impact of anxiety disorders.

Given the correlation between a history of severe trauma (such as physical or sexual abuse) and various mental illnesses (dissociative disorders, personality disorders, addictions, post-traumatic stress disorder), preventing such traumas could prevent mental health problems.

Recovery from Mental Illness

Most mental illnesses can be treated in order to reduce symptoms. Placing treatment within a recovery model, however, helps individuals go beyond symptom reduction toward improving their quality of life.

“Recovery does not refer to an end product or result. It does not mean that one is “cured” nor does it mean that one is simply stabilized or maintained in the community. Recovery often involves a transformation of the self wherein one both accepts one’s limitation and discovers a new world of possibility. This is the paradox of recovery, i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do. Thus, recovery is a process. It is a way of life. It is an attitude and way of approaching the day’s challenges. It is not a perfectly linear process. Like the sea rose, recovery has its seasons, its time of downward growth into the darkness to secure new roots and then the times of breaking out into the sunlight. But most of all recovery is a slow, deliberate process that occurs by poking through one little grain of sand at a time.”⁵⁵

Treatment to assist in recovery from mental illness must reflect its complex origins. A variety of interventions such as psychotherapy, cognitive-behavioural therapy, medication and occupational therapy can improve an individual’s functioning and quality of life. Since mental illnesses arise from disorders of brain functioning, medication is often an important part of treatment.

Making the correct diagnosis and tailoring effective treatment to the individual's needs are essential components of an overall management plan. The active involvement of the individual in the choice of therapy and his/her adherence to the chosen therapy are critical to successful treatment. Sometimes, protecting the health of the individual may require the involvement of alternate decision makers.

Recovery requires a variety of health and social service providers and volunteers organized into a comprehensive system of services. Service providers need to work as a team to ensure continuity of care.

An effective recovery system requires that all individuals have access to appropriate services where needed, such as in the community. Self-help organizations and programs connect individuals to others facing similar challenges and provide support to both individuals and family members.

A comprehensive, effective mental health care system to support recovery would include the following components:

Assumptions about Recovery	
Factors/Items	Reasons
1. <i>The task of consumers is to recover.</i>	Professionals do not hold the key to recovery: consumers do. The task of professionals is to facilitate recovery; the task of consumers is to recover. Recovery may be facilitated by the consumer's natural support system.
2. <i>A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.</i>	Seemingly universal in the recovery concept is the notion that critical to one's recovery is a person or persons in whom one can trust to "be there" in times of need.
3. <i>A recovery vision is not a function of one's theory about the causes of mental illness.</i>	Recovery may occur whether one views the illness as biological or not. The key element is understanding that there is hope for the future, rather than understanding the cause in the past.
4. <i>Recovery can occur even though symptoms reoccur.</i>	The episodic nature of severe mental illness does not prevent recovery. As one recovers, symptoms interfere with functioning less often and for briefer periods of time. More of one's life is lived symptom-free.
5. <i>Recovery is a unique process.</i>	There is no one path to recovery, nor one outcome. It is a highly personal process.
6. <i>Recovery demands that a person has choices.</i>	The notion that one has options from which to choose is often more important than the particular option one initially selects.
7. <i>Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself.</i>	These consequences include discrimination, poverty, segregation, stigma and iatrogenic effects of treatment.
Adapted from Anthony WA. A recovery-oriented service system: setting some system level standards. <i>Psychiatric Rehabilitation Journal</i> 2000;3:159-68.	

Education

Individuals and families directly affected by the disorders need information about signs and symptoms of mental illnesses, sources of help, medications, therapy and early warning signs of relapse. Booklets, videotapes and family consultations can help to raise awareness. Outcomes may be improved by educating people in order to enhance their abilities to identify episodes in their earlier stages and to respond with appropriate actions.

Community Education

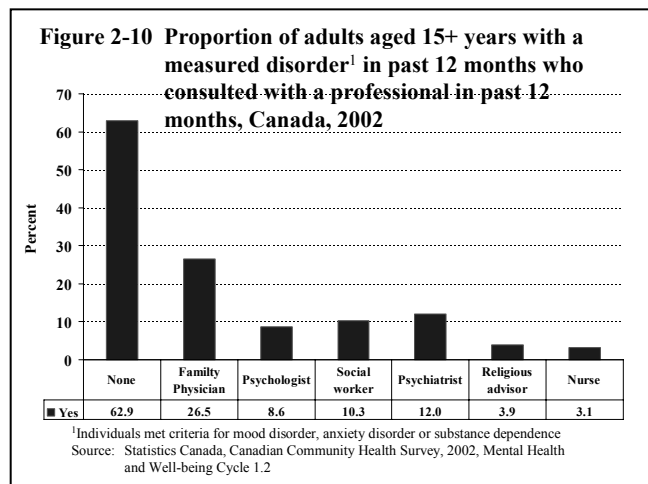
Dispelling the myths surrounding mental illnesses requires community education programs, including programs in schools. Such programs could help reduce the stigma associated with mental illnesses and improve the early recognition of a problem. They may also be instrumental not only in encouraging people to seek care, but also in creating a supportive environment for the individual.

Primary and Specialty Care

For most Canadians, their primary care physician is their first and often only contact with the health care system. According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), only 37.1% of individuals who met the criteria for an anxiety or mood disorder or substance dependence in the previous 12 months consulted with a professional. (Figure 2-10) Family physicians were the most frequently consulted health professional. Psychiatrists, social workers and psychologists were the next most frequently consulted. A small proportion consulted with either a religious advisor or a nurse.

Under-diagnosis, misdiagnosis and under-treatment of mental illnesses can result in poor outcomes. As a result, educating primary care physicians to properly recognize, diagnose and treat most mental illnesses within a recovery model and to know when to refer to others is a crucial factor in optimizing the care that they provide. Training of family medicine residents in these topics is also essential. Creating and distributing consensus treatment guidelines is a first step to increased knowledge about mental illnesses, their diagnosis and treatment. Encouraging the use of these guidelines requires attention to the predisposing, enabling and reinforcing factors that exist in the clinical setting.

In the Shared Care Model of mental health care delivery described by a Canadian Psychiatric Association and College of Family Physicians of Canada collaborative working group⁵⁶, psychiatrists and mental health care workers work with family physicians, providing support and counselling assistance in the daily clinic setting. Care providers and individuals requiring service have found this to be an effective model.



Other health professions, such as psychology and social work, also provide essential services to those with mental illness. An ideal primary care model would involve family physicians, psychologists, nurses, social workers, psychiatrists, occupational therapists, pharmacists and others, all working in a collaborative and integrated system.

Hospitals

The hospital emergency department is a valuable resource for crisis interventions and may be an individual's first point of contact with the health care system.

Hospitalization for a mental illness can assist in diagnosing the illness and stabilizing symptoms. It can provide a critical respite from the sometimes overwhelming challenges of daily living. The hospital can also serve as a safe and supportive environment when the risk of suicide is high or judgement is severely compromised by the presence of mental illness.

Multidisciplinary teams of physicians, nurses, occupational therapists, pharmacists, social workers and case managers work with the individual and family to identify and respond to the factors that influence symptoms. They also help the individual and family understand and cope with their personal response to the mental illness.

While hospitalization provides important short term respite and care, prolonged periods of hospitalization can remove the individual from their normal environment and weaken social connections, making re-integration into community living more challenging.

Hospital-based programs targeted at improving independent living skills can help individuals acquire social, communication and functional living skills that improve their ability to cope with the demands of living.

Reforms of the mental health system of the 1960s and 1970s reduced the number beds in psychiatric institutions. Many individuals with a mental illness moved from chronic care facilities back into the community. Communities have faced major challenges in helping both these individuals and those newly diagnosed with severe mental illness to create a reasonable quality of life in the community. (See Chapter 11 – Hospitalization)

Community Outreach Programs

Community mental health programs are varied and range from psychotherapeutic interventions to programs of assertive community treatment, such as mobile crisis teams, crisis stabilization units, community mental health workers in both rural and urban areas, early prevention and intervention programs, programs in schools, safe houses run by consumers, and clubhouse programs.

An investment in community outreach programs that support individuals to live productive, meaningful, and connected lives is an essential, cost-effective alternative to hospital-based care.

Some community outreach programs consist of multidisciplinary teams that share the clinical responsibility for each individual. A team aims to ensure adherence with treatment (particularly for those with schizophrenia and other psychotic illnesses) and, consequently, improve functioning in order to reduce the need for hospital readmission. The community outreach program also focuses on social skills training to improve social functioning and to resolve problems with employment, leisure, relationships and activities of daily living.

The elderly with mental illness are a prime example of the need for community outreach programs. It is difficult for them to move from

service to service and the complexity of their needs requires a team approach.

Workplace Supports

The workplace can play a critical role in the prevention of mental illness and in the recovery process through the development of a healthy work environment, education of employers and employees on mental health and mental illness, counselling and support, and supportive reintegration into the work environment for those experiencing mental illness. Vocational rehabilitation supports permanent competitive employment or the ability to hold a regular job in the community.

It is important to address the high levels of unemployment and poverty found among people with mental illness and support their desire for work. Consumer- or survivor-run businesses have proven effective in restoring employment among individuals with mental illnesses.

Other Supports

A variety of other programs and services—such as long-term care residences, community rehabilitation, special needs groups, specialty services (sleep laboratory, psycho-pharmacological consultation) and community crisis centres—can contribute to the diagnosis and recovery of individuals with mental illness and support their integration into the community. Support is also required to ensure adequate income and safe housing for individuals with mental illnesses.

Older homeless persons require long-term case management and help and would benefit from joint action by the gerontological service sector and the homeless sector. Further, increased supportive housing would serve older homeless persons for whom mainstream housing is not an option. Institutional care specific to the needs of the older homeless people is also required along with additional shelter options, particularly for older homeless women.⁵⁷

It is estimated that at least 75% of residents in nursing or personal care homes have a cognitive difficulty, a diagnosed mental illness, or both.⁵⁸ Some of these facilities now hire a psychiatric nurse as a mental health resource for the facility to develop programs to meet the specific needs of the patient and to educate staff and train them to follow through with the program.

Unmet Service Needs

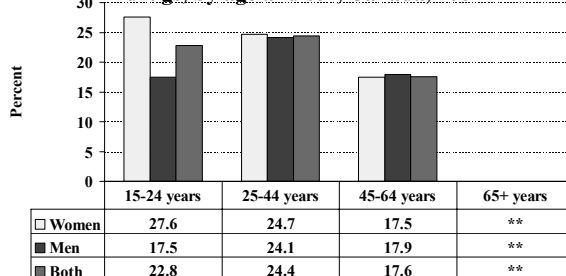
According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), 21.6% of individuals (22.9% of women and 20.0% of men) whose reported symptoms met the criteria for an anxiety or mood disorder or substance dependence in the previous 12 months reported that they wanted help for mental health problems but could not get it. (Figure 2-11)

Young women (15–24 years) were more likely than young men to report unmet needs. The proportion who reported unmet needs was higher among those 25–44 years of age than among those 45–64 years of age.

As the level of family income increased, fewer individuals who met the criteria for a mood or anxiety disorder or substance dependence reported that they had unmet needs related to their mental illness. Individuals in the lowest income category were 1.5 times more likely than those in the highest income category to report unmet needs. (Figure 2-12)

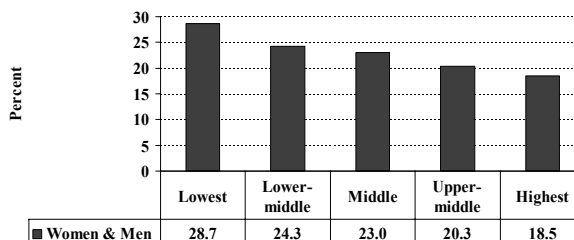
Among those who had unmet needs, the type of care most commonly felt to be required was therapy or counselling, help for personal relationships and information on mental illness or treatment.⁵⁹

Figure 2-11 Proportion of adults with a measured disorder¹ in past 12 months who had unmet needs related to emotions, mental health or use of alcohol or drugs, by age and sex, Canada, 2002



¹Individuals met criteria for mood disorder, anxiety disorder or substance dependence
 ** Sample size too small.
 Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 2-12 Proportion of adults aged 15+ years with a measured disorder¹ in past 12 months who had unmet needs related to emotions, mental health or use of alcohol or drugs, by income adequacy, Canada, 2002



¹Individuals met criteria for mood disorder, anxiety disorder or substance dependence
 Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Legal Issues Regarding Treatment of Mental Illness

“Without compulsory admission (to hospital) and psychiatric treatment, people who cannot accept voluntary treatment are abandoned to the consequences of their illness. Untreated ... these illnesses can cause great personal suffering including despair to the point that people, for no reason apparent to others, kill themselves to escape the torment of feelings of worthlessness or because a voice (hallucination) commands them to.”⁶⁰

Severe mental illnesses may affect personal insight to the degree that individuals are unable to recognize how seriously ill they are and voluntarily seek help, or even to accept help when it is offered. Mental health laws have been put in place to address situations in which an untreated mental illness is likely to cause significant harm to the person or others. These laws are only effective if there is effective service available to treat the individual involved, however.

While mental health laws are specific to each province and territory, they revolve around the following common societal values:⁶¹

- The need to provide protection and assistance to those who, through no fault of their own, cannot assist themselves;
- The need to protect other members of society from the conduct of those whose

mental illness overrules their capacity for self-control;

- The need for individuals in a civilized democratic society to be as unfettered as possible by legal intrusions.

The balance accorded to each value changes over time. In the past, greater emphasis has been placed on ensuring that people are not kept in hospital against their will. This has the potential to leave seriously ill people without treatment, however.

Recent changes to mental health acts are redressing this imbalance. Innovative practices—such as encouraging an individual to write explicit instructions about the treatment that he or she would like to receive if too ill to decide at a specific time—keep the individual rights at the forefront of substitute decision-making.

The mental disorder sections of the federal Criminal Code can be used by a judge to require a person who is found unfit to stand trial to receive compulsory psychiatric treatment. This requires, however, that adequate resources be available within the forensic hospital setting in order to receive the individual from the prison setting. Other parts of the Criminal Code that address conditional discharge or probation can encourage but not force psychiatric treatment.

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CHAPTER 3

MOOD DISORDERS

What Are Mood Disorders?

Mood disorders affect the way that an individual feels. They may involve depression or manic episodes. Both depressive and manic episodes can change the way an individual thinks and behaves and the way the body functions.

Individuals with mood disorders suffer significant distress or impairment in social, occupational, educational or other important areas of functioning.

In an episode of depression, individuals may feel worthless, sad and empty to the extent that these feelings impair effective functioning. They may also lose interest in their usual activities, experience a change in appetite, suffer from disturbed sleep or have decreased energy.

Individuals in a manic episode are overly energetic and may do things that are out of character, such as spending very freely and acquiring debt, breaking the law or showing lack of judgement in sexual behaviour. These symptoms are severe and last for weeks or months, interfering with relationships, social life, education and work. Some individuals may appear to function normally, but this requires more and more effort as the illness progresses.

Children with depression may not have the same symptoms as adults. They may be irritable rather than depressed and have more anxiety, temper-tantrum and behavioural problems. The symptoms of attention deficit disorder, major depressive disorder and bipolar

disorder may be very similar. Likewise, older adults may experience depression differently than younger people. It is more often expressed by anxiety, agitation and complaints of physical and memory disorders.

Major depressive disorder is characterized by one or more major depressive episodes (at least two weeks of depressed mood and/or loss of interest in usual activities accompanied by at least four additional symptoms of depression).¹

Bipolar disorder is characterized by at least one manic or mixed episode (mania and depression) with or without a history of major depression.² Bipolar 1 disorder includes any manic episode, with or without depressive episodes. Bipolar 2 is characterized by major depressive episodes and less severe forms of mania (hypomanic episodes).

Dysthymic disorder is essentially a chronically depressed mood that occurs for most of the day for more days than not over a period of at least two years,³ without long, symptom-free periods. Symptom-free periods last no longer than two months. Adults with the disorder complain of feeling sad or depressed, while children may feel irritable. The required minimum duration of symptoms for diagnosis in children is one year.

Perinatal depression, or depression surrounding the childbirth period, may be experienced by both pregnant women and new mothers.

<u>Symptoms</u>	
<u>Depression</u>	<u>Bipolar Disorder</u>
<ul style="list-style-type: none"> • Depressed mood • Feeling worthless, helpless or hopeless • Loss of interest or pleasure (including hobbies or sexual desire) • Change in appetite • Sleep disturbances • Decreased energy or fatigue (without significant physical exertion) • Sense of worthlessness or guilt • Thoughts of death • Poor concentration or difficulty making decisions 	<ul style="list-style-type: none"> • Excessively high or elated mood • Unreasonable optimism or poor judgement • Hyperactivity or racing thoughts • Decreased sleep • Extremely short attention span • Rapid shifts to rage or sadness • Irritability

How Common Are Mood Disorders?

Mood disorders are one of the most common mental illnesses in the general population. According to Statistics Canada’s 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2), 5.3% of the Canadian population aged 15 years and over reported symptoms that met the criteria for a mood disorder in the previous 12 months, including 4.8% for major depression and 1.0% for bipolar disorder.

One in 7 adults (13.4%) identified symptoms that met the criteria for a mood disorder at some point during their lifetime, including 12.2% for

depression and 2.4% for bipolar disorder. This lifetime prevalence for bipolar disorder is higher than expected for bipolar 1 disorder, likely because the survey tool was not able to differentiate between manic and hypomanic episodes.

Other studies have reported that between 3% and 6% of adults will experience dysthymic disorder during their lifetime.⁴

About 10% of women will experience depression while pregnant and about 10–15% will experience it after the baby is born.^{5,6,7}

Impact of Mood Disorders

Who Is Affected by Mood Disorders?

Men and Women

Studies have consistently documented higher rates of depression among women than among men: the female-to-male ratio averages 2:1.⁸ Men and women have similar rates of bipolar disorder. Women are 2 to 3 times more likely than men to develop dysthymic disorder.

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), 4.2% of men and 6.3% of women aged 15 years and over reported symptoms that met the criteria for a mood disorder in the previous 12 months: 3.7% and 5.9% of men and women, respectively, met the criteria for major depression; 1.0% of both men and women met the criteria for bipolar disorder.

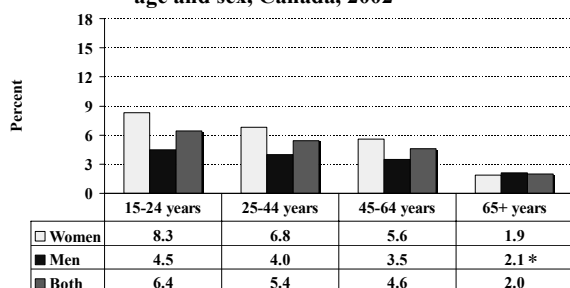
One in 10 men (10.5%) and 1 in 6 women (16.1%) met the criteria for a mood disorder at some point during their lifetime: 9.2% and 15.1%, respectively, for depression; and 2.4% and 2.3% for bipolar disorder.

In all age groups under the age of 65 years, a greater proportion of women than men reported symptoms that met the criteria for major depression during the previous 12 months and during their lifetime. (Figures 3-1 and 3-2)

Biological or social risk and protective factors may differ between men and women, which may explain the difference in the prevalence of depression. Gender differences in the symptoms that are associated with depression may also contribute to the differences in prevalence. While women express the more "classical" symptoms of feelings of worthlessness and helplessness, and persistent sad moods, men are more likely to be irritable, angry and discouraged when depressed. As a result, depression may not be as easily recognized in men. In addition, women are more likely than men to seek help from health professionals.

In contrast to depression, the proportions of men and women whose reported symptoms met the criteria for bipolar disorder during the previous 12 months and during their lifetime were similar in all age groups. (Figures 3-3 and 3-4)

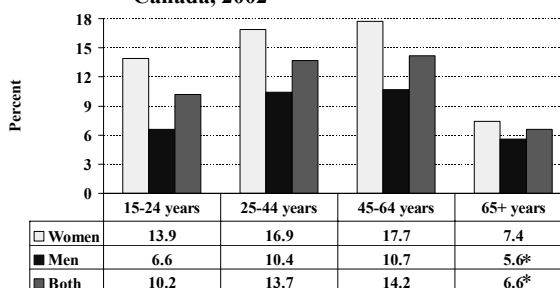
Figure 3-1 Proportion of population who met the criteria for depression during previous 12 months, by age and sex, Canada, 2002



* Small sample size. Interpret with caution.

Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

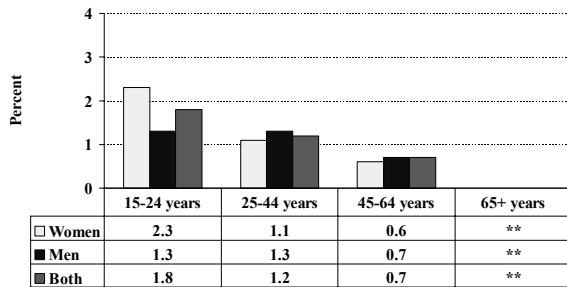
Figure 3-2 Proportion of population who met the criteria for depression during lifetime, by age and sex, Canada, 2002



* Small sample size. Interpret with caution.

Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

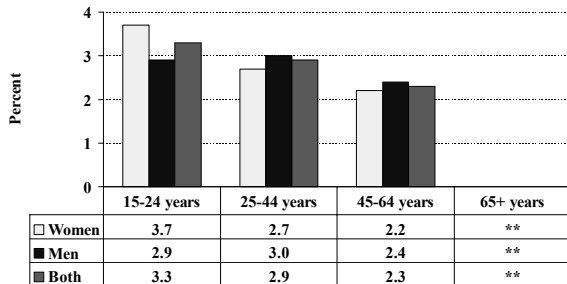
Figure 3-3 Proportion of population who met the criteria for bipolar disorder during previous 12 months, by age and sex, Canada, 2002



** Sample size too small.

Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 3-4 Proportion of population who met the criteria for bipolar disorder during lifetime, by age and sex, Canada, 2002



** Sample size too small.

Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Young Women and Men

Mood disorders affect individuals of all ages, but usually first appear in adolescence or young adulthood. The average age of diagnosis of major depressive disorder, however, is in the early twenties to early thirties,⁹ reflecting the delay in diagnosis.

Young women (15–24 years) had a higher 12-month prevalence of depression than all other age groups for both men and women.

Men and women in the 15–24 year age group had the highest proportion of individuals who met the 12-month criteria for bipolar disorder (1.8%). The 12-month prevalence of bipolar disorder decreased with age.

Adults in Mid-Life

Among both men and women, the proportion who met the criteria for depression during their lifetime increased into the mid-life years. This reflects the cumulative experience with depression as people age. One in 7 adults aged between 45 and 64 years met the criteria for depression during their lifetime: 1 in 10 men and 1 in 6 women.

About 1 in 50 adults aged 25–44 years or 45–64 years reported symptoms consistent with bipolar disorder at some point in their lifetime. The proportion of men and women who met the lifetime criteria for bipolar disorder decreased slightly with age.

Seniors

Among senior men and women, both the 12-month and lifetime prevalence of depression were lower than among all younger age groups. The lower lifetime prevalence may reflect either a reluctance to acknowledge symptoms of depression in the past, forgetting of prior episodes, or a real change in the prevalence of depression over time. Seniors may also have developed more effective coping skills during their lifetime. The questions used in the 2002 Mental Health and Well-being Survey (CCHS 1.2) may not have been sensitive enough to identify symptoms of depression specific to seniors. In addition, residents of long-term care facilities were not included in the survey.

The sample size of seniors in the 2002 Mental Health and Well-being Survey (CCHS 2.1) who reported symptoms that met the criteria for bipolar disorder was too small for estimating prevalence.

According to the Canadian Study of Health and Aging (originated in 1991, with follow-up in 1996 and 2001), 2.6% of seniors aged 65+ years had symptoms that met the criteria for major

depression and 4.0% had symptoms that met the criteria for minor depression.¹⁰ Major depression was defined as having five or more of the nine symptoms of depression during the previous two weeks. Minor depression was defined as having two to four symptoms.

Major depression was more common among seniors living in institutions (7.7%) than among those living in the community (2.2%). It was also more common among individuals with dementia (9.5%) than among those without (2.1%). As with younger age-groups, the prevalence of both major and minor depression was higher among women than men: 3.4% of women compared to 1.5% of men for major depression, and 6.0% of women versus 1.4% of men for minor depression.

Factors associated with depression among seniors included poorer overall health, the interference of health problems with activities, sensory impairment, and presence of chronic disease. Marital status was not found to be associated with depression.

How Do Mood Disorders Affect People?

Mood disorders present a serious public health concern in Canada because of their high prevalence, associated economic costs, the risk of suicide, and reduced quality of life.

Major depressive disorder is typically a recurrent illness with frequent relapses and recurrences. The more severe and long-lasting the symptoms in the initial episode (sometimes due to a delay in receiving effective treatment) the less likely is full recovery.

Depression also has a major impact on the mental health of family members and caregivers, whose own depression and anxiety symptoms may increase.

With **bipolar disorder**, individuals who experience one manic episode tend to have future episodes. Recovery rates vary with the characteristics of the disease: individuals with purely manic episodes fare better than those with both mania and depression, who tend to take longer to recover and have more chronic courses of illness.¹¹

Dysthymic disorder, due to its protracted nature, can be very debilitating.¹² Individuals with this disorder are also at high risk of experiencing an episode of major depression.¹³

Depression and bipolar disorder cause significant distress and impairment in social, occupational, educational or other important areas of functioning.¹⁴ According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), 9 out of 10 Canadians who reported symptoms that met the 12-month criteria for depression (90.1%) reported that the condition interfered with their lives. A similar proportion of those who met the 12-month criteria for bipolar disorder (86.9%) reported that it interfered with their lives.

According to the World Health Organization (WHO), major depression is among the leading causes of disability-adjusted life years (DALYs) in the world. Depression contributes to 4.5% of DALYs; ischemic heart disease, 3.9%; stroke, 3.3%; all cancer, 5.1%; and HIV/AIDS 5.7%.¹⁵

While most individuals with depression or bipolar disorder will not commit suicide, suicide rates are slightly higher than in the general population (approximately 5% versus 1-2%).^{16,17} (For more details see Chapter 8 – Suicidal Behaviour.)

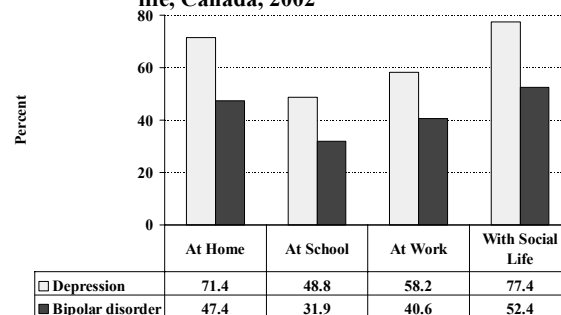
Child or spousal abuse or other violent behaviours may occur during severe manic episodes. Furthermore, loss of insight often occurs among individuals with bipolar disorder, resulting in resistance to treatment, financial difficulties, illegal activities and substance abuse. Other associated problems include occupational, educational or marital failure. Individuals with bipolar disorder may often have difficulty maintaining steady employment, which may create social and economic disadvantages.

Mood disorders frequently accompany other mental illnesses, such as anxiety disorders, personality disorders and problematic substance use. The presence of another mental illness increases the severity of the initial illness and results in a poorer prognosis.

Individuals with depression are more likely to develop chronic diseases such as diabetes,¹⁸ and individuals with chronic disease who have depression have a poorer prognosis.¹⁹

Depression and bipolar disorder affect life at home, school and work and in social interaction. (Figure 3-5) A higher proportion of individuals with depression than for bipolar disorder reported that their condition had interfered with their lives in each of the four areas. Mood disorders had a greater impact on home and social life than in school and work situations. This could be the result of withdrawing from the work or school environment due to illness.

Figure 3-5 Proportion of population aged 15+ years who met criteria for depression or bipolar disorder in past 12 months who stated it interfered with life, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Economic Impact of Mood Disorders

The high prevalence of mood disorders has a major effect on the Canadian economy. This effect is dual in nature: first, the loss of productivity in the workplace due to absenteeism and diminished effectiveness; and second, the high health care costs attributable to primary care visits, hospitalizations and medication.

A recent discussion paper, "Nature and Prevalence of Mental Illness in the Workplace" highlights the importance and impact of depression in the workplace.²⁰ One of the principal causes of absenteeism was mental and emotional problems (7% of Canadian workers). Between 62% and 76% of short-term disability episodes due to mental disorders were attributed to depression.²¹ Work-related productivity losses due to depression have been estimated to be \$4.5 billion.²²

At the individual and family level, the loss of income and cost of medication create a strain on the family financial resources.

Stigma Associated with Mood Disorders

Stigma against individuals with mood disorders has a major influence in determining whether an individual seeks treatment, takes prescribed medication or attends counselling. Stigma also influences the successful re-integration of the individual into the family and community.

Attitudes that attribute symptoms of depression among seniors as "just part of aging", contribute to the lack of recognition of clinical depression that can be treated. These attitudes can also prevent seniors from seeking help.

Employers may be concerned that the individual with a mood disorder may be unable to function at the level of other employees. When the illness goes untreated, this may be true. However, with treatment to reduce or manage symptoms, performance usually improves. Addressing the stigmatization of mental illness in the workplace will improve through increased knowledge and an employer's willingness and ability to respond appropriately to an employee's needs.²³ Enforcement of human rights legislation can reinforce voluntary efforts.

Causes of Mood Disorders

Mood disorders have no single cause, but several risk factors interact to produce the clinical symptoms of the various mood disorders.

Individuals with depression and bipolar disorder often find a history of these disorders among immediate family members.^{24,25} Many different genes may act together and in combination with other factors to cause a mood disorder.

Research is getting closer to identifying the specific genes that contribute to depression.

One episode of major depression is a strong predictor of future episodes. More than 50% of individuals who have an episode of major depression experience a recurrence.²⁶

Traditionally, stress has been viewed as a major risk factor for depression. Recent research suggests that stress may only predispose individuals for an initial episode, but not for recurring episodes.²⁷ Some individuals are more susceptible than others to depression following traumatic life events, when in difficult or abusive relationships, or as a result of socio-economic factors such as income, housing, prejudice and workplace stress.

A strong association exists between various chronic medical conditions and an increased prevalence of major depression.²⁸ Several chronic medical conditions, such as stroke and heart disease, obesity, Parkinson's disease, epilepsy, arthritis, cancer, AIDS, chronic obstructive pulmonary disease (COPD), and dementia and Alzheimer's Disease may contribute to depression.

This association may result from physiological changes associated with these conditions, such

as changes in various neurotransmitters, hormones and the immune system, or from associated disability and poor quality of life. In addition, some medications used to treat physical illnesses tend to cause depression. People who cope with more than one medical condition may be at particular risk for depression. Effective treatment of chronic physical illness includes the assessment, early detection and treatment of depression.

Episodes of mania may occur following physical illness or use of drugs.

Perinatal depression is likely caused by both biological and psychosocial elements, such as hormones, emotions and life circumstances.

A number of risk factors have been identified for postpartum depression. The experience of symptoms of depression during the pregnancy is one risk factor. The "baby blues", a mild mood disturbance that lasts only a few days after birth, can affect up to 80% of women. While generally it does not require treatment,^{29,30,31} up to 20% of women with the baby blues will develop postpartum depression within the first year after giving birth. One in 4 women (25%) with a history of depression is at risk for postpartum depression. Over one-half of women with previous episodes of postpartum depression (50%–62%) are also at risk.³² Other risk factors include lack of social support, low self-esteem, relationship problems and low socioeconomic status.³³

Prevention and Treatment of Mood Disorders

Prevention of major depression includes minimizing and coping with stress effectively, and managing chronic disease (focusing on enhancing quality of life and minimizing disability).

Prevention of depression in the perinatal period can include both medication (antidepressants, estrogen therapy and progesterone therapy) and psychosocial support (psychological therapy, antenatal and postnatal classes, intrapartum support, education and early identification).^{34,35}

Mood disorders are treatable. Early recognition and effective early treatment of mood disorders can improve outcomes and decrease the risk of suicide. Given that one episode predisposes an individual to subsequent episodes, relapse prevention with maintenance therapy is also important.

Many people with a mood disorder fail to consult health professionals, however, and suffer needlessly. Of those who do seek treatment, many remain undiagnosed or receive either incorrect or an inadequate amount of medication.³⁶

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), nearly 1 in 2 respondents who reported symptoms that met

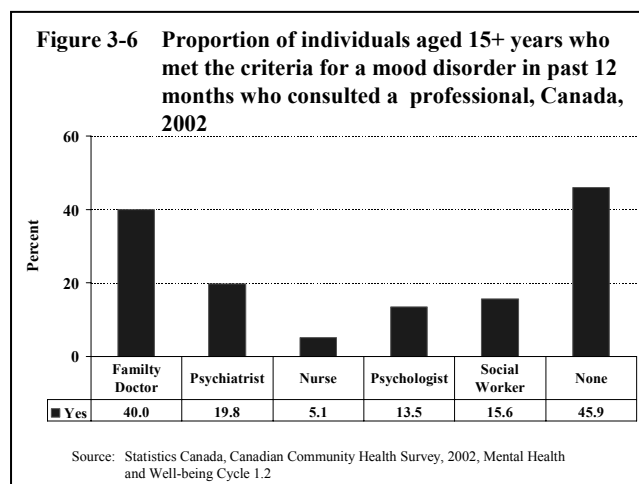
the criteria for a mood disorder in the previous 12 months had not consulted with a professional. (Figure 3-6) Family physicians were consulted by the highest proportion of individuals, followed by a psychiatrist, a social worker or a psychologist.

One in five respondents (22.0% of those with depression, and 21.1% with bipolar disorder) reported using natural health products for emotional, mental health, and drug or alcohol use problems.³⁷

Several factors, such as stigma, lack of knowledge or personal financial resources, or lack of available health professionals may discourage people from seeking help for depression or bipolar disorder. Among seniors in particular, mood disorders often go undiagnosed or untreated on the mistaken belief that they are a normal part of aging and that there is no effective treatment.

Primary care settings play a critical role in recognizing and treating mood disorders. Innovative practice models have shown that effective interventions can decrease symptoms and increase workdays.³⁸

Antidepressant medications and various forms of psychotherapy such as interpersonal



psychotherapy, cognitive-behavioural therapy—either alone or in combination—have been shown to be effective in treating depression in both teens and adults. A recent publication from the Canadian Psychiatric Association outlines the clinical guidelines for the treatment of depressive disorders.³⁹ Columbia University is currently preparing guidelines for the treatment of depression among children and youth.⁴⁰ The Canadian Coalition for Seniors Mental Health will soon be releasing national guidelines on the assessment and treatment of depression and of mental health issues in long-term care (focussing on mood and behaviour symptoms).

Individuals with mood disorders may also require hospitalization to adjust medication, to stabilize the disorder or to ensure protection against self-destructive behaviour.

Current initiatives to relieve the burden of mood disorders are focussing on education for individuals and families and for the community. Education is essential, not only to ensure the recognition of early warning signs of depression, mania and suicide and their appropriate assessment and treatment, but also to ensure adherence to treatment in order to minimize future relapses. Sound support networks are crucial during both the acute phase of the illness and the post-illness adjustment to daily life.

Major depression can result in poor productivity and sick leave from the workplace. The

workplace, therefore, is an important venue for addressing mental health issues. Supporting the development of healthy work environments, educating employers and employees in the area of mental health issues, and providing supportive reintegration into the work environment for those experiencing mental illness would help to minimize the effect of major depression on the workplace.

Depression in the perinatal period may be difficult for health professionals to detect. As a result, it is often under-diagnosed.⁴¹ This may be due to the fact that symptoms of pregnancy can mimic symptoms of depression. Furthermore, depression may develop gradually, healthcare providers may have limited knowledge or expertise in detecting depression, and women may be reluctant to disclose emotions or seek help.⁴²

Interventions and treatment for perinatal depression vary depending on the type and severity of symptoms. Mild to moderate depression may respond to psychotherapy and or social interventions. Partner support and telephone-based peer support have also been shown to be effective.^{43,44} Severe perinatal depression requires antidepressant medication in addition to psychosocial therapy.⁴⁵ It is estimated that between 70% and 80% of women with postpartum depression are able to recover with treatment.⁴⁶

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CHAPTER 4

SCHIZOPHRENIA

What Is Schizophrenia?

Schizophrenia is a brain disease and one of the most serious mental illnesses in Canada.

Common symptoms are mixed-up thoughts, delusions (false or irrational beliefs), hallucinations (seeing or hearing things that do not exist), lack of motivation, lack of insight, and social withdrawal.

People suffering from schizophrenia have difficulty performing tasks that require abstract memory and sustained attention. When symptoms first appear, many people do not realize that they have an illness.

All signs and symptoms of schizophrenia vary greatly between individuals. There are no laboratory tests to diagnose schizophrenia: diagnosis is based solely on clinical observation and history. To confirm a diagnosis of schizophrenia, symptoms must be present most of the time for a period of at least one month, with some signs of the disorder persisting for six months. These signs and symptoms are severe enough to cause marked social, educational or occupational dysfunction. The Canadian Psychiatric Association has developed guidelines for the assessment and diagnosis of schizophrenia.¹

<u>Symptoms</u>
<u>Schizophrenia</u>
<ul style="list-style-type: none">• Delusions and/or hallucinations• Lack of motivation• Social withdrawal• Thought disorders• Lack of insight

How Common Is Schizophrenia?

Estimates of the prevalence of schizophrenia in the general population vary between 0.2% and 2.0%, depending upon the instruments used to measure the disorder. However, a lifetime prevalence rate of 1% is generally accepted as the best estimate.²

According to the Statistics Canada's 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2),

0.25 % of respondents reported that they were professionally diagnosed as having schizophrenia: 0.2% of women and 0.3% of men. This is believed to underestimate the true prevalence since some people do not report that they have schizophrenia and the survey team did not reach those individuals with schizophrenia who were homeless, in hospital or in supervised residential settings.

Impact of Schizophrenia

Who Is Affected by Schizophrenia?

The onset of schizophrenia typically occurs between the late teens and mid-30s. Onset prior to adolescence is rare. Men and women are affected equally by schizophrenia but men usually develop the illness earlier than women. If the illness develops after the age of 45, it tends to appear among women more than men, and they tend to display mood symptoms more prominently.

While most individuals with schizophrenia are treated in the community, hospitalization is sometimes necessary to stabilize symptoms. Therefore, hospitalization data provide additional data on individuals with schizophrenia.

Hospitalization rates for schizophrenia in 2002/03 were much higher among young men than young women. (Figure 4-1)

Hospitalizations for women increased until the mid-40s, whereas they decreased for men after their 20s. Under the age of 45, hospitalizations for men were up to 3 times more frequent than for women, then levelled out in mid-life years (45–59). Over the age of 49 years, more women than men were hospitalized for schizophrenia.

How Does Schizophrenia Affect People?

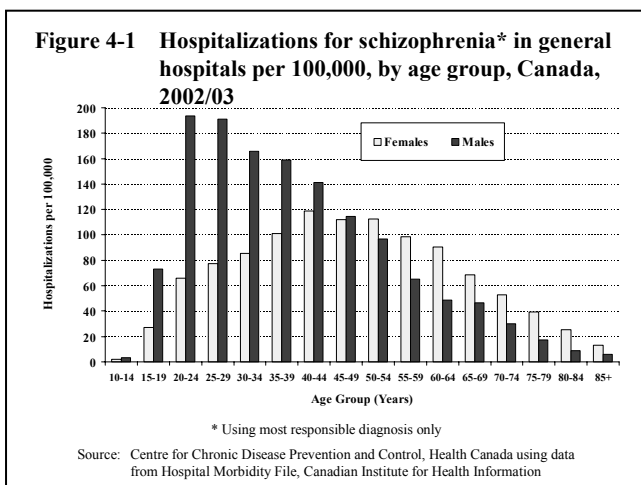
Schizophrenia has a profound effect on an individual's ability to function effectively in all aspects of life—self-care, family relationships, income, school, employment, housing, community and social life.³

Schizophrenia is one of the leading reasons for hospitalization for mental illness, accounting for 19.9% of separations from general hospitals and 30.9% of separations from psychiatric hospitals. (See Chapter 11 – Hospitalization and Mental Illness.)

Early in the disease process, people with schizophrenia may lose their ability to relax, concentrate or sleep and they may withdraw from friends or not even recognize that they are ill. Performance at work or school often suffers. With effective early treatment to control symptoms, individuals can prevent further symptoms and optimize their chance of leading full, productive lives.

The onset of schizophrenia in the early adulthood years usually leads to disruptions in an individual's education. Individuals with schizophrenia often find it difficult to maintain employment for a sustained period of time, and tend to be employed at a lower level than their parents.⁴

The majority of individuals with schizophrenia (60% to 70%) do not marry and most have limited social contacts.⁵ The chronic course of the disorder contributes to ongoing social problems. As a result, individuals with schizophrenia are greatly over-represented in prison and homeless populations.⁶



Up to 80% of individuals with schizophrenia will abuse substances during their lifetime.⁷ Problematic substance use is associated with increased rates of poor functional recovery, suicidal behaviour and violence.⁸

The primary responsibility for care of an individual with schizophrenia usually falls upon the shoulders of the family. This has many implications. Not only are the family's normal activities disrupted, but they must also cope with the person's refusal of treatment if they do not believe that they are ill, the family member's unpredictability, the side effects of the medication, and the frustration and worry about their loved one's future. In times of crisis, the decision to admit the individual to hospital involuntarily or to give treatment involuntarily is one of the most difficult dilemmas that a family may face. Schizophrenia is the most common diagnosis among those who are involuntarily hospitalized. In addition, the family often has to deal with the stigma attached to schizophrenia.

While a small proportion of people with schizophrenia become involved with the criminal justice system, they are disproportionately likely to become involved in the criminal justice system and disproportionately likely to be convicted of violent crimes.⁹ They may commit crimes (usually minor but occasionally major) because they are untreated or under-treated. The most

frequent diagnosis of people in forensic psychiatric facilities is schizophrenia. However, people with schizophrenia are more frequently the victims rather than the perpetrators of crime.

The mortality associated with schizophrenia is one of the most distressing consequences of the disorder. People with schizophrenia have an increased risk of sudden cardiac death.¹⁰ Approximately 40% to 60% of individuals with schizophrenia attempt suicide and they are 15–25 times more likely than the general population to succeed.¹¹ Approximately 10% of individuals with schizophrenia will die from suicide.

Economic Impact

Schizophrenia places a substantial financial burden on individuals with the illness, members of their family and the health care system. In 1996, the total cost of schizophrenia in Canada was estimated to be \$2.35 billion, or 0.3% of the Canadian Gross Domestic Product.¹² This included direct health care costs, administrative costs of income assistance plans, value of lost productivity, and incarceration costs attributable to schizophrenia. The indirect costs of schizophrenia were estimated to account for another \$2 billion yearly. Globally, nearly 3% of the total burden of human disease is attributed to schizophrenia.¹³

Stigma Associated with Schizophrenia

Public misunderstanding and fear contribute to the serious stigma associated with schizophrenia. Contrary to popular opinion, most individuals with the disorder are withdrawn and not violent. Indeed, when adequately treated, people with schizophrenia are no more violent than the general population.

Nonetheless, the stigma of violence interferes with an individual's ability to acquire housing, employment and treatment, and also compounds difficulties in social relationships. These stereotypes also increase the burden of families and caregivers.

Causes of Schizophrenia

Schizophrenia is recognized as a disease of the brain. Although its exact cause is unknown, it is likely that a functional abnormality in brain circuits produces the symptoms. This abnormality may be either the consequence or the cause of structural brain abnormalities.¹⁴

Immediate family members of individuals with schizophrenia are 10 times more likely than the general population to develop schizophrenia, and children of two parents with schizophrenia have a 40% chance of developing the disorder.¹⁵

A combination of genetic and environmental factors is probably responsible for the development of this functional abnormality.¹⁶ These factors appear to impact the development of the brain at critical stages during gestation and after birth.

Early environmental factors that may contribute to the development of schizophrenia include prenatal or perinatal trauma, influenza infection in the first part of pregnancy, being born in the winter or early spring (likely related to influenza infection), and being born in urban settings. Heavy cannabis use among teenagers who have a genetic vulnerability, or some baseline psychiatric symptoms increases the risk of schizophrenia. While studies have established a link between severe social disadvantage and schizophrenia, the results suggest that social factors do not cause schizophrenia, but rather that having the disorder may result in poor social circumstances.

Prevention and Recovery

Very little is known about preventing schizophrenia. Minimizing the impact of this serious illness depends primarily on early diagnosis, appropriate treatment and support.

Schizophrenia differs from several other mental illnesses in the intensity of care that it requires.

A comprehensive treatment program includes:¹⁷

- Antipsychotic medication, which forms the cornerstone of treatment for schizophrenia;
- Psychoeducation: Education of the individual about his/her illness and treatment;
- Family interventions: Family education and support;
- Peer support, self-help and recovery: Support groups and rehabilitation to improve the activities of daily living;
- Social skills training
- Vocational Interventions: Vocational and recreational support;
- Cognitive-behavioural interventions
- Treatment of co-morbid symptoms and
- Integrated addictions program

Most of these services occur in the community. Without them, an individual with schizophrenia faces almost insurmountable challenges to recover and lead a productive, high quality life.

The course of schizophrenia varies with each individual. In most cases, however, it involves recurrent episodes of symptoms. While medications can relieve many of the symptoms, most people with schizophrenia continue to suffer some symptoms throughout their lives. Appropriate treatment early in the course of the disease, and adherence to continued and adequate treatment, are essential in order to avoid relapses and prevent hospitalization.

During periods of remission (whether spontaneous or the result of treatment) the individual may function well. Newer medications have substantially reduced the prevalence of severe neurological side effects associated with older drugs. Unfortunately, some medications have other side-effects, such as weight gain, which may discourage the individual from continuing to take the medication or may contribute to other physical problems.

Optimizing the functional status and well-being of individuals with schizophrenia requires a wide range of services, including hospital, community, social, employment and housing services. Ideally, multidisciplinary community treatment teams provide these services. Liaison by care providers with police, courts, shelters, prisons and other services likely to come into contact with people with schizophrenia is essential. Linking with not-for-profit, family, and consumer advocacy and support organizations is also critical.

Social skills training strives to improve social functioning by working with individuals with schizophrenia to resolve problems with employment, leisure, relationships and activities of daily life.

Occasionally, timely admission to hospital to control symptoms may prevent the development of more severe problems. Where this is not possible on a voluntary basis, all provinces provide for involuntary hospitalization. A majority of provinces also allow for compulsory treatment in the community in cases where the person meets strict criteria in order to reduce relapses and provide treatment in the least restrictive setting.¹⁸

"Without compulsory admission and psychiatric treatment, people who cannot accept voluntary treatment are abandoned to the consequences of their untreated illness. Untreated these illnesses have a high fatality rate (10-17 per cent)¹⁹ and higher lifetime disability rates than many physical illnesses.²⁰ These illnesses can cause great personal suffering including despair to the point that people, for no reason apparent to others, kill themselves to escape the torment of feelings of worthlessness or because a voice (hallucination) commands them to."²¹

Schizophrenia may affect personal insight to the degree that individuals are unable to recognize how seriously ill they are and voluntarily seek help—or even accept help when it is offered.

Families may find themselves in the difficult position of recognizing that their family member with schizophrenia needs treatment before he or she does. They face the challenge of engaging the health care system without the individual's cooperation.

Mental health laws have been put in place to address the situation where the untreated mental illness is likely to cause significant harm to the person or others. These laws are only effective if there is effective service available to treat the individual in these situations.

Mental health laws are specific to each province and territory. They revolve around the following societal values:²²

- The need to provide protection and assistance to those who, through no fault of their own, cannot assist themselves;
- The need to protect other members of society from the conduct of those whose brain illness diminishes their self-control; and
- The need for individuals to be as unfettered by legal intrusions as possible in a civilized democratic society.

The balance accorded to each societal value changes over time. In the past, greater emphasis has been on ensuring that people are not kept against their will. This has the potential to leave seriously ill people without treatment. Recent changes to mental health acts are redressing this imbalance.

Innovative practices, such as having an individual write explicit instructions about the treatment they would prefer if they become too ill to decide it at a specific time, assuming that they do not refuse the treatment they need in order to be released, keep the individual rights at the front of substitute decision-making.

The mental disorder sections of the federal Criminal Code allow a judge to require that a person who is found unfit to stand trial receives compulsory psychiatric treatment. This requires the forensic hospital setting to have adequate resources in order to receive the individual from the prison setting. In cases of conditional discharge or probation, the Criminal Code can encourage but not force treatment.

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CHAPTER 5

ANXIETY DISORDERS

What Are Anxiety Disorders?

Individuals with anxiety disorders experience excessive anxiety, fear or worry, causing them to either avoid situations that might precipitate the anxiety or develop compulsive rituals that lessen the anxiety.

While everyone feels anxious in response to specific events, individuals with an anxiety disorder have excessive and unrealistic feelings that interfere with their lives in their relationships, school and work performance, social activities and recreation.

<u>Symptoms</u>
<p><u>Anxiety Disorders</u></p> <ul style="list-style-type: none">• Intense and prolonged feelings of fear and distress that occur out of proportion to the actual threat or danger• The feelings of fear and distress interfere with normal daily functioning

Types of Anxiety Disorders¹

Generalized Anxiety Disorder (GAD)

Excessive anxiety and worry about a number of events or activities occurring for more days than not over a period of at least six months with associated symptoms, such as fatigue and poor concentration.

Specific Phobia

Marked and persistent fear of clearly discernible objects or situations, such as flying, heights and animals.

Post-traumatic Stress Disorder (PTSD)

Flashbacks, persistent frightening thoughts and memories, anger or irritability in response to a terrifying experience in which physical harm occurred or was threatened, such as rape, child abuse, war or natural disaster.

Social Phobia, also known as Social Anxiety Disorder

Extreme fear or avoidance associated with social or performance situations, such as conversations, parties, meetings, public speaking and other situations in which a person may be embarrassed, humiliated or observed.

Obsessive-Compulsive Disorder (OCD)

Obsessions: Persistent thoughts, ideas, impulses or images that are perceived as intrusive and inappropriate and that cause marked anxiety or distress. Individuals with obsessions usually attempt to ignore or suppress such thoughts or impulses or to counteract them by other thoughts or actions (compulsions).

Compulsions: Repetitive behaviours (such as hand-washing, ordering or checking) or mental acts (such as praying, counting or repeating words) that occur in response to an obsession or in a ritualistic way.

Panic Disorder

Presence of recurrent, unexpected panic attacks, followed by at least one month of persistent concern about having additional attacks, worry about the implication of the attack or its consequences, or a significant change in behaviour related to the attacks.

The essential feature of the panic attack is a discrete period of intense fear or discomfort that is accompanied by at least four of thirteen physical symptoms such as:

- Palpitations, increased heart rate or pounding heart;
- Sweating;
- Trembling or shaking;
- Sensations of shortness of breath or smothering;

- Feeling of choking;
- Chest pain or discomfort;
- Nausea or abdominal distress;
- Dizziness, unsteadiness, light-headedness or fainting;
- De-realization or de-personalization;
- Fear of losing control or going crazy;
- Fear of dying;
- Paresthesias; and
- Chills or hot flashes.

Agoraphobia

Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of an unexpected or contextually cued panic attack or panic-like symptoms.

Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train or automobile.

How Common Are Anxiety Disorders?

As a group, anxiety disorders represent the most common of all mental illnesses. Population-based surveys provide various estimates of how common anxiety disorders are in the population. One Ontario study² estimated that 12% of adults between 15 and 64 years of age—9% of men and 16% of women—had experienced an anxiety disorder during the 12 months prior to the survey. The US National Comorbidity Survey (2001–2003) estimated that 18.1% of adults 18 years of age and over had an anxiety disorder in the 12 months preceding the survey.

According to Statistics Canada's 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2), 4.7% of Canadians 15 years of age and over reported symptoms that met the criteria for one of the following anxiety disorders in the previous 12 months: 1.6% panic disorder; 0.7% agoraphobia; and 3.0% social anxiety disorder. Over 1 in 10 adults (11.5%) reported symptoms that met the criteria for having had one of these anxiety disorders during their lifetime: 3.7% panic disorder; 1.5% agoraphobia; and 8.1% social anxiety disorder.

Earlier Canadian studies^{3,4,5} estimated the prevalence of various anxiety disorders during a one-year period among individuals between the ages of 15 and 64 years:

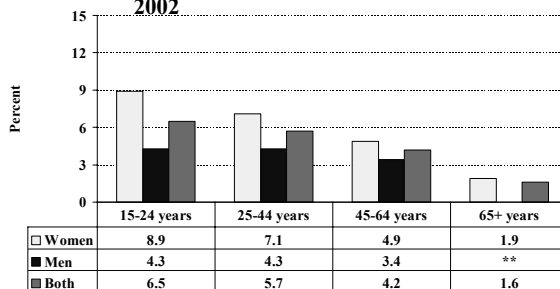
- 1.1% had generalized anxiety disorder;
- 6.2%–8.0% had specific phobia;
- 6.7% had social phobia;
- 1.8% had obsessive compulsive disorder and
- 0.7% had panic disorder.

Impact of Anxiety Disorders

Who Is Affected by Anxiety Disorders?

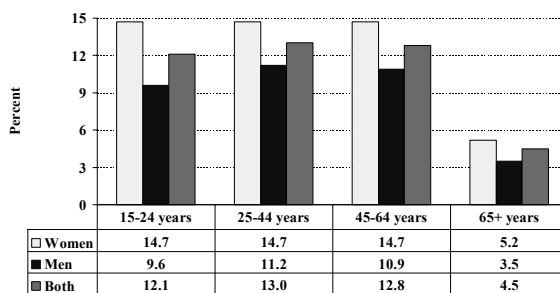
According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), a greater proportion of women than men under the age of 65 year had symptoms that met the criteria for one of the measured anxiety disorders during the previous 12 months. (Figure 5-1) The greatest difference was among young adults (15–24 years), where young women were twice as likely as young men to have an anxiety disorder (8.9% compared to 4.3%). The gap narrowed with age because the proportion of women with an anxiety disorder decreased with age. Seniors had lower 12-month and lifetime prevalence of anxiety disorder than all younger age groups. (Figure 5-2) Approximately 1 in 8 adults in Canada aged 15–24, 25–44 and 45–64 years reported symptoms that met the criteria for having had one of the selected anxiety disorders during their lifetime.

Figure 5-1 Proportion of population that met the criteria for one of the selected anxiety disorders in the previous 12-months, by age and sex, Canada, 2002



** Sample size too small.
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 5-2 Proportion of population that met the criteria for one of the selected anxiety disorders during lifetime, by age and sex, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

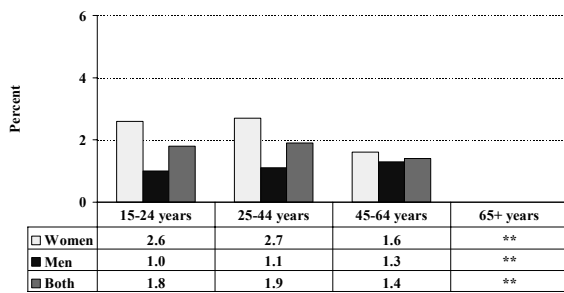
Women in the 15–24 and 25–44 year age groups were more likely than men to be identified as having **panic disorder** in the previous 12 months. (Figure 5-3) In the 45–64 year age group, the proportions among men and women were similar. Although the 12-month prevalence of panic disorder was lower in the 45–64 year-old age group, the lifetime prevalence was higher in this age group than in all other age groups. (Figure 5-4).

A greater proportion of young women than young men (15–24 years) reported symptoms that met

the criteria for having had **social phobia** during the previous 12 months. (Figure 5-5) The proportion among women decreased with age. Nearly 1 in 10 Canadians under the age of 65 years met the criteria for having had social phobia at some time in their lives. (Figure 5-6) Lifetime prevalence decreased dramatically over age 65 years.

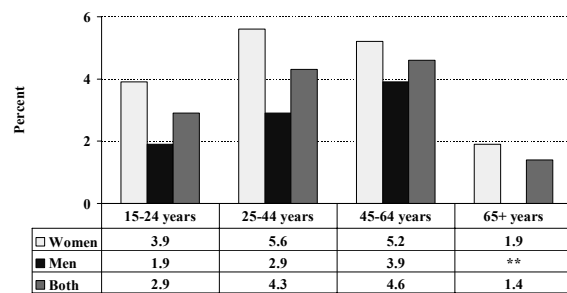
Women were twice as likely as men to report symptoms that met the criteria for **agoraphobia**: 1.0% versus 0.4%. The sample size was too small to assess the prevalence by age.

Figure 5-3 Proportion of population that met the criteria for panic disorder during the previous 12 months, by age and sex, Canada, 2002



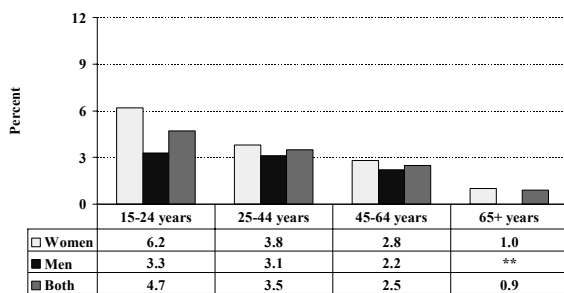
** Sample size too small.
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 5-4 Proportion of population that met the criteria for panic disorder during lifetime, by age and sex, Canada, 2002



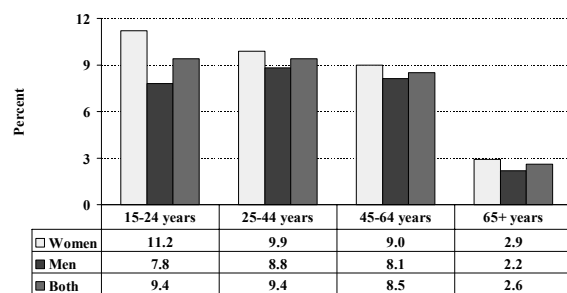
** Sample size too small.
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 5-5 Proportion of population that met the criteria for social phobia during the previous 12 months, by age and sex, Canada, 2002



** Sample size too small.
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 5-6 Proportion of population that met the criteria for social phobia during lifetime, by age and sex, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

How Do Anxiety Disorders Affect People?

Symptoms of anxiety disorders often develop during adolescence or early adulthood.⁶ People with anxiety disorders avoid situations that precipitate their symptoms. This avoidance can seriously restrict education, work, recreation and social activities.⁷

Individuals severely affected by one anxiety disorder are also more likely to have either another type of anxiety disorder, major depression or dysthymic disorder, problematic substance use, or a personality disorder.⁸ This compounds the impact of the anxiety disorder and presents challenges for effective treatment.

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), most of the individuals who reported symptoms that met the criteria for social phobia or panic disorder in the previous 12 months reported that it interfered with their lives: 75.6% of those with panic disorder and 82.6% with social phobia. These individuals reported that their conditions affected their home, school, work and social life. (Figure 5-7) Two-thirds (66.3%) of those with social phobia reported that it interfered with their social life. Approximately

1 in 2 of those with panic disorder stated that it interfered with home, work and social life.

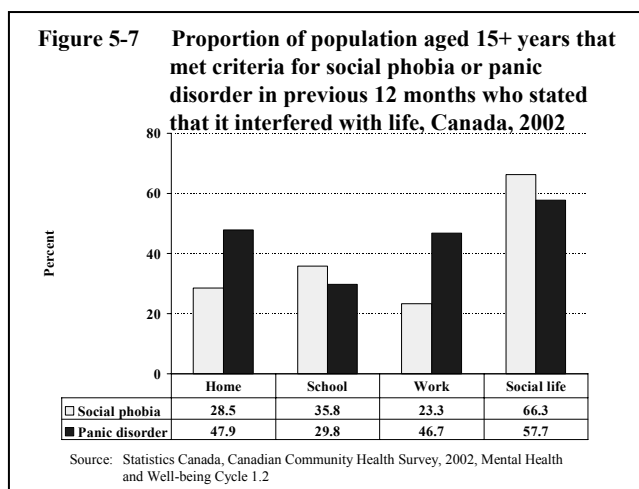
Economic Impact

Because they are so common, anxiety disorders have a major economic impact.⁹ They contribute to lost productivity due to both time away from work and unemployment. Other associated costs include claims on disability insurance.

Heavy use of the emergency department and primary care system in reaction to physical symptoms also contributes to significant health care costs.

Stigma Associated with Anxiety Disorders

Because anxiety disorders are the extension of what most people perceive as normal worry and concern, those who experience them may fear that others will label their worry and fear as excessive and weakness. As a result, they may keep their symptoms to themselves and try to deal with them alone.



Causes of Anxiety Disorders

Anxiety disorders develop from a complex interplay of genetic, biological, cognitive, developmental and other factors, such as personal, socio-economic and workplace stress. A variety of theories has been proposed to explain how these factors contribute to the development of anxiety disorders.¹⁰

The first is experiential: people may learn their fear from an initial experience, such as an embarrassing situation, physical or sexual abuse, or the witnessing of a violent act. Similar subsequent experiences serve to reinforce the fear.

A second theory relates to cognition or thinking, in that people believe or predict that the result of a specific situation will be embarrassing or harmful. This may occur, for example, if parents

are over-protective and continually warn against potential problems.

A third theory focuses on a biological basis. Research suggests that the amygdala, a structure deep within the brain, serves as a communication hub that signals the presence of a threat and triggers a fear response or anxiety. It also stores emotional memories, and may play a role in the development of anxiety disorders. The children of adults with anxiety disorders are at much greater risk of an anxiety disorder than the general population, suggesting that genetics may play a role as well.¹¹ Numerous studies have also confirmed that neurotransmitters in the brain, such as serotonin, norepinephrine, as well as hormonal factors influence the onset and course of anxiety disorders.

Recovery from Anxiety Disorders

Early recognition and appropriate management are imperative to the enhancement of the quality of life of individuals with anxiety disorders. Proper recognition and management also help to prevent common secondary disorders, such as depression and problematic substance use.

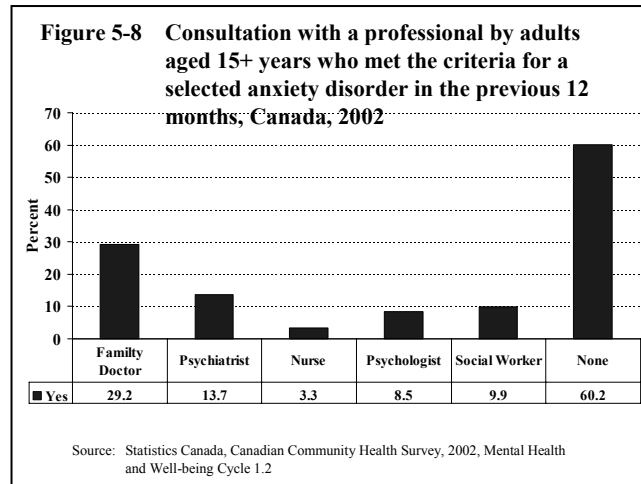
Several factors, such as stigma, lack of knowledge or personal financial resources, or lack of available health professionals, may discourage people from seeking help for anxiety disorders. In addition, family physicians may not always recognize the pattern in an individual's symptoms that would lead to a correct diagnosis. Too often, symptoms are not taken seriously and an individual with an anxiety disorder is labelled as being emotionally unstable. Education of both the public and family physicians would help to solve this problem.

A recent review of anxiety disorders research suggests that effective treatments include drug therapy (usually with anti-depressants or anti-anxiety drugs) and cognitive-behavioural therapy, which helps people turn their anxious thoughts into more rational and less anxiety-producing ideas and encourages them to confront feared situations and eliminate various safety behaviours.^{12,13} Support groups for individuals and families can also help develop the tools for minimizing and coping with the symptoms.

Anxiety disorders can be well managed in the primary care setting. Creating access to experts in cognitive-behaviour therapy through a shared-care model can help family physicians provide optimal care for the individuals under their care.

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), 3 of 5 individuals with one of the selected anxiety disorders reported that they did not consult a health professional

about their condition. (Figure 5-8) The most commonly consulted professional was the family doctor, followed by a psychiatrist, social worker or psychologist.



Endnotes

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CHAPTER 6

PERSONALITY DISORDERS

What Are Personality Disorders?

Personality disorders cause enduring patterns of inner experience and behaviour that deviate from the expectations of society. These disorders are pervasive, inflexible and stable over time and lead to distress or impairment.¹

"Personality is seen today as a complex pattern of deeply imbedded psychological characteristics that are largely non-conscious and not easily altered, which express themselves automatically in almost every area of functioning."²

Personality characteristics or traits are expressed on a continuum of social functioning. Personality disorders reflect personality traits that are used inappropriately and become

maladaptive.³ To some degree, this classification is arbitrary.

Some deviations may be quite mild and interfere very little with the individual's home or work life. Others may cause great disruption in both the family and society. Specific situations or events trigger the behaviours of a personality disorder. In general, individuals with a personality disorder have difficulty getting along with others and may be irritable, demanding, hostile, fearful or manipulative.

Personality disorders exist in many forms.⁴ (Table 1-1) Classification of personality disorders is arbitrary. Each person is unique and can display mixtures of patterns.

<u>Symptoms</u>
<p><u>Personality Disorders</u></p> <ul style="list-style-type: none">• Difficulty getting along with other people. May be irritable, demanding, hostile, fearful or manipulative.• Patterns of behaviour deviate markedly from society's expectations and remain consistent over time.• Disorder affects thought, emotion, interpersonal relationships and impulse control.• The pattern is inflexible and occurs across a broad range of situations.• Pattern is stable or of long duration, beginning in childhood or adolescence.

Table 6-1 Types of Personality Disorders	
<u>Type</u>	<u>Patterns</u>
<i>Borderline Personality Disorder</i>	Instability in interpersonal relationships, self-image and affect, and marked impulsivity.
<i>Antisocial Personality Disorder</i>	Disregard for, and violation of, the rights of others.
<i>Histrionic Personality Disorder</i>	Excessive emotionality and attention seeking.
<i>Narcissistic Personality Disorder</i>	Grandiosity, need for admiration and lack of empathy.
<i>Avoidant Personality Disorder</i>	Social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.
<i>Dependent Personality Disorder</i>	Submissive and clinging behaviour related to an excessive need to be taken care of.
<i>Schizoid Personality Disorder</i>	Detachment from social relationships and a restricted range of emotional expression.
<i>Paranoid Personality Disorder</i>	Distrust and suspiciousness in which others' motives are interpreted as malevolent.
<i>Obsessive-Compulsive Personality Disorder</i>	Preoccupation with orderliness, perfectionism and control.
<i>Schizotypal Personality Disorder</i>	Acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behaviour.

How Common Are Personality Disorders?

Canadian data on the prevalence of personality disorders is lacking. United States estimates of the prevalence of diagnosis of any personality disorder, however, range from 6% to 9%, depending upon the criteria used for definition.⁵

Epidemiological studies most often measure and report antisocial personality disorder. A 1991 Ontario survey estimated that the one-year

prevalence rate of antisocial personality disorder in the general population was 1.7%.⁶ An Edmonton study in the 1980s found that 1.8% of the population had an antisocial personality disorder in the six-month period prior to the survey and 3.7% reported having had a personality disorder at some point in their lives.^{7,8}

Impact of Personality Disorders

Who Develops a Personality Disorder?

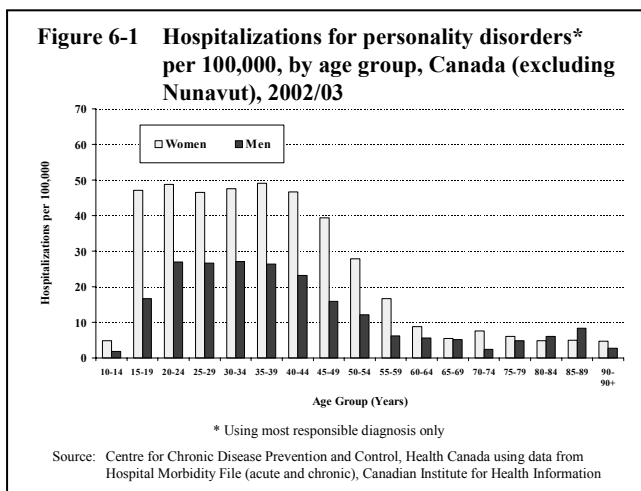
Studies have shown that men tend to be diagnosed more often than women with anti-social personality disorder (3% versus 1%)⁹ while women are more often diagnosed with borderline personality disorder (representing approximately 75% of cases).¹⁰ This gender difference may be related to men’s and women’s differential social experiences, socialization effects and professional labelling bias.

Ideally, data from a population survey would provide information on the age and sex distribution of individuals with personality disorders. At the present time, however, hospitalization data provide the best available description of individuals with personality disorders. These data have limitations, however: most people with personality disorders if treated, are treated in the community rather than in hospitals, unless they show suicidal behaviour; and individuals with borderline personality disorder have higher rates of admission than other disorders because of their high rate of suicidal behaviour.

In 2002/03, hospitalizations for personality disorders were most frequent between the ages of 15 and 50 years. (Figure 6-1) In this age group, women were hospitalized more often than men. The hospitalization rate among young women 15-19 years old was nearly triple the rate of young men in the same age group.

What Are the Effects of Personality Disorders?

Although personality disorders usually onset in adolescence or early adulthood, they can also become apparent in mid-adulthood. To some extent, timing depends on the type of personality disorder and the situation or events surrounding the individual. For example, borderline personality disorder usually peaks in adolescence and early adulthood and then becomes less prominent by mid-adulthood. On the other hand, narcissistic personality disorder may not be identified until middle age when the individual experiences the sense of loss of opportunity or faces personal limitations.



Since personality disorders usually develop in adolescence or early adulthood, they occur at a time when most people develop adult relationship skills, complete their education and establish careers. The result of the use of maladaptive behaviours during this life stage has implications that extend for a lifetime.

A history of alcohol abuse, drug abuse, sexual dysfunction, generalized anxiety disorder, bipolar disorder, obsessive-compulsive disorder, depressive disorders, eating disorders, and suicidal thoughts or attempts often accompany personality disorders.^{11,12} Research has shown that up to one-half of prisoners have antisocial personality disorder. This is because of its associated behavioural characteristics, such as substance abuse, violence and vagrancy, which lead to criminal behaviour.¹³ Other social consequences of personality disorders include:

- Spousal violence;
- Child maltreatment;
- Poor work performance;
- Suicide; and
- Gambling.

Personality disorders have a major effect on the people who are close to the individual. The individual's fixed patterns make it difficult for them to adjust to various situations. As a result, other people adjust to the individual. This creates a major strain on all relationships among family and close friends and in the workplace. At the same time, when those around the individuals with the personality disorder do not adjust, they can become angry, frustrated, depressed or withdrawn. This establishes a vicious cycle of interaction, causing the individuals to persist in the maladaptive behaviour until their needs are met.

Stigma Associated with Personality Disorders

Since the behaviours shown in some personality disorders remain close to what is considered "normal", others often assume that the individuals can easily change their behaviour and solve the interpersonal problem. When the behaviour persists, however, it may be perceived as a lack of will or willingness to change. The fixed nature of the trait is poorly understood by others.

Causes of Personality Disorders

Personality disorders likely result from the complex interplay of genetic and environmental factors. Genetic factors contribute to the biological basis of brain function and to basic personality structure. This structure then influences how individuals respond to and interact with life experiences and the social environment. Over time, each person develops distinctive patterns or ways of perceiving their world and of feeling, thinking, coping and behaving.

Individuals with personality disorders may have impaired regulation of the brain circuits that control emotion. This difficulty, combined with psychological and social factors such as abuse, neglect or separation, puts an individual at higher risk of developing a personality disorder. Strong attachments within the family or a supportive network of people outside the family, in the school and in the community help an

individual develop a strong sense of self-esteem and strong coping abilities. Opportunities for personal growth and for developing unique abilities can enhance a person's self-image. This supportive environment may provide some protection against the development of a personality disorder.

Diagnoses of borderline personality disorder tend to be highly correlated with experiences of early childhood physical and sexual abuse and with addictions in women.¹⁴

For biologically predisposed individuals, the major developmental challenges that are a normal part of adolescence and early adulthood—separation from family, self-identity, and independence—may be the precipitating factors for the development of the personality disorder. This may explain why personality disorders usually onset in these years.

Treatment of Personality Disorders

The greatest challenge in treating personality disorders is that the problem is often unrecognized by the individual. They often blame others for relationship problems. Intensive individual and group psychotherapy, combined with anti-depressants and mood stabilizers, can be at least partially effective for some people. Difficulties arise from both the

persistence of symptoms and the negative impact of these symptoms on the therapeutic relationship.

Individuals with borderline personality disorder have more frequent hospitalizations, use outpatient psychotherapy more often, and make more visits to emergency rooms than individuals with other personality disorders.¹⁵

Endnotes

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CHAPTER 7

EATING DISORDERS

What Are Eating Disorders?

Eating disorders involve a serious disturbance in eating behaviour (either eating too much or too little).¹ This chapter addresses anorexia nervosa, bulimia nervosa and binge eating disorder.

Eating disorders are unhealthy eating patterns that take on a life of their own. They are not a function of will. While the voluntary eating of smaller- or larger-than-usual portions of food is common, for some individuals this develops into a compulsion.

Individuals with **anorexia nervosa** cannot maintain a minimally normal body weight, carry an intense fear of gaining weight, and have a distorted perception of the shape or size of their bodies.²

Individuals with **bulimia nervosa** undertake binge eating and then use compensatory methods to prevent weight gain, such as induced vomiting, excessive exercise or laxative abuse. They also place excessive importance on body shape and weight. In order for a diagnosis of bulimia nervosa, the binge eating and compensatory behaviours must occur, on average, at least twice a week for three months.³

A diagnosis of **binge eating disorder** is made if the binge eating is not followed by some compensatory behaviour, such as vomiting, excessive exercise or laxative abuse. This disorder is often associated with obesity.

Symptoms Eating Disorders		
<u>Anorexia</u>	<u>Bulimia</u>	<u>Binge Eating Disorder</u>
<ul style="list-style-type: none"> • Inability to maintain body weight at or above a minimally normal weight for age and height with an intense fear of gaining weight or becoming fat, even though underweight. 	<ul style="list-style-type: none"> • Recurrent episodes of binge eating, accompanied by inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, use of laxatives, or excessive exercise. 	<ul style="list-style-type: none"> • Binge eating without compensatory behaviours, such as vomiting, excessive exercise or laxative abuse • Individuals are often obese.

How Common Are Eating Disorders?

According to Statistics Canada's 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2), 0.5% of Canadians aged 15 years and over reported that they had been diagnosed with an eating disorder in the previous 12 months. Through a separate set of questions, the survey also found that 1.7% of Canadians aged 15 and over reported symptoms that met the 12-month criteria for an eating attitude problem.

Anorexia nervosa and bulimia nervosa are most predominant among adolescent girls and young women; 5-15% of anorexia nervosa and bulimia nervosa and 40% of binge eating disorders are among boys or men, however.^{4,5} In most cases, binge eating disorder onsets during adolescence or young adulthood.

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), women were more likely than men to report an eating disorder: 0.8% versus 0.2%, respectively. More women than men met the criteria for an eating attitude problem: 2.9% of women versus 0.5% of men. Among young women (15–24 years), 1.5% reported that they had an eating disorder. Two percent reported symptoms that met the criteria for an eating attitude problem.

Approximately 3% of women will be affected by an eating disorder in their lifetime.⁶ Between 0.5% and 3.7% of women will develop anorexia nervosa during their lifetime,^{7,8} and between 1.1% and 4.2% will develop bulimia.^{9,10}

Binge eating disorder affects about 2% of the population.¹¹

Impact of Eating Disorders

How Do Eating Disorders Affect People?

Individuals with anorexia nervosa and bulimia may recover after a single episode of the disorder. Other individuals may have a fluctuating pattern of weight gain and relapse while others will continue to have issues with food and weight throughout their lives. Poorer long-term outcomes are associated with a lifetime history of problematic substance use at the time of diagnosis and longer duration of symptoms before diagnosis.¹²

Individuals with anorexia nervosa and bulimia may develop serious physical problems that can lead to death, such as heart conditions, electrolyte imbalance and kidney failure. Suicide is also a possible outcome.

Even after the acute episode has been resolved, eating disorders may cause long-term psychological, social and health problems.¹³

Anorexic individuals are more susceptible to major depression, alcohol dependence and anxiety disorders, either at the time of their illness or later in life.^{14,15,16}

An eating disorder causes young people to miss school, work and recreation activities. The physical weakness associated with the illness also seriously affects their social interaction with friends and their involvement in life in general. Friends also have difficulty knowing how to react and how to help.

Families of individuals with eating disorders also live under great stress. They may blame themselves, feel anxious about their loved one's future, worry that the family member will die or face the stigma associated with having a child with a mental illness. Parents, especially, experience the tension between their natural protective instinct to force healthy behaviours on the child (which can often make the situation worse) and the child's need to take control over his/her illness and health.

Stigma Associated with Eating Disorders

The stigma associated with eating disorders comes from the lack of understanding that an eating disorder is a problematic coping strategy.

The mistaken impression among many is that parents are to blame if a child has anorexia nervosa or bulimia. This stigmatization isolates parents from their peers and other family members.

The individual with an eating disorder may feel shame about weight fluctuations. Stigma is also associated with the presumption of a loss of control around eating, stealing binge food or bingeing in secret.

Individuals with binge eating disorder who are obese contend with negative societal attitudes toward obesity, which tend to make them feel isolated. The loss of self-esteem also exacerbates the illness.

Causes of Eating Disorders

Eating disorders are complex syndromes strongly associated with other mental illnesses such as mood, personality and anxiety disorders. The development of an eating disorder is believed to result from a combination of biological, psychological and social factors. In addition, the secondary effects of the maladaptive eating practices likely contribute to the disorder.¹⁷ (Table 7-1)

Eating disorders are more frequent in females. In particular, teen girls and young women are at

higher risk for disordered eating, shape and weight preoccupation, and dieting behaviour.

Adolescents go through major hormonal and physical changes during puberty that often result in a heightened awareness and altered perception of their body image. Images of female beauty portrayed in magazines and on TV are often unrealistic and unattainable. Media attention on the “ideal” weight and size for both females and males may foster a negative self-perception when those ideals are not achieved.

	Eating-Specific Factors (Direct Risk Factors)	Generalized Factors (Indirect Risk Factors)
Biological Factors	Eating disorder-specific genetic risk Physiognomy and body weight Appetite regulation Energy metabolism Sex	Genetic risk for associated disturbance Temperament Impulsivity Neurobiology (e.g., 5-HT mechanisms) Sex
Psychological Factors	Poor body image Maladaptive eating attitudes Maladaptive beliefs about shape and weight Specific values or meanings assigned to food, body Overvaluation of appearance	Poor self-image Inadequate coping mechanisms Self-regulation problems Unresolved conflicts, deficits, post-traumatic reactions Identity problems Autonomy problems
Developmental Factors	Identifications with body-concerned relatives, or peers Aversive mealtime experiences Trauma affecting bodily experience	Overprotection Neglect Felt rejection, criticism Traumata (physical, emotional and sexual abuse) Object relationships (interpersonal experience)
Social Factors	Maladaptive family attitudes to eating and weight Peer-group weight concerns Pressures to be thin Body-related teasing Specific pressures to control weight (e.g., through ballet, athletic pursuits) Maladaptive cultural values assigned to body Gender	Family dysfunction Aversive peer experiences Social values detrimental to stable, positive self-image Destabilizing social change Values assigned to gender Social isolation Lack of social support Impediments to means of self-definition Gender Media imagery concerning girls and women Pressures for thinness among girls Increasing population and availability of cosmetic surgery and body improvements Cultural differences and sex difference affecting ideal weight images and calculations.

According to the World Health Organization’s 2002 Health Behaviour in School-aged Children (HBSC) Canadian survey, approximately 60% of students from Grades 6 to 10 reported that their body image was just right: 59% of males and 56% of females. Almost 1 in 3 (31%) young women thought that they were too fat. The proportion increased with age, so that by Grade 10, 44% felt that they were too fat. (Figure 7-1). The proportion is much lower among young men (22% overall) and varied only slightly with age.

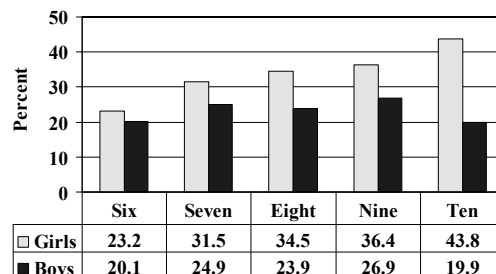
By comparison, boys across all grades were more likely than girls to indicate that they were too thin rather than too fat. (Figure 7-2) This proportion increased during the early high school years.

Unrealistic perceptions of body size may carry various health risks. These range from inappropriate attempts at dieting (which can lead to anorexia nervosa or bulimia) to failure to recognize and manage weight gain. Psychologically, perceiving that one’s body is outside the “normal” range or having unfavourable body image may lead to low self-esteem and self-confidence.

“While the media is not the cause of eating disorders, it is a significant sociocultural determinant of why so many people (particularly women) convey their distress through the language and behaviour of an eating disorder.”¹⁸

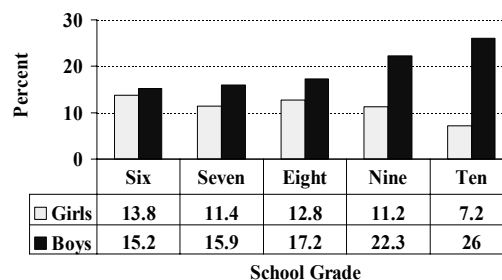
According to the 2002 HBSC Canadian survey, the proportion of young women who indicated that they were on a diet to lose weight was 2.2 times greater than the proportion of young men (20% versus 9%, respectively). This was consistent across all grade levels. (Figure 7-3) By Grades 9 and 10, over 25% of young women were on a diet at the time of the survey.

Figure 7-1 Proportion of students who rated their body image as too fat, by sex and grade, Canada, 2002



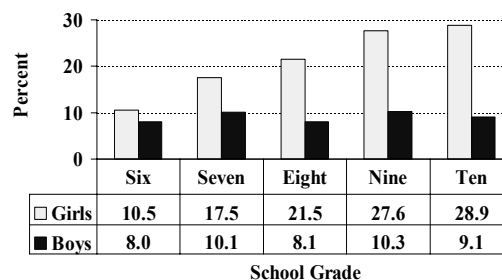
Source: WHO, Health Behaviour in School-Aged Children Study, 2002

Figure 7-2 Proportion of students who rated their body as too thin, by sex and grade, Canada, 2002



Source: WHO, Health Behaviour in School-Aged Children Study, 2002

Figure 7-3 Proportion of students who are presently on a diet, by sex and grade, Canada, 2002



Source: WHO, Health Behaviour in School-Aged Children Study, 2002

Prevention and Treatment

Preventive interventions are generally targeted at school age children, professional schools with specific high risk populations (such as ballet students, female athletes, fashion models, culinary students), or young girls and women showing unhealthy eating behaviours. Studies of the effectiveness of various interventions show mixed results. More research is needed to study risk factors; to identify factors that characterize successful interventions; and to predict which interventions will be effective on particular populations.¹⁹

Eating disorders can be treated and healthy weight restored. Treatment is most effective if started in the early stages of the disorder. Routine assessment of teens and young adults for the signs of an eating disorder can help the early identification of those who have a problem.

Treatment of eating disorders has changed dramatically over time.^{20,21} Nutritional stabilization has replaced the former practice that emphasized long-term psychotherapy and potentially harmful medications. Once an individual's nutrition status has improved, a variety of psychotherapies (cognitive-analytical, family and cognitive-behavioural) can improve the illness. Young women who are not afraid of

weight gain and who do not have a distorted body image have a better prognosis.²²

Eating disorder behaviours are very valuable for the individual: weight loss can provide a sense of accomplishment; or binge-and-purge episodes can help in managing or avoiding difficult emotions. As a result, motivational issues must be addressed throughout treatment to ensure that it matches a client's readiness for change.^{23,24}

A comprehensive treatment plan should include an investigation of problematic substance use and the experience of trauma. Treating co-existing mental illnesses, such as depression, anxiety and alcoholism, is also essential.

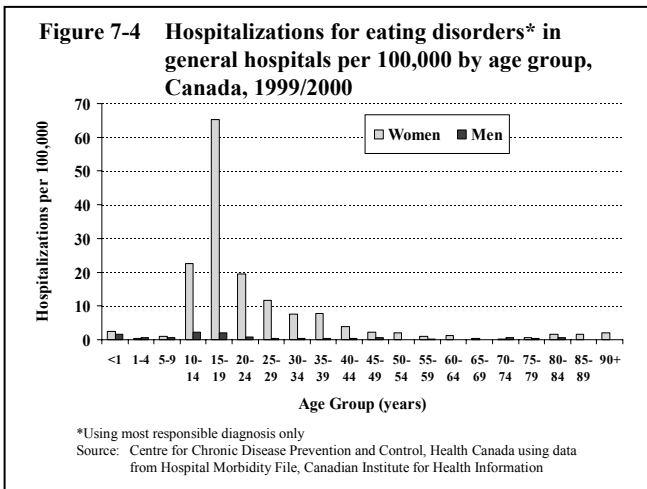
Anti-depressants have been shown to be useful in the treatment of bulimia nervosa.²⁵ Some medications are also useful for treating binge eating disorder. Unfortunately, effective drugs for treating anorexia nervosa have not been identified.

For people who have been ill for many years with anorexia nervosa, brief time-limited admissions to hospital with supportive psychotherapy can help stabilize weight loss and treat metabolic complications.

Hospitalization rates for eating disorders are highest among young women in the 15–19 year-old age group. (Figure 7-4) The next highest rates are among the 10–14 and 20–24 year-old age groups.

The National Eating Disorders Information Centre (<http://www.nedic.ca>) offers several suggestions for family and friends of an individual who is experiencing food and weight problems. Suggestions include:

- Focus on feelings and relationships, not on weight and food;
- Avoid comments on appearance;
- Realize that the individual needs to work at getting better at his or her own pace;
- Be careful not to blame them for their struggle; and
- Try to understand eating problems as a problematic coping strategy for dealing with painful emotions and experiences.



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CHAPTER 8

SUICIDAL BEHAVIOUR

What Is Suicidal Behaviour?

Suicidal behaviour is an important and preventable public health challenge in Canada. Many people who seriously consider suicide feel life to be unbearable. It usually marks the end of a long road of hopelessness, helplessness and despair. Suicide may also be precipitated by a significant crisis.

Suicidal behaviour includes deaths by suicide (**completed suicides**), **suicide attempts** that do not result in death, and suicidal thoughts and intentions (**suicidal ideation**).

Attempted suicide is a sign of serious distress and can be a turning point for the individual if given sufficient assistance to make the necessary life changes.¹ However, prior suicide attempts are one of the most important risk factors for completed suicide.

Suicidal behaviour is viewed as a call for help for many people.

<u>Warning Signs</u>
<u>Suicidal Behaviour</u>
<ul style="list-style-type: none">• Repeated expressions of hopelessness, helplessness, or desperation.• Changes in sleep pattern• Loss of appetite• Loss of energy• Expressing negative comments about self• Loss of interest in friends, hobbies or previously enjoyed activities• Giving away prized possessions or putting personal affairs in order• Telling final wishes to someone close• Expressing suicidal thoughts• Expressing intent to commit suicide and having a plan, such as taking pills or hanging oneself at a specific place and time

How Common Is Suicidal Behaviour?

Suicidal Thoughts

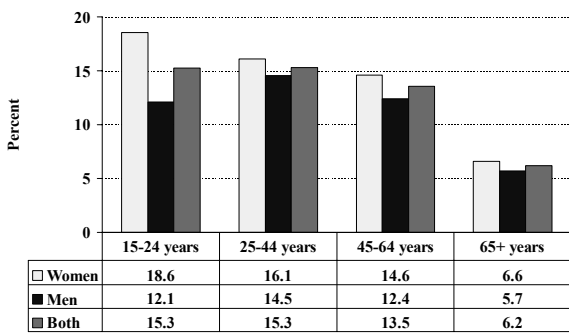
Suicidal thoughts are fairly common. Although only a small percentage of persons who consider suicide will attempt or complete suicide, thinking about and planning to end one’s own life is an important warning. Their expressions of suicidal thoughts should be taken seriously and their intentions verified.

According to Statistics Canada’s 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2), 13.4% of adults aged 15 years and over reported that they had seriously thought about suicide during their lifetime: 14.4% of women and 12.3% of men. A greater percentage of young women than young men (15–24 years) reported having had suicidal thoughts at some point in their lives.

(Figure 8-1) Among women, the proportion who reported suicidal behaviour decreased with age. While the highest percentage of women who reported suicidal thoughts in their lifetime was found among 15–24 year-olds, the percentage among men peaked between the ages of 25 and 44 years.

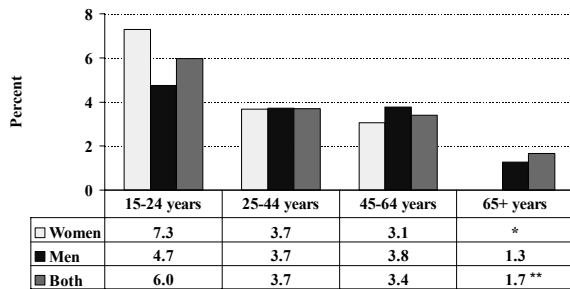
Among adults aged 15 years and over, 3.6% reported thinking about suicide in the previous 12 months: 3.8% of women and 3.6% of men. A greater percentage of young women than young men (15–24 years) reported suicidal thought in the previous 12 months. (Figure 8-2) Overall, the proportion of individuals who reported serious suicidal thoughts decreased with age.

Figure 8-1 Proportion who reported suicidal thought in lifetime, by age and sex, Canada, 2002



Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 8-2 Proportion of population who reported suicidal thought in past 12 months, by age and sex, Canada, 2002



*Sample size too small.

** Small sample size; interpret with caution.

Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Attempted Suicide

Attempted suicide includes attempts that result in hospitalization as well as attempts that do not result in medical attention and, consequently, are not reported in hospitalization statistics. Furthermore, suicide attempters who receive medical attention are often identified only by the nature of their medical problem, such as poisoning or lacerations and do not appear in suicide attempt data. As a result, assessing the incidence of attempted suicide is very difficult.

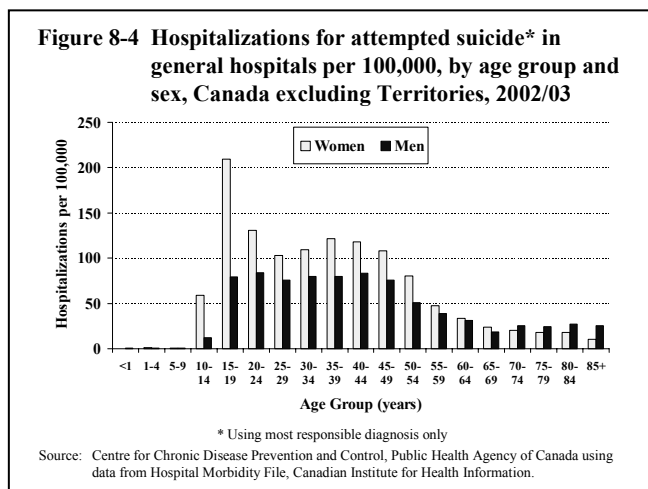
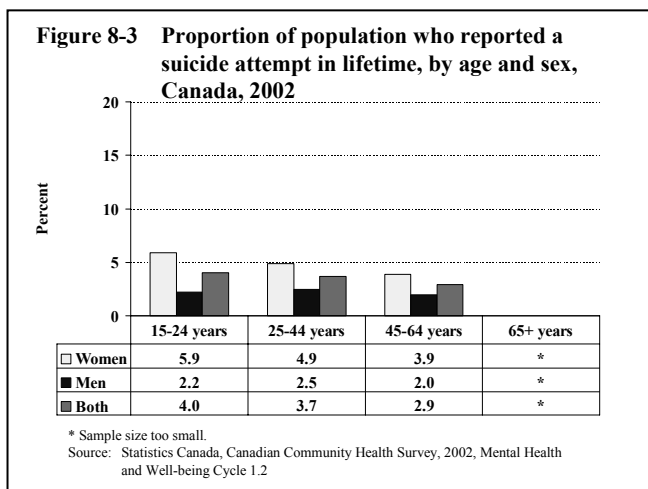
According to Statistics Canada’s 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS) 1.2), 3.1% of adults aged 15 years and over reported that they had attempted suicide in their lifetime: 2.0% of men and 4.2% of women. In addition, 0.5% reported having attempted suicide in the previous 12 months: 0.4% of men and 0.6% of women.

Women in all age groups were more likely than men to have attempted suicide at some point in their lives. (Figure 8-3) While reported suicide

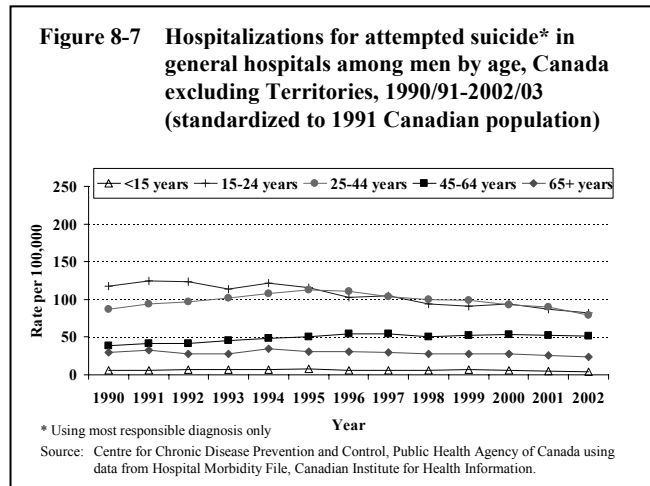
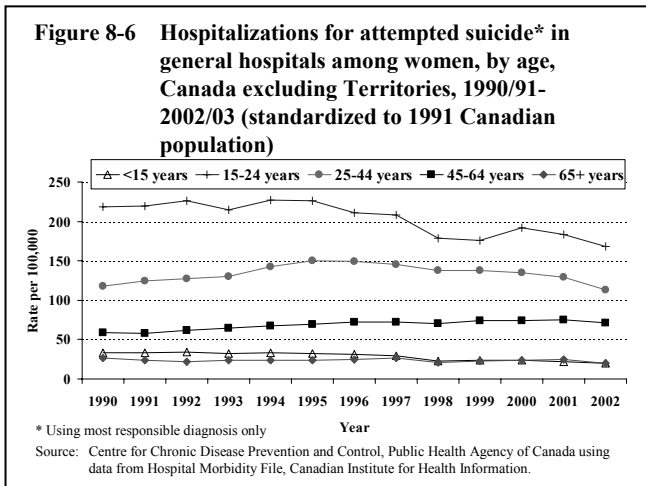
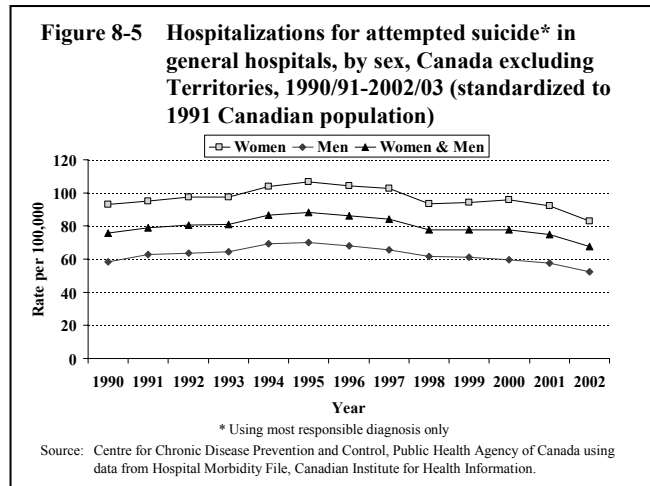
attempts decreased with age among women, reported attempts remained fairly constant among men.

Individuals are sometimes hospitalized both for their own protection and to address the underlying factors that precipitated the crisis. Hospitalization data provide some insight into attempted suicide, but must be interpreted with caution because they only provide part of the picture.

In 2002/03, hospitalization rates for attempted suicide were higher among women than among men in all age groups up to the age of 70 years. (Figure 8-4) Among women, hospitalizations peaked in the 15–19 year age group then rose again in the years approaching mid-life. Between the ages of 10 and 14 years, hospitalizations among women were 5 times those reported among young men; among 15–19 year-olds, the hospitalization rate among young women was 2.5 times the rate among young men.



Between 1996/97 and 2002/03, hospitalization rates for attempted suicide decreased for both sexes. (Figure 8-5) This decrease was mostly due to a decrease in hospitalization rates for attempted suicide among the 15–24 and 25–44 year age groups. (Figures 8-6 and 8-7)



Suicide

Early in 2002, in a summary report on suicide deaths and attempted suicide in Canada, Statistics Canada reported that suicide is one of the leading causes of death for both men and women from adolescence to middle age.²

In 2003, suicide caused the deaths of 3,765 Canadians (11.9 per 100,000): 27 individuals aged under 15 years; 522 aged 15–24 years; 1,437 aged 25–44 years; 1,337 aged 45–64 years; and 442 aged 65 years and over. This represented 1.7% of all deaths in Canada.

These figures likely underestimate the actual number of suicide deaths, either because

information about the nature of the death may only become available after the original death certificate is completed, or because assessing whether the death was intentional may be difficult in some situations.³

When the cause of death is uncertain, a coroner may initially code the death as "undetermined", and later, after further investigation, confirm the death as a suicide. This change does not appear in the mortality database. The decision as to the coding on the death certificate may also be influenced by the stigma attached to suicide.

In 2003, overall mortality rates due to suicide among men were nearly 4 times higher than among women (18.5 per thousand versus 5.4 per thousand).

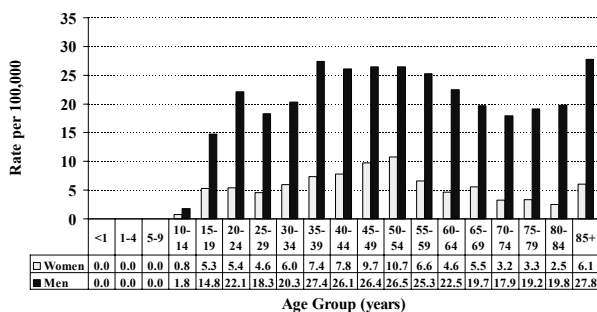
Mortality rates due to suicide are much higher among adult men than adult women in all age groups. (Figure 8-8) Among men, suicide rates increase to the age of 45–49 years, then decrease to age 65–69 years, then increase again. Among women, suicide rates increase after age 10–14 years until age 55–59 years. After age 60 to 64 the rate decreases considerably.

Over 1 in 5 of all deaths among young adults 15–24 years of age was due to suicide. (Figure 8-9) The percentage of all adult deaths due to suicide decreased with age, and the percentage is higher among men than women in all adult age groups.

While the overall mortality rate due to suicide decreased slightly between 1990 and 2003, the decrease was greater among men than among women. (Figure 8-10)

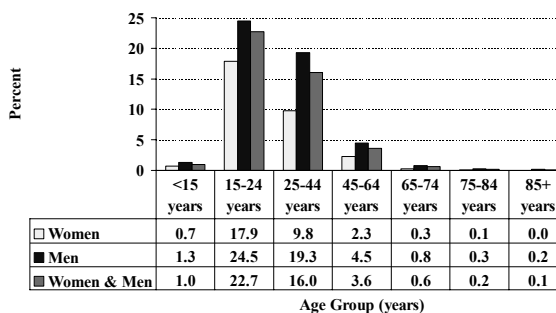
While suicide rates among women of all ages fluctuated between 1990 and 2003, the overall changes have been small. A slight decrease in rates is seen for women aged 25–44 and 65–74 years. (Figure 8-11) Rates among seniors aged 75 to 84 and 85+ fluctuate considerably from year to year, but when 5 year averages are considered, little changes are indicated in recent years.

Figure 8-8 Mortality rates due to suicide per 100,000, by age and sex, Canada, 2003



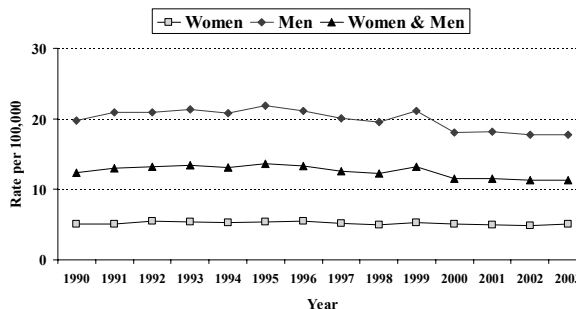
Source: Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada using data from the Mortality File, Statistics Canada

Figure 8-9 Percent of all deaths due to suicide, by age and sex, Canada, 2003



Source: Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada using data from the Mortality File, Statistics Canada

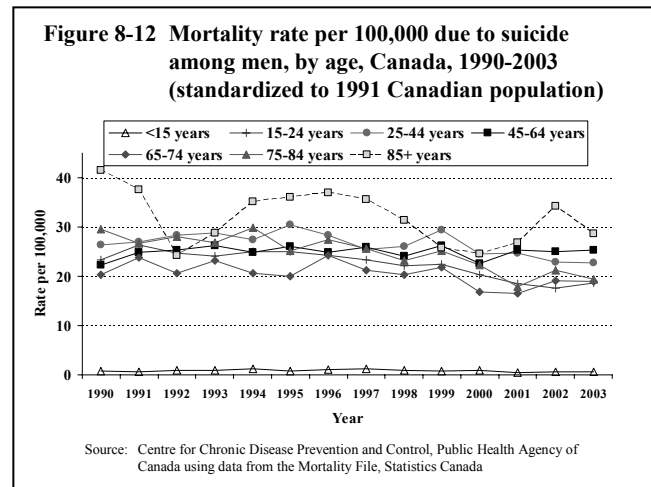
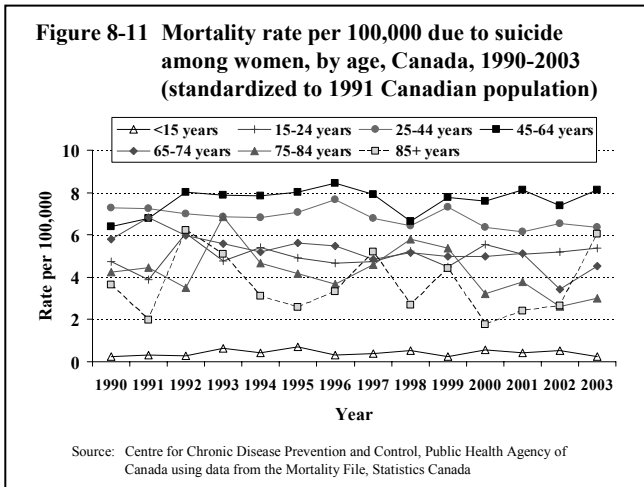
Figure 8-10 Mortality rate per 100,000 due to suicide, by sex, Canada, 1990-2003 (standardized to 1991 Canadian population)



Source: Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada using data from the Mortality File, Statistics Canada

The mortality rate due to suicide for men aged 15–24 and 25–44 years has decreased between 1995 and 2003. The small numbers of deaths and the small population size among men aged 75–84 and 85+ years results in unstable

mortality rates in these groups. However, the rates among men aged 85 years and over are consistently higher than the other age groups. (Figure 8-12)



Discussion

The difference in rates of suicide and attempted suicide among men and women has several possible explanations.⁴ Men may more often express their despair through fatal acts by, for example, the use of a firearm (26%) or hanging (40%). Although women are now using more violent methods, such as hanging, they are still more likely to choose non-fatal methods, such as an overdose of pills, where there is a greater probability of saving the individual's life. Suicidal men are less likely than women to seek help and confide their problems to others.

Youth suicide relates in part to events associated with this life stage. Resolving the challenges that are part of youth development, such as identity formation, gaining acceptance and approval among peers, and gaining acceptance from families is a stressful time for teenagers.⁵ Loss of a valued relationship or interpersonal conflict with family and friends and the perceived pressure for high scholastic achievement can be overwhelming. For those who are vulnerable to suicide, these

developmental stressors can create a serious crisis for which suicide seems to be the only solution. The impulsiveness of youth and their lack of experience in dealing with stressful issues also contribute to the higher risk of suicide.

Seniors face related challenges. They also experience the loss of relationships, but more through the death and chronic illness of their life partners and friends. They may also experience loss of their physical and mental abilities. Symptoms of depression may not be recognized and treated as such. Primary care physicians as well as family and friends have an important role in detecting mental illness that can lead to suicide.⁶ In addition, being constantly faced with their own mortality, they may choose death on their own terms.

Suicide rates are much higher in some Aboriginal communities.^{7,8,9,10} For a fuller discussion of mental health, well-being and suicide among Aboriginal Peoples, see Chapter 12 – Aboriginal Mental Health and Well-being.

Impact of Suicide

"I feel as though I am in a crowded room, watching everyone around me dance, but I can't hear the music," said Claire, a survivor who lost both her father and sister to suicide.

When a loved one dies by suicide, family members in mourning are left alive, left behind, left alone.¹¹

A suicide affects everyone in the individual's circle of family, friends and community. To begin with, everyone impacted by the suicide experiences a great sense of loss. Some may blame themselves for what has happened or question whether they could have done something to prevent the tragedy. They experience a mixture of emotions, including abandonment, disbelief, shock, extreme grief and sadness, and anger. In some cases, those left behind feel anger inwardly towards themselves or outwardly toward family members or the person who committed suicide.

Sometimes, a suicide leads to additional completed or attempted suicides within the individual's community or circle of peers.

In Aboriginal communities, a suicide affects the entire community. Family, friends and community members will engage in traditional ceremonies, such as sharing circles or sacred fires, to help cope with the loss, and offer ways to express their thoughts and feelings amidst the support of others.

Stigma Associated with Suicide

Stigma... is externally imposed by society for an unacceptable act and internally imposed by oneself for unacceptable feelings.¹²

Stigma against suicide operates at several levels: cultural, social, personal and spiritual. In all cases, stigma is a major obstacle to frank discussion and emotional healing.

In general, society does not condone suicide. To some extent, this is due to the influence of religion. Many institutions refuse to bury in consecrated ground a person who has completed suicide. This creates a stigma against suicide that is felt intensely by the family. They may sense discussion among their friends, but because the subject is never broached directly, they feel isolated and as though they

are being blamed. If the individual who completed suicide also had a mental illness, the family and friends must cope with the double stigma of suicide and mental illness.

Family and close friends often feel isolated because the stigma associated with suicide makes it difficult to share their feelings with others. They find it hard to believe that anyone else could understand their feelings. Within the family, each member may blame themselves or others for the death or may feel anger toward the individual who has died. Because they judge

these emotions as unacceptable, maintaining silence often seems to be the best solution.

Persons bereaved by suicide may feel more comfortable sharing their feelings with other survivors in support groups. Support groups for survivors can greatly aid both in coping with the death and in adjusting to life without the individual.

Spiritually, some people lose faith and stop engaging in spiritual activities because of their own feelings of hopelessness. This may be especially true if they feel that the church has frowned upon or abandoned their loved one because of the cause of death.

Because of social stigma, individuals who are considering suicide may avoid confiding in others directly and seeking help

Causes of Suicidal Behaviour

The risk factors for suicidal behaviour are complex and the mechanisms of their interaction are not well understood. It is important to take an ecological perspective when considering the layers of influence on the individual. These layers include the self, family, peers, school, community, culture, society and environment.¹³

The factors associated with suicidal behaviour fall into four categories—predisposing factors, precipitating factors, contributing factors and protective factors.¹⁴

Predisposing Factors

Predisposing factors are enduring factors that make an individual vulnerable to suicidal behaviour, such as mental illness, abuse, early loss, family history of suicide and difficulty with peer relationships.

Almost all people who kill themselves have a mental illness, such as depression, bipolar disorder, schizophrenia or borderline personality disorder or problematic substance use. Of these, depression is the most common, often in combination with problematic substance use. Nevertheless, only a minority of people living with depression are suicidal.

Previous attempts at suicide are one of the strongest predictors of completed suicide.

Precipitating Factors

Precipitating factors are acute factors that create a crisis. The most common precipitating factors are losses, including the end of a love relationship or divorce, loss of job and loss of stature in society. Other precipitating factors include pressure to succeed, conflict with the law, financial difficulties and rejection by society for some characteristic, such as ethnic origin or sexual orientation.

"The common stimulus in suicide is unendurable psychological pain.... The fear is that the trauma, the crisis, is bottomless - an eternal suffering. The person may feel boxed in, rejected, deprived, forlorn, distressed, and especially hopeless and helpless. It is the emotion of impotence, the feeling of being hopeless-helpless, that is so painful for many suicidal people. The situation is unbearable and the person desperately wants a way out of it."¹⁵

Contributing Factors

Contributing factors increase the exposure of the individual to either predisposing or precipitating factors. These include physical illness, sexual identity issues, unstable family, physical illness, risk-taking or self-destructive behaviour, suicide of a friend, isolation and problematic substance use.

Protective Factors

Protective factors are those that decrease the risk of suicidal behaviour, such as personal resilience, tolerance for frustration, self-mastery, adaptive coping skills, positive expectations for the future, sense of humour, having good social supports and particularly having at least one positive healthy relationship with a confident.

Prevention and Recovery

Using the framework described above¹⁶, suicide prevention programs must address the predisposing, precipitating, contributing and protective factors for suicidal behaviour:

- Early identification and treatment programs address the predisposing factors.
- Crisis intervention addresses the precipitating factors.
- Treatment programs address the contributing factors.
- Mental health promotion programs address the protective factors.
- For Aboriginal communities, ceremonies and community control and ownership of education, housing, employment and health are protective factors. They also address predisposing factors.¹⁷

Many provinces, territories and communities have developed suicide prevention programs. Programs need to be both population-wide and targeted toward those who are at higher risk.

A comprehensive program has a framework, goals and objectives and a commitment to adequate funding. Promotion of good mental health of the entire Canadian population, reduction of risk factors, early recognition of those at risk for suicidal behaviour, and reduction of stigma associated with suicide through education programs play essential roles in decreasing suicide and attempted suicide.¹⁸

A comprehensive program has the following strategies.¹⁹

1. Promote awareness in every part of Canada that suicide is a preventable problem.
2. Develop broad-based support for suicide prevention and intervention.
3. Develop and implement a strategy to reduce stigma, to be associated with all suicide prevention, intervention and bereavement activities.
4. Increase media knowledge regarding suicide.
5. Develop, implement and sustain community-based suicide prevention programs, respecting diversity and culture at local, regional, and provincial/territorial levels.
6. Reduce the availability and lethality of suicide methods. Since suicidal behaviour is impulsive and often occurs during a transitory crisis, restricting access to lethal means can substantially reduce the risk of the completion of a suicide attempt.²⁰ This includes reducing access to firearms, bridges and dangerous sites, and restricting the quantity of common over-the-counter and prescription medications available for sale.

7. Increase training for recognition of risk factors, warning signs and at-risk behaviours and for provision of effective intervention, targeting key gatekeepers, volunteers and professionals.
 8. Develop and promote effective clinical and professional practice (effective strategies, standards of care) to support clients, families and communities.
 9. Improve access and integration with strong linkages between the continuum-of-care components/services/families.
 10. Prioritize intervention and service delivery for high-risk groups while respecting local, regional and provincial/territorial uniqueness.
 11. Increase crisis intervention and support.
 12. Increase services and support to those bereaved by suicide.
 13. Conduct research and evaluation to inform the development of effective suicide prevention programs. These research efforts need to address the causes of suicidal behaviours, factors that increase risks for these behaviours, and factors that are protective and that may facilitate resiliency in vulnerable persons. Research must also evaluate the effectiveness of suicide prevention programs.
- Older adults are not generally considered at risk for suicide and, as a result, warning signs are often missed. The Canadian Coalition for Seniors Mental Health will soon be releasing national guidelines on the prevention and assessment of suicide among seniors.²¹

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CHAPTER 9

GAMBLING AND PROBLEM GAMBLING

Defining Gambling and Problem Gambling

Gambling takes place whenever an individual takes the chance of losing something of value (such as money or possessions) when the outcome of winning is determined mostly by chance. Examples of gambling include casino games; bingo; keno; slot machines; lottery tickets; scratch; break-open or pull tickets; betting on card games, mah-jong, or dominoes; horse racing; sports betting; games of skill (such as golf or pool); tombola; Internet gambling; and stock market speculation. Gambling can also include informal card and board games with family and friends.

Problem gambling involves much more than losing money. Although financial loss is a central problem, problem gambling has a negative effect on all aspects of the gambler's

life. Gambling is considered a problem when it interferes with work, school or other activities, causes harm to mental and/or physical health, hurts the finances of the gambler and his/her family, damages the gambler's reputation, or causes problems in relationships with family and others.¹

Problem gambling is overwhelmingly a hidden disorder; people with gambling problems will go to great efforts to hide their problem from others. Unlike other addictions, such as problematic drug abuse, problem gambling has no physical signs, making it much more difficult to detect. Often, a sudden and serious financial crisis is the first indication of a gambling problem within the family.

<u>Symptoms</u>
<p><u>Problem Gambling</u></p> <ul style="list-style-type: none">• Spending large amounts of time gambling.• Placing larger, more frequent bets.• Growing debts.• Pinning hopes on the "big win".• Promising to cut back on gambling.• Refusing to explain, or lying about, behaviour.• Frequent highs or lows.• Boasting about winning and minimizing losses.• Preferring gambling to a special family occasion.• Seeking new places to gamble, both close to home and away.²

According to the Diagnostic and Statistical Manual of Mental Disorders, problem or pathological gambling is an impulse control disorder. The presence of five or more of the following indicates problem or pathological gambling:

- Need to put increasing amounts of money into play to get the desired excitement.
- Repeated attempts (and failure) to control or stop gambling.

- Feelings of restlessness or irritability when trying to control gambling.
- Use of gambling to escape from problems.
- Frequent attempts to recoup losses.
- Lying to cover up the extent of gambling.
- Stealing to finance gambling.
- Jeopardizing a job or important relationship.
- The need to rely on others for money to relieve the consequences of gambling.
- Preoccupation with gambling.

How Common Is Gambling and Problem Gambling?

Gambling, in its many forms, is as old as antiquity. Legalized gambling in Canada is a relatively new phenomenon, however. In 1969, the federal government changed the Criminal Code of Canada to give provinces exclusive control over gambling activities. Since the 1980s, gambling has rapidly grown.³

Governments typically conduct four major types of gaming activities: lotteries, casino gambling, video lotteries (VLTs) and, in some cases,ingos. Non-casino electronic machines and casinos tend to account for the majority of revenues.

One measure of the level of gambling activity in the population is the revenue from government-run gambling. Net revenue from government-run lotteries, VLTs and casinos rose from \$3.2 billion in 1993 to \$11.8 billion in 2003 (\$6.5 billion was profit), representing a fourfold increase.

According to Statistics Canada's 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle

1.2), three-quarters of Canadians (18.9 million) aged 15 years and over spent money on some form of gambling in 2002. Over 1 in 4 (27%) described themselves as "regular gamblers", playing at least once a week.

Buying lottery tickets is the most popular gambling activity (65% of survey population), followed by instant win tickets (36%), going to a casino (22%), bingo (8%), VLTs not in casinos (6%), and horse racing (4%).⁴

Statistics Canada reports that average spending on gambling by Canadians 18 years and older was \$483 per person in 2002—more than a threefold increase from \$130 in 1992.

The dramatic change in gambling behaviour represents a significant shift in public attitude towards gambling, which not so long ago was seen as an illegal activity and social vice. Overall, Canadians feel that gambling is an acceptable activity, and this high level of support is based on the knowledge that it is government regulated.⁵

The 2002 Mental Health and Well-being Survey (CCHS 1.2) found that almost 1 in 50 adults (1.5%) were at moderate risk for problem gambling (370,000), and 0.5% (120,000) reported symptoms that met the criteria for problem gambling using the Canadian Problem Gambling Index. In

addition, 2.8% (700,000) were identified as gamblers who were at some, but low risk of becoming problem gamblers.

Approximately 62% of problem gamblers spent more than \$1,000 a year on gambling, compared with only 4% of people who gambled but experienced no problem.⁶

Who Is Affected by Problem Gambling?

Gambling problems can range from mild to severe and the level of severity can change over time. Individuals move along a continuum of problems based on a number of risk or protective factors. Problems can arise suddenly or develop slowly over the course of years. While anyone who gambles may be at risk of developing a problem, given the right set of circumstances, some individuals may be more vulnerable than others.

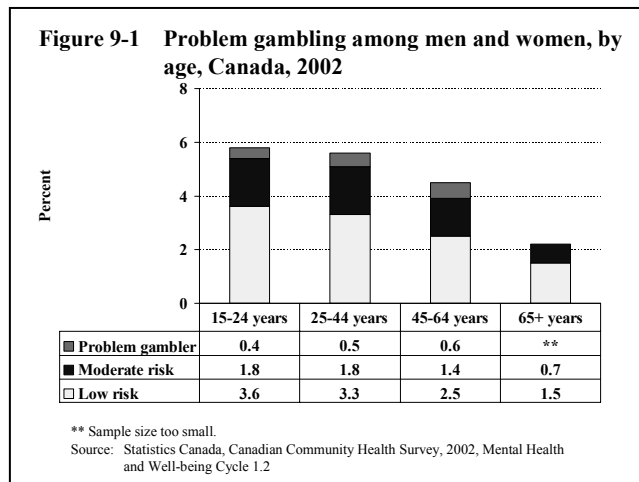
According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), the proportion of the population at some level of risk for problem gambling was higher in the 15–24 and 25–44 year age groups, than those aged 45–64 and 65+ years. (Figure 9-1) Among 15–24 year-olds, 5.8% were at risk for or were identified as problem gamblers: 3.6% were at some, but low,

risk of becoming problem gamblers; 1.8% were at moderate risk and 0.4% were considered problem gamblers. The proportions were similar for 25–44 year-olds.

Men and Women

Historically, the prevalence of problem gambling among men has been much higher than among women. Over time, however, the gender gap in prevalence rates of problem gambling is closing.

The 2002 Mental Health and Well-being Survey (CCHS 1.2), found that twice as many men as women reported symptoms that met the criteria for both problem gambler (0.6% versus 0.3%) and moderate risk for problem gambling (2.0% versus 1.0%).



Typically, men begin to gamble in adolescence whereas women often start gambling later in life. Women who develop gambling problems do so more quickly than men, however. This may reflect the difference in the reasons given for gambling and the preferred game of choice: men tend to gamble for the thrill, excitement and risk of the game while women choose to gamble to escape problems and relieve negative moods. The wide availability of electronic gaming machines (such as VLTs and slots) and the broader social acceptance of gambling within society are also considered factors in the closing of the gender gap.^{7,8,9}

Teenagers

According to McGill University's International Centre for Youth Gambling and High-Risk Behaviours, approximately 70% of Canadian teens engage in some form of gambling.¹⁰ As among adults, gambling among teens has increased over the past 20 years.

The lure of excitement, entertainment and financial freedom that accompany gambling is attractive to youth. The Centre's research has also found that:

- More young men than women gamble;
- Gambling problems among youth are associated with poor coping skills;
- Between 4% and 8% of adolescents have a serious gambling problem, while another 10% to 15% are at risk.
- Youth with serious gambling problems are at a greater risk for thoughts of suicide and suicide attempts; and
- The shift from social to problem gambling is more rapid among youth.

Youth who are involved in problematic gambling are more likely to use drugs and alcohol, have conflict with authority, do poorly in their studies, drop out of school prematurely and commit serious crimes.¹¹ Detecting gambling problems is

difficult because, in comparison to other addictions, there are no visible signs, such as intoxication or consumption.

Since this is the first generation to grow up exposed to widespread government-operated and legalized gambling, the impact is only beginning to be understood. Whether these elevated levels of problem gambling will persist over time or simply reflect the increased risk-taking associated with adolescence that tends to diminish with age, is not yet known.

Seniors

The gambling industry has recognized older adults as a target market and has introduced programs and bonuses, such as special promotions, inexpensive transportation and free lunches to encourage seniors to come and gamble.¹² Seniors enjoy gambling and report feeling safe in the brightly lit and well-supervised settings.

The reasons commonly given by seniors for gambling include opportunity and availability, boredom, loneliness, escape, pain relief, excitement, social interaction and the hope of a big payoff.¹³

Older adults are less likely than younger adults to develop gambling problems.¹⁴ However, the consequences for the elderly who have a gambling problem are often more severe than for younger adults; the elderly are less able to replace lost savings. Those who have an addiction problem (such as alcoholism, drug addiction or smoking), have recently experienced the loss of a loved one, are having health problems, lack a strong social network or alternative work or leisure activities, may be at greater risk of experiencing problems if they do choose to gamble.

Aboriginal Peoples

Historically, Aboriginal Peoples have always gambled and games of chance hold an important spiritual, emotional, mental and physical development role within Aboriginal communities and between nations.

Over the last decade, First Nations across Canada have pursued increased on-reserve gambling opportunities as a means of stimulating economic development, creating jobs and providing revenues to develop infrastructure and social programs.¹⁵ The social impact of this change is just beginning to be understood.

Identified risk factors for problem gambling within the Aboriginal community include:

- Intergenerational trauma and family dislocation resulting from residential schools;
- Addictions;
- Poverty; and
- Intergenerational violence.¹⁶

Mental Illness

Gamblers have higher rates of mental illness than the general population. The most common disorders found are depression and anxiety. Many people gamble to cope with feelings of loss, avoid difficult situations or cope with depression and anxiety. However, rather than alleviating depression and anxiety, gambling appears to worsen mood.^{17,18}

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), one-quarter of problem gamblers reported suffering major clinical depression at some point in their lives, and 1 in 5 had contemplated suicide during the previous year—a rate 6 times the proportion (3%) of non-problem gamblers.

People with gambling problems are also found to have significantly higher rates of problematic substance use.

Gambling, mood disorders and drinking are a very volatile mix. According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), 3.1% of individuals with alcohol or illicit drug dependence were problem gamblers, compared to 0.4% of non-drinkers.¹⁹ Among those with substance dependence, individuals with a mood or anxiety disorder were twice as likely to be problem gamblers. It appears that when these three elements combine, gambling problems are more severe, emotional and physical health is worse, and the risk of suicide increases.

What Is the Impact of Problem Gambling?

People with moderate to severe gambling problems experience social, emotional, financial and health consequences including:^{20,21}

- Significant levels of financial loss;
- Work related difficulties, including lower productivity, higher absenteeism or job loss;
- Higher rates of serious emotional or health problems, including depression, anxiety and drug and alcohol abuse in both gamblers and their families;
- Higher rates of suicide;
- Higher rates of marital and family breakdown; and
- Involvement in illegal activities, such as fraud and passing bad cheques to support their gambling.

People who gamble excessively will sometimes seek help for the financial, employment, relationship or health problems caused by their gambling without addressing the root cause of their problems. Without managing their gambling problems, those who gamble excessively are likely to repeat; unfortunately, this can only worsen their situation. Credit counsellors estimate that gambling accounts for 1 in 10 personal bankruptcies.^{22,23} Up to two-thirds of problem gamblers commit illegal acts in order to continue gambling.²⁴

Families also experience serious financial, social, mental, emotional and physical harm because of gambling problems. Families have higher rates of depression, anxiety, stress-related problems such as poor sleep, ulcers and headaches, and elevated levels of suicidal thoughts and action. There are also higher rates of family violence and marital breakdown. When gambling problems are hidden, communication within the family breaks down and trust is seriously eroded.^{25,26} Children experience higher levels of stress and emotional problems, including more frequent use of alcohol and other drugs. They are more likely to gamble as well and get into trouble at school and with the law.²⁷

Stigma

Addiction is often perceived as a moral weakness. People who have gambling problems are seen as weak and lacking in willpower. Problem gamblers often hide their behaviours from others due to embarrassment. The secrecy is often maintained by family members who share the embarrassment. Secrecy will cut them off from their normal community of support.^{28,29}

Causes of Problem Gambling

A combination of environmental, biological, and psychological factors lead to problem gambling. As more factors converge, the likelihood of developing gambling problems increases.

A number of theories attempt to explain problem gambling. One theory sees problem gambling as an addiction, "a dependent state acquired over time by a predisposed person in an attempt to relieve a chronic stress condition."³⁰ To be predisposed, a person must first have a persistent state of either chronic excitement or depression and "childhood experiences that have produced a deep sense of personal inadequacy and rejection." Further, an environment that supports addictive behaviour must exist and the individual must experience "a chance triggering event" which leads them to pursue similar experiences in the future. People use their addictions as a way of "entering and maintaining a dissociative-like state" such as the "trance" of the problem gambler.³¹

A second model, The Pathways Model, describes three distinct sub-groups of problem gamblers.³²

- The first group develops gambling problems due to faulty thinking, misunderstandings or incorrect beliefs concerning randomness and probabilities. While the outcome of gambling is determined by chance, these problem gamblers do not always behave as if they understand that it is impossible to control the outcome of the game: they believe that their "system" of play gives them an advantage. Throughout their gambling experience, occasional random wins have likely reinforced these beliefs. A "big" early win is an important risk factor.³³
- The second group uses gambling as a means of avoiding or coping with difficult challenges and negative moods. Through

prolonged play, they are able to disassociate from their painful circumstances, losing track of time and place. Gambling has been found not to alleviate depressed and anxious moods—in fact, it makes matters worse through inevitable financial losses.

- The final group may be more vulnerable than the general population because of predisposing biological factors. This group includes people with major mental illnesses such as depression, bipolar disorders, personality disorders, and impulse control disorders such as Attention Deficit and Hyperactivity Disorder (ADHD).

Risk Factors Associated with Problem Gambling

Many risky gambling practices and known risk factors are associated with developing gambling problems.³⁴ Risky gambling practices include:

- Steadily betting more money than was planned or can be afforded;
- Gambling for prolonged periods of time and regularly spending more time gambling than was intended;
- Continuously thinking about and seeking out gambling opportunities;
- "Chasing losses" to win back lost wagers;
- Borrowing money to gamble, or participating in illegal or immoral activities to raise money for gambling;
- Holding a mistaken understanding of probabilities and randomness—or the likelihood of winning, false beliefs about the role of luck; superstitions; and illusions of control;
- Mixing gambling and alcohol;

- Using gambling as a way of dealing with problems or negative emotions such as anger, loneliness or depression;
- Gambling alone;
- A personal or family history of drug, alcohol, gambling or overspending problems;
- A personal or family history of mental illness, particularly depression, impulse control problems, stress or trauma;
- A recent loss or change such as divorce, job loss, retirement or death of a loved one;
- Social isolation, low-self esteem, lack of leisure activities, feeling powerless and controlled by others; and
- Financial problems.

Protective factors

Protective factors can help buffer those with social, emotional or biological risks and reduce the negative impact of gambling.³⁵ There are two general categories of protective factors including: first, a personal orientation and commitment to healthy living, and social support for engaging in healthy behaviours; and second, active involvement with social institutions, such as family, school, and communities of faith. People with an active social life, meaningful work, a strong religious affiliation, a wide variety of leisure interests, a supportive partner, and close friends are less vulnerable to developing gambling problems.

Prevention and Recovery

The Ottawa Charter for Health Promotion of the World Health Organization provides a useful framework for preventing and addressing gambling problems.³⁶ This includes developing personal skills, strengthening community capacity, creating supportive environments, building healthy public policy and re-orienting health services.

Public education, risk-reduction policies, socially responsible programs within the gambling industry, reduction in underage access to gambling products, and early intervention programs will hopefully prevent the development of problem gambling. Possible activities include:³⁷

- Education in schools;
- Publicly posted warning labels in gambling venues and on gambling products;
- Public awareness campaigns about the risks and signs of gambling problems;
- “Responsible gambling” programs and policies in the gambling industry that include training for gambling industry employees, bingo and lottery sales staff;
- Workplace health promotion activities; and
- Self-diagnosis tools.

Education of the public at large could be supplemented with intensive interventions for high-risk individuals, through such activities as:

- Outreach – Making connections within groups who are known to be at risk, such as teens, seniors and individuals with mental illness;
- Early identification – Developing and making available easy-to-use diagnostic tools to

help health care providers, financial counsellors and others identify gambling problems among those with mental illnesses, substance abuse and stress-related disorders.

- Education – Developing specialized programs that address the specific needs and realities of the at-risk group, such as people with mood disorders.

Only a small fraction of those with gambling problems seek specialized professional help. The barriers identified include ambivalence about giving up gambling, a strong desire to self-manage gambling problems, the stigma associated with gambling problems, uncertainty about the counselling process, and a lack of knowledge about available services.

It is not unusual for men with gambling problems to have gambled for decades before seeking treatment. On the other hand, women tend to enter treatment within a few years after problems have developed.

Problem gambling is associated with high levels of denial. Most people enter treatment under pressure from others rather than on a voluntary basis. Most people who gamble excessively have mixed feelings about their gambling; they may know it is causing harm to people they love and may, therefore, be angry and unhappy. Because the urge to gamble is overwhelming, even if they promise to quit, they may find it impossible to follow through. This drives them deeper into hiding and further into debt as they hope for the “big win” that will solve their problems.

Problem gambling can be effectively treated. Treatment options commonly include:

- Cognitive-behavioural therapies;
- Individual and group psychotherapy;
- Relaxation, leisure, and vocational counselling;
- Self-help support groups such as Gamblers Anonymous; and
- Treatment of co-morbid conditions.

Cognitive-behavioural therapy, which is designed to modify gambling-related behaviours and thinking, has been the most effective treatment. Given the high prevalence of co-occurring mental illnesses and substance abuse disorders, treatment for problem gambling should include adequate assessment and appropriate treatments for these underlying conditions.³⁸

Harm reduction is a commonly used counselling approach which helps clients assess their gambling and reduce its negative impact on their lives. Some gamblers may choose to set time and money limits, or to stay away from those gambling activities that cause them the most harm. Others recognize that the only solution to

their problem is through abstinence and stop gambling completely.³⁹

Relapse prevention strategies help people who have chosen to reduce or abstain from gambling to reduce the recurrence of problems.

Approaches can include developing a positive support network, learning to handle stress and other problems, understanding and controlling gambling urges, communicating with a sponsor (as in Gamblers Anonymous), and learning effective life skills. Often, treatment is undertaken only after patients have already accumulated large debts and suffered serious social consequences. Problem gambling counsellors can help people repair their financial and legal situation and heal family relations and restore trust lost through gambling.⁴⁰

Even if the person with a gambling problem refuses treatment, counselling can help spouses or parents take measures to protect their assets, identify ways to improve family functioning and improve self-care. Strategies to encourage the gambler to consider change can also be explored. The success of treatment is enhanced when the whole family understands the problem and supports change.

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CHAPTER 10

PROBLEMATIC SUBSTANCE USE

What Is Problematic Substance Use?

Substance use refers to the use of psychoactive substances that change the way people think, feel and act. Substance use occurs along a continuum from beneficial use to problematic use.¹ Over time, individuals may remain at one point along this continuum or move from one point to another.

Beneficial substance use has a positive social, spiritual or health impact.

Non-problematic substance use includes recreational, casual or other use that has negligible negative health or social impact.

Problematic substance use is the contextually inappropriate and improper use of any substance that results in seriously or potentially serious harmful outcomes for the individual or others.² This includes, but is not limited to, substance abuse and dependence.

Substance abuse is defined as

“A pattern of substance use leading to significant impairment or distress. One of the following must be present within a 12 month period:

1. Recurrent use resulting in a failure to fulfill major obligations at work, school, or home;
2. Recurrent use in situations which are physically hazardous (e.g., driving while intoxicated);
3. Recurrent legal problems resulting from use; or

4. Continued use despite significant social or interpersonal problems caused or exacerbated by the substance use.”³

Substance dependence is characterized by the presence of three or more of the following in a 12-month period:

1. Increased tolerance (increasing amounts of a substance to obtain the same effect or diminished effect at the same dose);
2. Symptoms of withdrawal when substance use is stopped or reduced, or maintained use to avoid withdrawal symptoms;
3. Consumption of larger quantities of the substance over longer periods of time than intended;
4. An acknowledged desire to reduce use or stop or unsuccessful attempts to do so;
5. A great deal of time spent in activities associated to obtain, use or recover from the use;
6. Neglect of important social or occupational events; or
7. Continued use despite knowledge of negative effects associated with this use.

Substance dependence can be specified as having a component of physiological dependence if the criteria 1 and 2 are present.⁴

The use of a wide range of psychoactive substances can lead to dependence. These include alcohol, non-prescription and prescription drugs, illicit drugs, solvents and inhalants. Tobacco is generally not included in discussions of substance use but is often described as a gateway drug, since prevalence of alcohol and illicit drug use is higher among smokers than non-smokers.⁵ This chapter focuses on alcohol and illicit drugs.

Substance dependence is a process more than an event. In the initial stages people often experience no problems, but with continued use they may become more focused on the substance than on other areas of their lives. This process is influenced by biological make-up and the psychological response to life events, challenges, stress and distress, and social factors. Substances may be used to escape from troubling feelings and demanding situations, such as anxiety, abuse or trauma. Peer and social groups can also normalize substance use; when under stress from work or family situations, familiar substances can become part of an individual's coping strategy.

How Common Is Substance Use?

While the use of psychoactive substances is very common in Canada, exactly how common is difficult to determine. Population surveys are the best tools for measuring use, but people may not accurately report their use, especially if the substances are illegal. As a result, the actual use of psychoactive substances is likely to be higher than reported and the statistics presented here should be interpreted with caution.

Two recent studies of adults 15 years of age and older—Statistics Canada's 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2) and the 2004 Canadian Addiction Survey (CAS)⁷—provide data on substance use in Canada. The two surveys should be

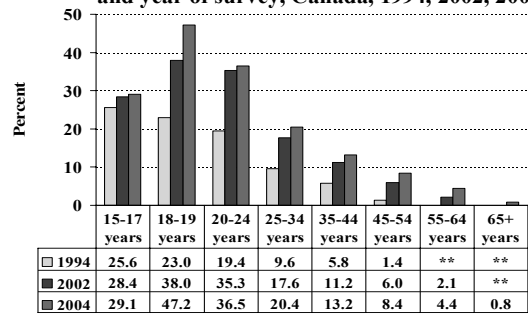
compared with caution in light of the methodological differences such as response rates and data collection methods.

Table 10-1 summarizes findings from these two studies. Three-quarters of adults 15 years of age and over consumed alcohol at some time in the previous 12 months. About one-third drank heavily (5+ drinks) on at least one occasion in the previous 12 months: the proportion among men was twice that of women. Between 10.2% and 14.1% of adults had used cannabis in the previous 12 months and 2.5% had used it daily. About 3% had used another illicit drug in the previous 12 months. The highest use of other illicit drugs was young adults 18–24 years of age.

Table 10-1 Self-reported substance use among adults aged 15 years and over, 2002 and 2004, Canada		
Substance and Measure	CCHS 1.2 2002*– Interview Survey Adults 15+ years	CAS 2004** – Telephone Survey Adults 15+ years
<u>Alcohol</u>		
Consumed alcohol in previous 12 months	77.1% (19.3 million) ⇒ 82.0% of men; 72.5% of women	79.3% ⇒ 82.0% of men; 76.8% of women
Drank heavily (5+ drinks on a single occasion) at least once in the previous 12 months	35.3% (8.8 million) ⇒ 46.6% men; 24.3% women	
<u>Illicit Drugs</u>		
<u>Used any illicit drug in the previous 12 months</u>	12.6% (3.1 million) 15.9% men; 9.4% women Of 12 month users, 9.0% were daily users ⇒ 10.2% of men; 6.9% of women	
<u>Cannabis</u>		
Used cannabis in previous 12 months	10.2% (2.5 million) ⇒ 12.7% of men; 7.8% of women	14.1%
Used cannabis daily in previous 12 months		2.5% of the total population 18.1% of users in the previous 12 months
Used cannabis at least once in their lifetime		44.5% ⇒ 50.1% of men; 39.2% of women
<u>Other Illicit Drugs</u>		
Used illicit drugs in previous 12 months	Cocaine, ecstasy, hallucinogens, heroin and sniffing solvents 2.4% (590,000) ⇒ 3.2% of men; 1.6% of women	One of: hallucinogens, cocaine, ecstasy, speed or heroin 3% of Canadians ⇒ 4.3% of men; 1.8% of women Ecstasy users were mostly under age 35. Cocaine and speed use were reported by all age-groups. The highest use of illicit drugs was by men, young adults aged 18–24 years, and non-rural residents.
Used illicit drugs in lifetime		One of: hallucinogens, cocaine, ecstasy, speed or heroin 16.5% ⇒ 11.4% hallucinogens ⇒ 10.6% cocaine ⇒ 4.1% ecstasy ⇒ 6.4% speed
*Statistics Canada. 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2) **Adlaf, EM, Begin P, Sawka E. 2004 Canadian Addiction Survey (CAS).		

According to data from the 1994 Canada's Alcohol and Other Drugs Survey, the 2002 Mental Health and Well-being Survey (CCHS Cycle 1.2) and the 2004 CAS, the proportion of the adults who reported using cannabis in the previous 12 months doubled or nearly doubled between 1994 and 2004 in all age groups except 15–17 year-olds and adults aged 55+ years. (Figure 10-1)

Figure 10-1 Proportion of Canadians consuming* cannabis in the past 12 months, by age group and year of survey, Canada, 1994, 2002, 2004



*Self-reported for all Canadians 15 years of age and older
 **Sample size too small
 Sources: 1994 Canada's Alcohol and Other Drugs Survey; Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2; 2004 Canadian Addiction Survey

How Common Is Problematic Substance Use?

Table 10-2 outlines the findings of the interview-based 2002 Mental Health and Well-being Survey (CCHS 1.2) and the telephone-based 2004 CAS⁶ for problematic substance use. Among heavy drinkers, nearly 1 in 5 adults 15 years of age and over (18.6%) reported regular heavy drinking (5+ drinks on one occasion at least once per week). Slightly more than 1 in 5 current alcohol drinkers reported exceeding the low-risk drinking guidelines (for men, an average of 14 drinks or less per week; for women, 9 drinks or less per week).

According to the CAS, 17.0% of current alcohol

drinkers reported patterns of drinking and symptoms that indicated harmful use or possible dependence on alcohol. According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), about 3% of adults aged 15+ years reported symptoms that met the criteria for substance dependence: 2.6% for alcohol and 0.8% for illicit drugs. Among those who used cannabis in the 3 months prior to the survey, 42.9% reported failure to control their use at some point in their life, and 40.4% reported a strong desire to use cannabis during that 3-month period.

Table 10-2 Self-reported problematic substance use among adults aged 15 years and over, 2002 and 2004, Canada		
Substance and Measure	CCHS 1.2 2002* – Interview survey Adults 15+	CAS 2004* – Telephone survey Adults 15+
<u>Alcohol</u>		
Regular heavy drinking (5+ drinks on one occasion at least once a week) in the past 12 months among heavy drinkers	18.6% ⇒ 23.0% of men; 10.3% of women	
Exceeded low-risk drinking guidelines (men -14 drinks or less per week, and women - 9 drinks or less per week)		22.6% of current alcohol drinkers ⇒ 30.2% of men; 15.1% of women who had drank in the past year
Reported symptoms meeting criteria for being dependent on alcohol or illicit drugs	3.1% ⇒ 2.6% (641,000) dependence on alcohol ⇒ 0.8% (194,000) dependence on illicit drugs. ⇒ 4.5% of men; 1.7% of women	
Drinking hazardously indicating harmful use or possible dependence on alcohol ^a ,		17.0% of current alcohol drinkers ⇒ 25.1% of men; 8.9% of women who had drank in the past year
<u>Cannabis</u>		
Past-3-month cannabis users report problems		42.9% reported failure to control their use at some point in their life 40.4% reported a strong desire to use cannabis (during previous 3 months)
*Statistics Canada. 2002 Mental Health and Well-being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2)		
**Canadian Centre on Substance Abuse. 2004 Canadian Addiction Survey (CAS).		
^a According to the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT)		
^b According to the World Health Organization's Alcohol, Smoking and Substance Involvement Screening Tool (ASSIST)		

Impact of Problematic Substance Use

Who Is Affected by Problematic Substance Use?

Men are more likely than women to engage in problematic substance use. (Table 10-2) This may be due to men’s greater exposure to opportunities to use substances.⁷

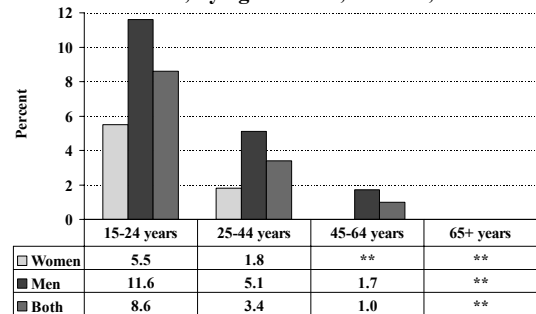
While women are less likely than men to experience substance use problems, they face unique issues that have important treatment implications. Two-thirds of women with substance use problems have concurrent mental health problems such as depression, eating disorders, post-traumatic stress disorder or panic disorder. Women who have substance use problems are also more likely to have been victims of domestic abuse, rape, child physical assault and incest.

In 1989, women reported higher usage than men of prescription medication such as painkillers, tranquilizers, sleeping pills, anti-depressants and diet pills. They were twice as likely as men to be prescribed mood-altering drugs.⁸

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), probable substance dependence during the previous 12 months decreased dramatically with age among both sexes. (Figure 10-2) About 1 in 10 men and 1 in 20 women between the ages of 15 and 24 years reported symptoms that met the criteria for substance dependence.

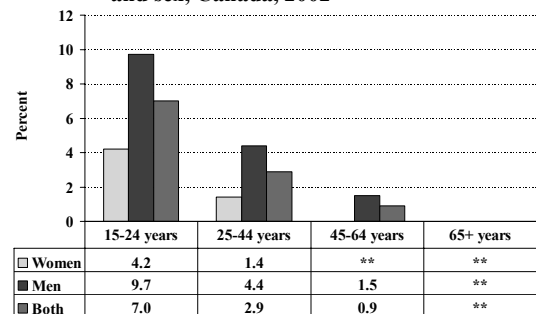
One in 14 young adults between 15 and 24 years of age (7.0%) reported symptoms that met the criteria for alcohol dependence in the

Figure 10-2 Proportion of population meeting criteria for alcohol or illicit drug dependence in past 12 months, by age and sex, Canada, 2002



** Sample size too small.
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

Figure 10-3 Proportion of population meeting criteria for alcohol dependence in past 12 months, by age and sex, Canada, 2002



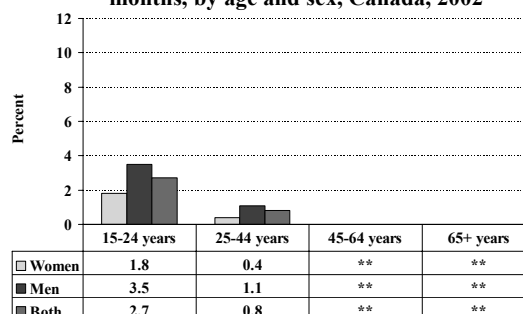
** Sample size too small.
Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

12 months preceding the survey. This decreased to 2.9% among those aged 25–44 years and 0.9% of those aged 45–64 years. (Figure 10-3) More men than women reported symptoms that met the criteria for alcohol dependence.

The proportion who met the criteria for illicit drug dependence was much lower than for alcohol, but showed the same decrease with age. (Figure 10-4) These percentages may underestimate illicit drug dependence because respondents may be hesitant to report any symptoms that may identify them as dependent.

The proportion of men and women aged 20–24 years who reported regular heavy drinking (five or more drinks on one occasion at least once a week) increased from 2000 to 2004, using data from the 2000–2001, 2002, 2003 and 2004 Canadian Community Health Surveys. (Figures 10-5 and 10-6)

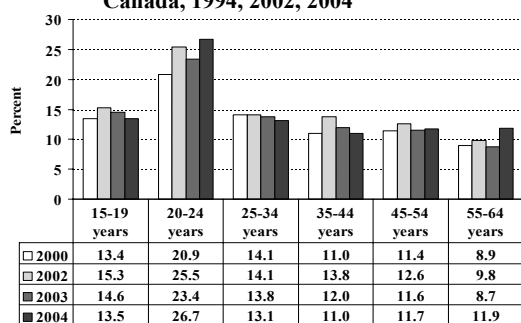
Figure 10-4 Proportion of population meeting criteria for illicit drug dependence in past 12 months, by age and sex, Canada, 2002



** Sample size too small.

Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

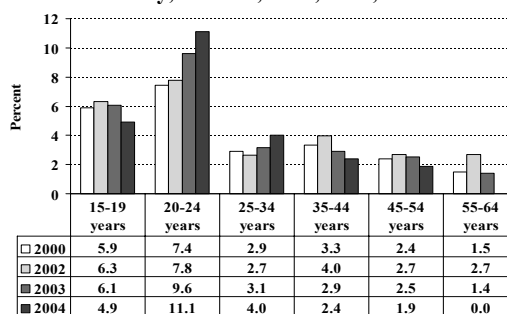
Figure 10-5 Proportion of men involved in regular heavy drinking by age group and year of survey, Canada, 1994, 2002, 2004**



**Self-reported consumption of 5 or more drinks on one occasion at least once a week in the past 12 months.

Source: Statistics Canada: 2000/01, 2002, 2003, 2004 Canadian Community Health Surveys

Figure 10-6 Proportion of women involved in regular heavy drinking by age group and year of survey, Canada, 1994, 2002, 2004**



**Self-reported consumption of 5 or more drinks on one occasion at least once a week in the past 12 months.

Source: Statistics Canada: 2000/01, 2002, 2003, 2004 Canadian Community Health Surveys

Youth

Figure 10-7 and Table 10-3 present the results of the 2004 CAS concerning youth. Many teens and young adults reported being heavy drinkers (typical drinking day is 5+ drinks), and more than 1 in 4 reported exceeding the low-risk drinking guidelines on a weekly basis (14 drinks or less each week for men; 9 drinks or less per week for women).

Almost 2 out of 3 young people had used cannabis at some point in their lives, and almost 1 in 2 teens 18–19 years of age had

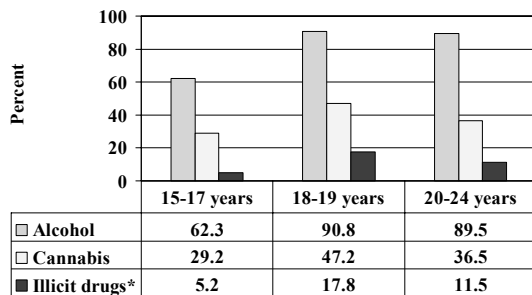
used cannabis in the previous year. Ten percent of teens 15–19 years of age and 13.4% of young adults aged 20–24 years reported using ecstasy in the previous year.

According to the 2002 Health Behaviour of School-Aged Children Survey:

- Students in Grades 9 and 10 experimented with a wide variety of substances. (Figure 10-8) Young men were more likely than young women to experiment with all types of substances.

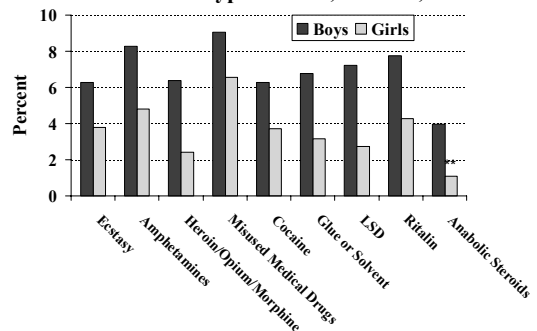
Table 10-3 Self-reported substance use among youth, Canadian Addiction Survey, Canada, 2004	
Indicator	CAS 2004*
Alcohol	
Typical drinking day included 5+ drinks among those who drank alcohol in the previous year	28.8% of 15–17 years 42.5% of 18–19 years 31.6% of 20–24 years
Weekly heavy drinking (5+ drinks for men or 4+ drinks for women on a single occasion) among those who drank alcohol in the previous year	7.6% of 15–17 years 16.1% of 18–19 years 14.9% of 20–24 years
Exceeded the low-risk drinking guidelines; among those who drank alcohol in the previous year (low risk drinking for men: 14 drinks or less each week; for women: 9 drinks or less per week.)	24.6% of 15–17 years 32.3% of 18–19 years 38.0% of 20–24 years
Cannabis	
Ever used cannabis	61.4% of those 15–24 years
Used cannabis in the previous year	29.2% of 15–17 years 47.2% of 18–19 years 36.5% of 20–24 years
Illicit Drugs	
Ever used hallucinogens, cocaine, speed, ecstasy or heroin.	19.8% of teens (15–19 years) 28.1% of young adults (20–24 years) Hallucinogens - 13.2% of teens and 19.2% of young adults Cocaine - 9.8% of teens and 15.0% of young adults Speed - 8.3% of teens and 11.2% of young adults Ecstasy - 10.1% of teens and 13.4% of young adults
* 2004 Canadian Addiction Survey (CAS).	

Figure 10-7 Substance use in the previous year among youth, Canada, 2004



* Illicit drugs includes any of hallucinogens, cocaine, speed, ecstasy or heroin.
Source: 2004 Canadian Addiction Survey

Figure 10-8 Proportion of Grade 9 & 10 students using* various substances in their lifetime by substance type and sex, Canada, 2002



* Includes any self-reported lifetime consumption ** Interpret with caution, high sampling variability
Source: Health Behaviour of School-Aged Children Survey, 2002, WHO.

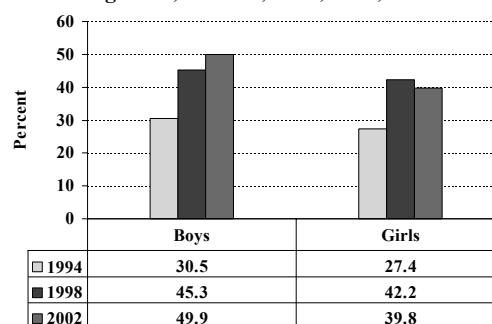
- The proportion of Grade 10 students who had used cannabis at least once in their lifetime increased from 1994 to 2002 among both young men and women. (Figure 10-9) In 2002, 49.9% of young men and 39.8% of young women had used cannabis.

Although most teens experiment with alcohol and drugs before they complete high school, for the vast majority it does not lead to problematic substance use. However, a small but significant number of Canadian youth are engaging in heavy substance use. The prevalence of substance use amongst teens increases with age and is related to adolescent psychological development when independence and peer relationships assume greater importance. The transition from primary to secondary school is a time of vulnerability for some students.

The most common problems among youth associated with problematic substance use are vandalism and self-injury. Sexual activity associated with substance use has significant implications, including sexual assault or unprotected sex. School dropout rates are higher among youth who use substances regularly or heavily.

Street-involved youth—children and adolescents who experience marginal or chronic homelessness—have elevated rates of heavy drinking and illicit drug use compared to other adolescents. They are more likely to use substances with the intent of becoming intoxicated and to use more than one substance, incurring risks due to the additive or synergistic effects of combining different drugs.⁹ A multi-site Canadian study reported that in 1989 more than one-quarter of street-involved youth reported regular heavy drinking. Seventy-one percent reported that they had used cannabis in the year before the

Figure 10-9 Proportion of Grade 10 students using* cannabis in their lifetime by survey year and gender, Canada, 1994, 1998, 2002



* Includes any self-reported lifetime use. Note that grade 9's were not surveyed in 1994 and 1998. Source: 1994, 1998, 2002. Health Behaviour of School-Aged Children Survey, WHO.

survey and 31% had used cocaine.¹⁰ Injection drug use is also prevalent among street-involved youth, placing them at risk of infection with HIV and other blood-borne viruses, such as hepatitis C.

Seniors

Alcohol is the substance most commonly used by seniors. According to the 2004 CAS, 14.8% of Canadians over the age of 65 years drank four or more times a week. With increasing age comes the increasing potential of pain or insomnia as a result of health problems.

Adults who develop problematic substance use after the age of 40 tend to be more successful with treatment.¹¹

Alcohol misuse among seniors may make other health problems worse and increase the risk of falls. Some of these risks result from lifelong alcohol abuse, but even heavy drinking that begins late in life can also be associated with negative health consequences. The use of medications by seniors is common—alcohol use can interact with prescription or over-the-counter medications to decrease their effectiveness or produce adverse reactions. The typical signs of problematic substance use among seniors

include memory loss, falls or cognitive impairment. Attributing these to natural aging may miss problematic substance use among seniors.¹²

Mental Illnesses

The relationship between mental illnesses and problematic substance use is complex. For some people, mental health problems can be risk factors for problematic substance use; for others, problematic substance use contributes to the development of mental health problems.

Substance use, which is neither abuse nor dependence, may also interfere with the recovery of some people with mental illness and is therefore an important consideration in treatment. Substances may also interact with psychotropic medications, reducing their efficacy.¹³

The 2002 Mental Health and Well-being Survey (CCHS 1.2) found that nearly 1 in 10 adults with an anxiety disorder (9.6%) or a mood disorder (11.3%) met the criteria for substance dependence in the previous 12 months. This was higher than the proportion of the general population who had symptoms consistent with substance dependence (3.0%).

Fifteen percent of people who were alcohol-dependent had also been depressed in the previous year, compared to 4.8% of the general population. For those who were dependent on illicit drugs, the prevalence of depression was even higher at 26%. Women who were dependent on alcohol were about twice as likely as men to also be depressed.¹⁴

Gay, Lesbian, Bisexual, Transgendered and Transsexual Individuals

Problematic substance use in the lesbian, gay, bisexual, transgendered and transsexual communities is significantly higher than in the general population.¹⁵ About 30% of individuals who are gay or lesbian have a history of substance abuse, compared to 10%–12% in the general population.¹⁶ It is thought that coping with the manifestations of homophobia (including harassment or assaults, marginalization in school, and the perceived need to hide one's identity and orientation) leads to a higher-than-average use of drugs and alcohol.

Aboriginal Peoples

There is widespread concern in First Nations and Inuit communities about problematic use of alcohol and drugs. According to surveys in selected regions, three-quarters of all residents feel that problematic substance use is a problem in their community; about one-third state that it is a problem in their own family or household; and approximately one-quarter say that they have a personal problem with alcohol or need to cut back on their drinking.^{17,18}

Despite these signs, surveys typically find that lower-than-average proportions of First Nations and Inuit people drink alcohol. The problem seems to be that many of the people who do drink, drink heavily (consume 5 or more drinks on a single occasion). Whereas fewer than one-half of all drinkers in Canada ever drink heavily, 74% of Inuit drinkers drink heavily at least occasionally and the proportion among First Nations people appears to be similar (based on figures from one province). (See Chapter 12 – Aboriginal Mental Health and Well-Being: Table 12-4)

Socio-economic Factors

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2),¹⁹ individuals who were separated/divorced or never married, lived in a low-income household, and did not

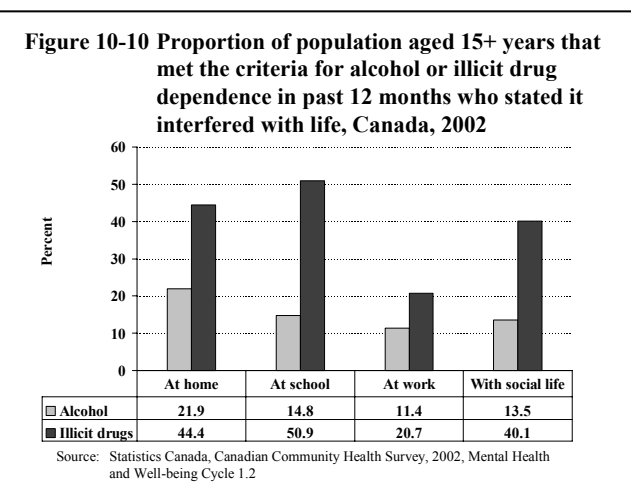
have a post-secondary degree or diploma were more likely than other individuals to have symptoms of substance dependence. People born in countries outside Canada were less likely to report symptoms of alcohol dependence.

How Does Problematic Substance Use Affect People?

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), one-third of individuals who met the criteria for illicit drug dependence (32.9%) and 15.2% of those who met the criteria for alcohol dependence in the previous 12 months reported that the substance use had interfered with their lives. Much higher proportions of those dependent on illicit drugs rather than alcohol reported that their use interfered with home, school, work and social life. (Figure 10-10)

Health-related Problems

Heavy use of alcohol and drugs is associated with many health problems, including falls, motor vehicle accidents, cirrhosis, heart problems, gastrointestinal problems, impotence, nutritional deficiencies, alcohol-related dementia, liver and other cancers, brain damage, and acute toxicity. In any given year, an estimated 8% of all hospitalizations in Canada are the result of these health problems attributed to heavy alcohol and drugs use, and accounts for 10% of the total number of days spent in hospital.²⁰ Women are more likely than men to develop cirrhosis of the liver with smaller amounts of alcohol taken over shorter durations.



Illicit drug use contributes to drug-induced psychosis and drug-related assaults, and to HIV/AIDS and hepatitis B and C among injection drug users.

Problematic substance use increases the risk of suicide. (See also Chapter 8 – Suicidal Behaviour.)

Driving while impaired by alcohol or other substances continues to be a major cause of vehicle crashes, injuries and deaths in Canada. In 2001, 38% of drivers killed in crashes tested positive for alcohol.²¹

Foetal alcohol spectrum disorder (FASD) refers to a range of birth defects caused by heavy drinking of alcohol during pregnancy, including facial, cardiac, skeletal, renal, ocular or auditory deformities; growth retardation; central nervous system (CNS) dysfunction; and neuro-developmental disorders. It is estimated that between 1 and 3 of every 1,000 live births in North America are affected by Foetal alcohol syndrome (FAS) or FASD.^{22,23} Since researchers have been unable to determine a safe level of drinking during pregnancy, it is wise to avoid alcohol altogether.

Impact on the Family

Family members are almost always affected when a spouse, parent, child, or other relative has a problem with substance use.

Communication within the family becomes less open as people avoid talking about concerns or expressing emotions; family breakdown is high. Some family members take on responsibilities that have been abandoned by the person, leading to role strain. There is an increased risk of physical and emotional aggression within the family.

Parents with substance use problems are more likely to abuse or neglect their children's physical, emotional and cognitive needs. Discipline and daily routines are disorganized and family roles disrupted. Children who grow up in an environment of substance abuse are more likely to have physical and mental health problems, including problematic substance use and eating disorders, to perform more poorly in school, and to get into trouble with the law.²⁴

Workplace

Consequences of problematic substance use in the work place include injury and death, loss of productivity, absenteeism, high benefits claims, lateness, theft, high turnover, poor decision-making, relationship problems among employees, and low morale.²⁵

Economic Costs

The cost of substance dependence goes far beyond its impact on the individual. It can have a serious, far-reaching impact on the family, community and society as a whole.

In 2002 the estimated substance abuse-related costs to the Canadian economy were \$39.8 billion per year (\$24.3 billion in lost productivity and \$8.8 billion in health care costs), or approximately \$1,267 per person. Alcohol abuse accounted for \$14.6 billion, of which an estimated \$7.1 billion related to lost productivity in the workplace and premature death, \$3.1 billion for law enforcement, and \$3.3 billion for health care costs.

The cost of illicit drug use was estimated to be \$8.2 billion in 2002. Of that, \$4.7 billion was for lost productivity or premature death, \$2.3 billion for law enforcement and \$1.1 million in health care costs.²⁶

Involvement with the Law

Substance use and dependence are often associated with illegal activities that use resources related to policing, the courts, and corrections systems.²⁷

Substance abuse has been identified as a problem among a high proportion of inmates.

Among men:

- 34.3% in minimum-, 45.8% in medium- and 42.1% in maximum-security facilities had an alcohol problem.
- 36.4% in minimum-, 51.2% in medium- and 51.4% in maximum-security facilities had a drug problem.

Among women:

- 29.3% in minimum-, 49.4% medium- and 69.6% in maximum-security facilities had an alcohol problem, and
- 40.1% in minimum-, 67.5% in medium- and 78.3% in maximum-security facilities had a drug problem.²⁸

Stigma

People who have substance use problems are seen as weak and lacking in will power. As a result, they often hide their behaviour from others. This is particularly true for women, who experience severe social sanctions when they have substance use problems. This stigma influences whether individuals seek help for problematic substance use.

Causes of Substance Abuse and Dependence

Problematic substance use has no single cause: it is the result of a combination of biological, environmental and psychological factors.

Biological Factors

There is a genetic predisposition to substance dependence. Studies have shown that children of alcohol dependent parents have an increased risk of alcohol dependence.²⁹

The physiological effects of prolonged substance use on the body, brain, and nervous system also contribute to dependency.

Those who experience intense pleasure when using substances or who experience relief from distressing emotions such as anxiety, anger or depression, are also at greater risk of developing dependency on mood-altering substances.

Alcohol may have more potency in seniors due to age-related physiological changes that

slow down the metabolism. These changes include: the percentage of body fat increases in proportion to total body weight; the amount of lean body mass decreases; and the total volume of water in the body diminishes.

Psychological Stress

Alcohol and drugs may be used to cope with psychological stress and distress from a variety of sources:

- Childhood trauma (physical or sexual assault, neglect or abandonment);
- Women and men who are subjected to violence;
- Significant losses such as job loss, death, divorce or retirement;
- Distressing symptoms of mental illness;
- Post-traumatic stress disorder (PTSD) which can arise in the wake of combat experiences, accidents, assaults, robbery, rape or other serious life-threatening events;

- Illness, impairment, isolation and loss (of loved ones, of roles, of social networks), particularly among the elderly.

Refugees may bring with them past experiences of war, violence, displacement, loss and grief. These life experiences render them vulnerable to a number of problems, including substance use.

Physical illness

When chronic pain from physical illness or accident is treated with prescribed opiate medication, some people become dependent on the medication and unable to stop using it even after they have become well.

Some people may also self-medicate with substances such as alcohol to cope with pain, insomnia and other physical health problems or disability.

Social Factors

The attitudes of family, friends and peers both shape the values and beliefs an individual holds about the acceptability of substance use and model its use. Alcohol is widely marketed as an agreeable way to enhance social occasions. Among youth, easy access and availability, and peer pressure and the desire to “fit in” all play a role in substance use.

Many people are uncomfortable in social situations, dating or in work relationships. Most struggle on with their insecurities and shyness; some, however, turn to alcohol or drugs to ease their discomfort. Moderate use may escalate over time into problematic use and dependence. This can further affect the development of social skills as the individual becomes increasingly isolated and preoccupied with the dependency.

Prevention and Recovery

Launched in 1987, Canada’s Drug Strategy is the federal response to addressing the harmful use of substances. Canada’s Drug Strategy seeks to ensure that Canadians can live in a society increasingly free of the harms associated with problematic substance use. The strategy takes a balanced approach to reducing both the demand for, and the supply of, drugs. It contributes to a healthier, safer Canada through prevention, treatment, enforcement, and harm reduction initiatives.³⁰

- **Prevention** includes measures to prevent the problematic use of alcohol, other drugs and substances through education to help people make informed, healthy choices;
- **Treatment** (and recovery) focuses on activities for those who have developed an unhealthy dependency on legal or illegal substances;
- **Enforcement** involves measures that halt the unlawful import, export, production, distribution and possession of controlled substances, and the seizure and forfeiture of assets gained through the drug trade; and

- **Harm reduction** focuses on measures to limit possible secondary effects of substance use, such as the spread of HIV/AIDS and Hepatitis C.

The Canadian Drug Strategy's goals are to create supportive environments that promote health and resiliency of individuals, families and communities in order to prevent problematic use of alcohol, other drugs and substances, and to reduce the harm to individuals, families and communities across Canada that is associated with alcohol and other drugs and substances.

According to the 2002 Mental Health and Well-being Survey (CCHS 1.2), a high proportion of Canadians who met the criteria for alcohol or illicit drug dependence reported that they had not consulted with a professional in the previous 12 months: 80.1% of those with alcohol dependence and 65.3% of those with illicit drug dependence. (Figure 10-11) A family physician was the most frequently consulted health professional: 12.3% of those with alcohol dependence and 20.5% of those with illicit drug dependence. Social workers were consulted by 14.4% of those with illicit drug dependence.

People may be identified or self-identify as substance dependent in a variety of settings beyond the health care system, such as school, work, prison or justice systems, community programs and social services sector. Professionals in these settings should be aware of and prepared to address these issues.

Since the pathways to problematic substance use are complex, treatment and recovery must reflect the unique needs of each individual in order to be effective. This requires addressing their problematic substance use and its harm as well as dealing with the factors that contribute to its development and continuation.

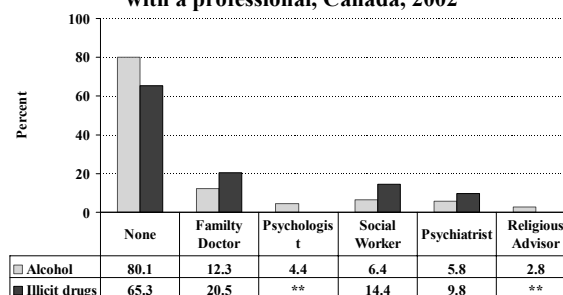
Treating the latter may involve social and life skills training, stress management, and cognitive-behavioural therapy. Involving the family is an important aspect of treatment—to help strengthen the family unit, to improve communication and to promote ongoing recovery and change.

Promoting abstinence (complete withdrawal from substance use) is based on a disease model of dependency and has dominated treatment for decades. The goal is to encourage the client to give up substance use completely.

Harm Reduction is an approach to policies and programs that focuses on minimizing harms to those who use drugs, without necessarily requiring a reduction in use or abstinence on the part of the substance user. As a public health approach, it aims to contain and subsequently reduce adverse health, social and resulting economic consequences—for the user, families, and the community at large.

This approach acknowledges that the use of alcohol and other drugs and substances occurs and has a harmful effect on society; recognizes that access to health and social services is a human right that must be provided regardless of whether an individual

Figure 10-11 Proportion of population aged 15+ years that met the criteria for alcohol or illicit drug dependence in past 12 months who consulted with a professional, Canada, 2002



** Sample size too small.

Source: Statistics Canada, Canadian Community Health Survey, 2002, Mental Health and Well-being Cycle 1.2

abuses a substance; fosters changes in individual behaviour including safer practices or patterns of use, while recognizing abstinence as a possible approach; and establishes a series of achievable goals, which when taken one step at a time, can result in both a healthier life for the substance user and a safer, healthier community³¹

Harm reduction strategies include:

- Needle exchange programs;
- Substitution treatment—such as methadone for heroin users;
- Educational materials that teach safe injection techniques and safe sex strategies;
- Distribution of condoms and dental dams;
- Referrals to health care professionals who will treat the health-related effects of problematic substance use without judgment; and

Relapse-prevention strategies help to reduce the likelihood of a recurrence of problematic substance use. Relapse is an anticipated part of the recovery and learning process. Approaches include helping the client develop a positive support network, identifying triggers, communicating with a sponsor (as in Alcoholics Anonymous), learning effective life skills, relaxation and leisure skills, obtaining better housing and employment, and other activities that are particular to an individual's needs.

The various treatments that are available for people with substance use problems are targeted to serve a narrow group—those who have self-identified as having serious problems, have been referred by employers or health providers, or have come into contact with the law as a result of their substance use. Treatment services include a variety of options.

Withdrawal management centres (detox services) offer short-term stays in a non-medical community-based environment and focus on the basics of life—food, a place to sleep, showers, fresh clothes, referral to medical assistance if withdrawal symptoms emerge, and help with social assistance and housing.

Not everyone exhibits withdrawal. For those who do, it is now thought that the symptoms can be managed on an outpatient basis with the administration of short-term medication (such as benzodiazepine for alcohol withdrawal) to manage the period when symptoms are the most severe. Research has shown that older adults require more attention and care during the withdrawal phase and that the detoxification period is significantly longer for older adults.^{32,33}

Hospitalization can provide support for critical and acute consequences of problematic substance use, such as overdoses, life-threatening physical complications, an episode of mental illness that puts the individual or others in personal danger, or suicide attempts.

People who benefit from residential treatment are those whose social environment is unstable or unhealthy. They see themselves as lacking the interpersonal, relational or vocational skills necessary to resist their environment and be treated in the community. It is thought that a complete break from their surroundings is a beneficial start to longer-term treatment, followed by referral to, or return to, outpatient or community services.

Medication may be used to reduce the symptoms of withdrawal. It can also decrease or block the reinforcing effects of the substance, reduce cravings or make continued use of the substance extremely unpleasant. Some medications provide a substitute for a

much more harmful substance, as in the substitution of methadone for heroin. People may be prescribed medication for co-occurring physical or psychiatric disorders.

Cognitive-behavioural therapies help people identify the various triggers that lead to problematic substance use and offer new strategies to manage mood and behaviour. Group therapy allows people with similar problems to learn new ways of thinking and of behaving together, with peers reinforcing positive change. Family or marital therapy assists people in developing more positive interpersonal relationships.

Many people with substance use problems combine professional treatment with self-help, while others choose one or the other path. Alcoholics Anonymous (AA) is perhaps the most well known self-help group of all, offering positive role models of people who have “been there.”

Story telling allows the individual to recognize that there is hope for the future. The sponsor program pairs each member with another who is further along in his or her journey so that they have someone to turn to when the craving is overwhelming. People can also

come and go from AA without judgment as they deal with relapses.

Self-help groups are also available for spouses/partners and children of problematic substance users so they can learn how to understand, cope with, and keep from supporting their loved one’s substance use behaviour.

A variety of community-based services benefit people with substance use (and mental health) problems. These include supported housing, case management, assertive community treatment teams (ACT teams), court diversion programs, drop-in centres, distress lines, employment programs and social/recreational programs. Most people desire to live, work and learn in their own communities while receiving help for their problems. These services support that goal.

With the exception of mood and anxiety disorders, where it is recommended that problematic substance use be addressed first, best practice guidelines for all other psychiatric disorders recommend an integrated treatment approach that treats both problems at the same time.³⁴

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CHAPTER 11

HOSPITALIZATION AND MENTAL ILLNESS

History of Hospitalization for Mental Illness

In the 10th century in the Middle East and early in the 19th century in Europe, psychiatric asylums served as places where individuals suffering mental illness could rest and receive personal care intended to restore their health. In Europe, this represented a change from the demonization and imprisonment that had previously faced many psychiatric patients—at least for those with means. Poor people with mental illness continued to live outside walled cities in packs and risked being stoned.

In Canada, mental health services initially took a humanitarian approach with the development of asylums for the mentally ill in Upper and Lower Canada at the end of the 19th century. Some people with mental illness were taken from prisons and poor houses and put into these asylums.

By the early 20th century, however, the personal attention and curative environment of the asylums had been replaced by a treatment model set in larger psychiatric institutions, with their impersonal custodial service and the bleak environment of public hospitals for the mentally ill. This degradation of services continued for the first half of the 20th century with the development of large isolated institutions that lacked sufficient staff to sustain the quality of care provided in the old asylums. The limited individual therapeutic attention and, ultimately, the limited effectiveness of psychiatric treatments¹ betrayed the primary function of psychiatric hospitalization and suggested an alternate—the removal of those with mental illness from the public sphere.²

With the introduction of effective anti-psychotic and anti-depressant medications in the 1950s, psychotic symptoms could be better controlled, allowing people with mental illness to live outside institutions. A number of other conditions also motivated deinstitutionalization: poor living standards, high cost of maintaining psychiatric hospitals, a greater emphasis on treatment in the community and in psychiatric units of general hospitals, and greater restrictions on the involuntary admission of individuals to psychiatric hospitals. By the latter half of the 20th century, the population of individuals in psychiatric hospitals was reduced dramatically. By 1980, the number of patients living in psychiatric hospitals had decreased significantly from the high of 66,000 after World War II.³ This decline was, in part, offset by an increase in the amount of services provided in psychiatric sections of general hospitals. Between 1960 and 1976, the number of beds in Canadian psychiatric hospitals decreased from 47,633 to 15,011, while the number of psychiatric beds in general hospitals increased from 844 to 5,836.⁴

Initial efforts to address the rehabilitation, treatment and housing needs of the deinstitutionalized psychiatric population were inadequate. By 1970, many individuals with mental illness were living on the streets or imprisoned. In large urban centers, the problem was particularly acute and compounded by substance use problems.

Deinstitutionalization posed a particular problem for those whose illnesses were severe, as the treatment offered by psychiatric units in general hospitals and in the community was either too fragmented or simply inadequate to fulfill the

needs of this displaced population.⁵ In addition, the transition could be very difficult for individuals who had lived in institutions for many years; many lacked the fundamental skills necessary for survival outside the institution.

The Current Role of Hospitalization for Mental Illness

Today, hospitalization is only one of a number of approaches to mental health care in Canada. With advances in psychiatric medications, the development of a spectrum of community-based services, and the high costs associated with institutionalization, most mental health care is provided outside of the hospital setting. Additionally, advances in the understanding of mental illnesses and their possible treatments, has meant that important distinctions can be made between moderate mental illnesses, which make up the majority of cases, and those which are severe and persistent and which are most likely to require care in specialized hospitals.⁶

For the latter group and for those in crisis situations, hospitalization remains an essential part of the treatment continuum.⁷ The nature of hospital-based psychiatric care has changed, however, such that treatment is likely to occur within a broader domain that emphasizes shorter durations and transitional care that ultimately returns the individual to the community. Indeed, community integration (or reintegration) is invariably the desired outcome for the majority of mental health treatment models.

Hospitalization offers immediate medical attention, a comprehensive assessment of an individual's mental and physical condition, a resumption of medication, and access to psychotherapy from psychiatrists, psychologists, social workers, occupational therapists, and other mental health professionals who can help stabilize the individual's condition. Involuntary admission plays a vital role in avoiding the harm associated with untreated mental illness.

Hospitalization does not need to be either continuous or of long duration. In 2002/03, nearly one-half of all mental illness separations⁸ from general hospital were after stays of one week or less and over 85% were after stays of one month or less.

The funding of acute care psychiatric units in general hospitals has prompted the development of a stronger link between psychiatric care and general and primary care medicine.

After reaching a more stable condition, many hospitalized individuals are transferred to partial hospitalization programs where they may receive therapy at a hospital during the day and return home in the evening. Eventually, such hospital services may aid the individual in both identifying and making the transition to community-based services.

The transition to community-based services has not been without problems however. At times, community services may be inappropriate, provide inadequate coverage, or lack sufficient resources to provide the needed psychiatric services.⁹

Because of restructuring and the concurrent decrease in the number of psychiatric hospital beds, some individuals who become unstable due to a recurrence of symptoms or through cessation of medication use may "fall through

the cracks". Such individuals can find themselves destitute, on the streets or in prison. Indeed, the rise in the proportion of prison inmates with mental illness suggests that some have exchanged the psychiatric ward for the prison ward.^{10,11}

This discontinuity and inadequacy of care after hospitalization is common among seniors who have lived with schizophrenia for most of their lives. After being transferred from psychiatric institutions they may find themselves in long-term care facilities that generally have limited availability of mental health professionals. This despite estimates that 80%–90% of residents of long-term care facilities have a mental disorder (including dementia, delirium, mood disorder, psychotic disorder, personality disorder).¹²

Reasons for Hospitalization and Length of Stay

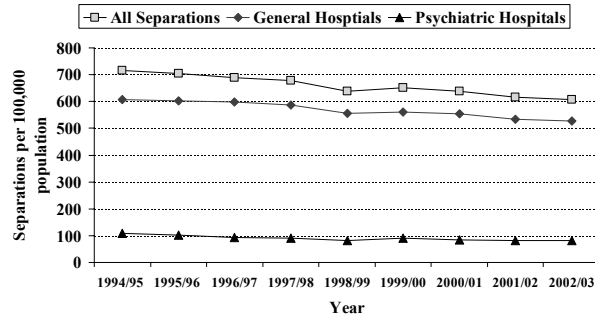
According to Statistics Canada and the Canadian Institute for Health Information (CIHI), hospital separation rates (which include discharges and deaths) for mental illness in Canada have been declining since the early 1980s.^{13,14} The number of separations per 100,000 population was 769 in 1982/83, 727 in 1992/93, and 606 in 2002/03. The number of general hospital separations per 100,000 population was 630 in 1982/83, 619 in 1992/93, and 525 in 2002/03. The number of psychiatric hospital separations per 100,000 population were 150 in 1982/83, 116 in 1992/93, and 81 in 2002/03.

(Figure 11-1 illustrates the decline in hospital separation rates between 1994/95 and 2002/03.)

Since the early 1980s, the majority of hospital separations for mental illnesses have been from general hospitals: 82% in 1982/83; 85% in 1992/93; and 87% in 2002/03.^{15,16}

These proportions are consistent with the systemic changes that have occurred in the way mental health services are provided. With the ongoing restructuring in the tertiary mental health care sector, the role of psychiatric hospitals is expected to continue to diminish.

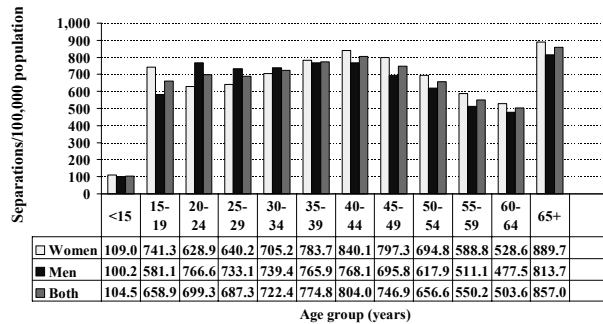
Figure 11-1 Hospital separation rate for mental illness by type of hospital, Canada, 1994/95–2002/03



Source: Hospital Mental Health Services Database, Canadian Institute for Health Information.

Hospitalization for mental illness appears to be discretely linked with age, particularly in the teen years. It appears to increase dramatically in the 15–19 year-old age group. (Figure 11-2) This corresponds to the age of onset of many mental illnesses, such as mood disorders and substance dependency. Hospitalization rates also increased among individuals aged 65 years and over, corresponding with the onset of organic disorders such as dementia.

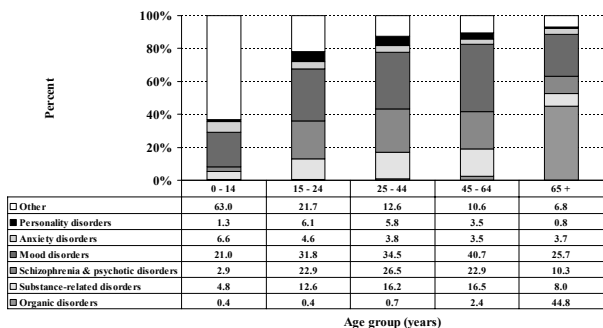
Figure 11-2 Hospitalization separation rate for mental illnesses, by age, Canada, 2002/03



Source: Hospital Mental Health Services Database, Canadian Institute for Health Information.

Age also appears to bear a relation to the type mental illness diagnosed upon separation from hospital. (Figure 11-3) For separations among people under the age of 15 years, the “other” diagnosis (which includes adjustment disorders, and attention-deficit and disruptive behaviour disorders) was most prominent. Between the ages of 15 and 64 years, mood disorders and schizophrenic and psychotic disorders were the most prominent diagnoses for hospital separations due to mental illness. Among seniors, organic disorders were the most common.

Figure 11-3 Proportion of hospitalization separations for mental illnesses, by type of disorder and age, Canada, 2002/03



Source: Hospital Mental Health Services Database, Canadian Institute for Health Information.

The average length of stay (ALOS) in hospital can serve as an indicator of the intensity of service usage, as well as the severity and nature of a particular condition. The ALOS for mental illness has changed in the past twenty years in both general and psychiatric hospitals (Figure 11-4):

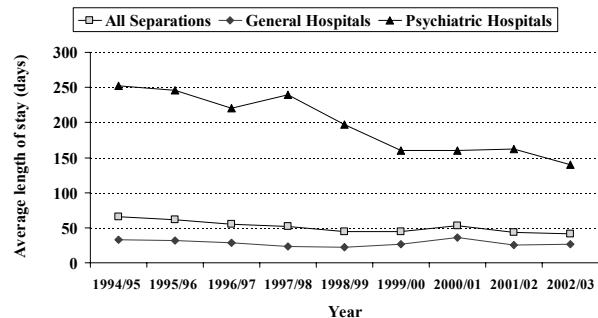
- ALOS was 27 days, 33 days, and 26 days for general hospitals in 1982/83, 1992/93, and 2002/03 respectively; and
- ALOS was 193 days, 274 days, and 140 days for psychiatric hospitals in the same years.

Although only about 13% of all hospital separations in 2002/03 were from psychiatric hospitals, because their ALOS was much longer than general hospital separations, they accounted for a large proportion of total hospital days (46% in 2002/03). This proportion has decreased in the past 20 years from 61% of all hospital patient days in 1982/83 and 64% in 1993/94.

To some extent, the differences in ALOS between general and psychiatric hospitals reflect differences in the types of illnesses being treated. The largest category of diagnoses among separations from general hospitals was mood disorders (34.7%). (Figure 11-5)

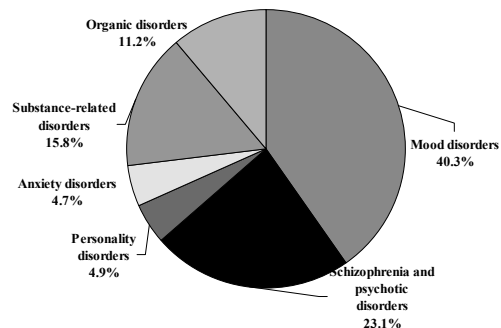
In comparison, the largest diagnosis category of separations from psychiatric hospitals was schizophrenic and psychotic disorders (30.9%). (Figure 11-6) The severely debilitating delusions and disturbances of thought that characterize schizophrenia often necessitate the specialized care and longer stays that are characteristic of psychiatric hospitals. Thus, the ALOS for schizophrenia separations from psychiatric hospitals tend to be among the longest, across both type of hospital, and type of diagnosis.

Figure 11-4 Average length of stay for mental illness by type of hospital, Canada, 1994/95–2002/03



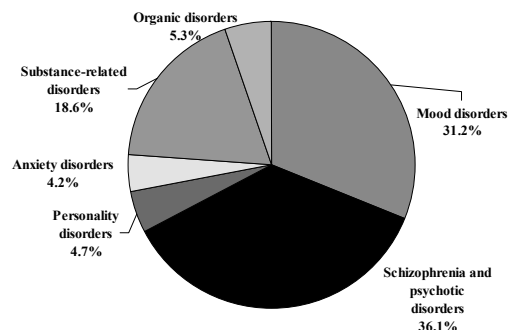
Source: Hospital Mental Health Services Database, Canadian Institute for Health Information.

Figure 11-5 Percentages of separations for mental illnesses from general hospitals, by diagnosis, Canada, 2002/03



Source: Hospital Mental Health Services Database, Canadian Institute for Health Information.

Figure 11-6 Percentages of separations from psychiatric hospitals, by diagnosis, Canada, 2002/03



Source: Hospital Mental Health Services Database, Canadian Institute for Health Information.

The general/psychiatric dichotomy for hospitals that provide mental health services is rather a simple one. Provincial variations in the type of institutions that provide inpatient services to those with mental illness do not always allow classification into such a neat dichotomy. For instance, the Hébergements, or nursing homes, that provide long-term care for individuals with severe intellectual deficits in Quebec are classified here as general hospitals, although they do not fit the classic definition, which would more likely be aligned with acute care. Nonetheless, the dichotomy remains a useful one for the purpose of distinguishing types of service.

Some characteristics of the individuals who were in general and psychiatric hospitals are presented in Table 11-1.

- More women than men were hospitalized in general hospitals, which may be associated with a higher prevalence of mood disorders among women.
- More men than women hospitalized in psychiatric hospitals, which may be associated with the earlier and greater impact of schizophrenia among men.
- Mental illness can affect young people from childhood, but hospitalizations begin

appearing with some regularity in adolescence and young adulthood.

- Over 60% of hospitalizations occur between the ages of 45 and 64 years when most people are in the productive working phases of their lives.
- Mental illnesses continue to affect individuals after the age of 65, when many are also challenged by physical illness and possibly other life changes.

The Canadian Institute for Health Information (CIHI) report, *Hospital Mental Health Services in Canada 2002-2003*, provides a more in depth discussion of hospitalization data for mood disorders, schizophrenia and substance-related disorders.

Changes in mental health care have made treatment in general hospitals more common, and through primary care and community based services have created the possibility of avoiding hospitalization altogether. Although hospital treatment remains an important part of mental health care, such changes suggest that it is less likely to entail long periods of internment in monolithic institutions, away from family, friends, and the community.

	General Hospital	Psychiatric Hospital	Total
Mean Age (years)	44.3	42.9	44.1
Male (%)	46.4	56.1	47.7
Age Group (%)			
0–14 years	3.5	1.6	3.2
15–24 years	15.5	14.5	15.3
25–44 years	37.3	42.7	38.0
45–64 years	25.3	27.8	25.6
65+ years	18.5	13.4	17.9
Death in Hospital (%)	0.8	1.3	0.9
At least one additional mental illness present during stay (%)	43.5	48.2	44.1

Source: Hospital Mental Health Services Database, Canadian Institute for Health Information

Endnotes

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CHAPTER 12

THE MENTAL HEALTH AND WELL-BEING OF ABORIGINAL PEOPLES IN CANADA

Aboriginal Peoples in Canada

Aboriginal peoples in Canada include First Nations (Indian), Inuit and Métis peoples. In 2001, approximately one million Canadians (about 3% of the population) reported that they belonged to one of these peoples. Although “Aboriginal” is the umbrella term, in fact the groups differ substantially in language, customs, circumstances and area of residence.

First Nations

According to the Department of Indian and Northern Affairs, there are presently 734,000 registered First Nations people in Canada. Slightly more than one-half (57%) live on one of the many reserves spread across the country; the rest live off-reserve, often in the large cities such as Vancouver and Winnipeg. There are 614 First Nations bands—groups that share common values, traditions and practices—and Band Councils typically govern the reserves.^{1,2} The economic foundation in First Nations communities has changed greatly over the years. Although land-based activities such as hunting, fishing or agriculture are still common in some northern regions, most First Nations communities have now adapted to a greater or lesser extent to the wage-based economy. However, levels of employment, education and income in many of these communities are far below Canadian averages.

Inuit

According to the 2001 Census, there are 45,000 Inuit in Canada. The majority live in fifty-three communities spread across Nunavut, the Northwest Territories, northern Quebec (Nunavik), and the coast of Labrador (Nunatsiavut). Over 90% of these communities are inaccessible by road.

Inuktitut continues to be the language in common use: 70% of Inuit can carry on a conversation in Inuktitut, and it is the language of daily use in the eastern arctic. Many Inuit—especially the younger generation—also speak English or French as their second language.^{3,4}

Because of their remote locations, Inuit came into sustained contact with European culture later than the other Aboriginal groups and, until comparatively recently, continued to live off the land in small family groupings. This began to change in the 1950s, however, as explained by the Inuit Women’s Association:

“Since the early 1950s, the pressures to change their culture and adopt many aspects of the foreign culture increased dramatically for the Inuit as they began to move into settlements. While they were ‘pulled’ to settlements for access to the schools, health care, housing and material goods, they were also ‘pushed’ from the land by a drastic reduction in the caribou herds and low fur prices which left them impoverished, and occasionally starving.”⁵

The shift from a subsistence to a wage-based economy has been turbulent, and many Inuit communities have high unemployment rates. While land-based activities have diminished, they have not disappeared: hunting is still an important source of food for some families, and many Inuit continue to feel a strong cultural need to spend time “on the land.”

Métis

Historically, the term “Métis” applied to the children of French traders and Cree women in the Prairies, and of British traders and Dene women in the north. Today, the term is broadly used to describe a group of people of mixed First Nations and European ancestry who see themselves as distinct from First Nations, Inuit and non-Aboriginal people.⁶

According to the 2001 Census, there are 292,000 Métis in Canada. Unlike First Nations and Inuit, Métis people usually do not have specific territories that are allocated to them, or in which they form a majority. Instead, more than two-thirds of Métis live in urban areas, especially the western cities of Winnipeg, Edmonton, Vancouver, Calgary and Saskatoon.⁷ Although the traditional Métis language is Michif, most Métis people speak either English or French

Self-government Arrangements

Beginning in 1995, federal government policies began to recognize the right of First Nations and Inuit communities to self-government. In practice, this has meant negotiating agreements under which communities increasingly take control of their own affairs: now, many communities administer their own schools, policing services, social services and health services. Through other more complex agreements, a group of First Nations or Inuit communities provide services to an entire region. Collectively, these agreements are referred to as “transfer arrangements.” There are few such arrangements for Métis groups.

Availability of Health Information

Most of the information presented in the remainder of this chapter relates to the mental health and mental illness of First Nations people living on reserve, and Inuit. Unfortunately, there is very little health information for Métis and other Aboriginal peoples who live in urban areas.⁸

First Nations, Inuit and Métis Concepts of Mental Health and Well-being

Given the great diversity of Aboriginal peoples in Canada, one might expect to find a corresponding diversity in concepts of mental health and illness. While there are important cultural and regional differences, corresponding to different histories, ways of life, and social structures, Aboriginal peoples also share commonalities in ways of understanding health and illness.

Traditional ideas of health did not separate mental health from other aspects of well-being.⁹ Aboriginal peoples lived in close connection to the land and everyday activities needed for survival included a spiritual dimension that maintained harmonious relations with the animals, the environment and, indeed, the universe as a whole.

For Aboriginal peoples who were primarily hunters, animals played a crucial role in every aspect of their lives.¹⁰ Health and healing stemmed from the spiritual power mediated by good relationship with animals. For those who were also agrarian, a good relationship to the land was equally important for individual and collective well-being. This relationship to the land was not conceived of in terms of ownership but as one of respect and responsibility expressed through everyday attention and ceremonial action.¹¹

In contrast to the emphasis on the individual in much of Euro-Canadian society, the concept of the healthy person common to most Aboriginal cultures emphasizes relations and connections to others. The person is seen as embedded in a web of sustaining relations. These connections extend to those who have come before, the ancestors, who may be present in memory, stories and ceremonial practices. The

ancestors, sometimes referred to personally as “grandfather” or “grandmother”, also require attention and honour and, in return, provide a sense of connectedness across time. This sense of connection includes others within the family, clan or community. Wise men and women within the community may be recognized by some individuals as elders and turned to for guidance and advice on practical, moral and spiritual concerns.

Health and wellness is achieved when there is a morally and spiritually correct relationship with others in the family and community, with ancestors, and with the larger web of relations that make up the world and that can insure well-being for future generations.

The social and historical events that have reshaped the lives of Aboriginal communities and individuals are receiving increased recognition. Many Aboriginal people understand the causes of contemporary suffering as rooted in the history of colonization and subsequent cultural oppression, including the impact of sedentarization, forced acculturation, and residential schools.¹² They thus see their individual and collective difficulties as consequences of historical trauma.

In recent years, many Aboriginal peoples have been influenced by a spirituality that emphasizes these principles of connectedness to nature and ancestors, harmony and balance, and these are presented in the imagery of the Medicine Wheel and through healing practices such as the Sweat Lodge, Pipe Ceremony and other practices.^{13,14} These practices have spread from their original cultures because they express values shared by many Aboriginal individuals and communities

and assert elements of a common vision and identity.

The Medicine Wheel, a relatively new tool, represents the totality of human experience in terms of four quadrants or dimensions—mental, physical, emotional and spiritual. Health involves the balance and harmony of these four dimensions. Mental health cannot be separated from emotional, physical and spiritual dimensions of experience but is one aspect of the balance and harmony of the whole.

Many Aboriginal peoples have also adopted Christianity and its specific notions about health and illness.¹⁵ Christian and Aboriginal spiritual traditions share both the notion of the unity of human beings and the natural world in Creation and the practice of prayer to the Creator.

Many Aboriginal individuals are also knowledgeable about popular psychology as conveyed through the media. This has promoted the value of explaining individual suffering in terms of individual biographical events, in particular, the importance of spiritual, psychological, physical and sexual trauma as a cause of later difficulties in life. Popular psychology has also encouraged a model of healing through telling one's story and bearing witness to suffering that fits well with traditional practices in some communities. At the same time, there are Aboriginal traditions of storytelling that may heal by relating individual predicaments to larger cultural myths.¹⁶

Not every Aboriginal person is equally knowledgeable about all of these perspectives or traditions. Some experience contradictions between Christianity and older Aboriginal forms of spirituality and feel they must choose one or the other. Some find that psychological approaches to mental health ignore the social origins and political dimensions of problems or give insufficient place to spirituality. It is important, therefore, to avoid over-generalizing or stereotyping and to understand the specific paths followed by an individual or community.

Most people have multiple models available for thinking about mental health and illness. They bring these to bear, depending on the aspects of the problem that they are addressing. Because of the pervasive effects of cultural oppression and historical trauma, many Aboriginal people see their situation as requiring an ongoing process of individual and collective healing.¹⁷ This may involve efforts to re-connect with family and community, to live on the land, to recollect and preserve traditional knowledge, and to affirm cultural values and identity. It includes active efforts to regain political control and find creative ways to embrace spiritual values while meeting the challenges of a globalizing world.

This process of healing does not involve Aboriginal people alone, but calls for reflection and action by the larger society. Health, then, is not a static state of well-being, but a process of achieving harmony, balance and connectedness within oneself and in relation to others.

Mental Health and Illness

General

The Regional Health Survey coordinated by the First Nations Centre at the National Aboriginal Health Organization and ten First Nations regional organizations¹⁸ (2002/03) surveyed First Nations living on-reserve and asked respondents about their emotional well-being.

- Most adults reported that they felt in balance in the four aspects of their lives most of the time: 71% felt in balance physically; 71% emotionally; 75% mentally; and 69% spiritually.
- Nearly 4 in 10 adults (38%) reported experiencing instances of racism in the previous 12 months;
- Three in 10 adults (30%) experienced a time when they felt sad, blue or depressed for two weeks or more in the previous year;
- Girls were more likely than boys to report feeling “sad, blue or depressed” for two weeks or more in a row during the previous year (44% of girls compared to 22% of boys aged 15 to 17 years).

Surveys suggest that Aboriginal people are more likely than other Canadians to seek help for mental health problems. Whereas 8% of all Canadians had consulted a mental health professional in the previous year, in some First Nations groups the proportion seeking help was as high as 17% and would probably have been even higher if more mental health professionals were available in northern and isolated areas.

(Table 12-1)

Distress, Anxiety and Depression

In Alberta, First Nations people were 2.5 times more likely than other residents to see a doctor for anxiety, and 1.4 times more likely to see one for depression in 2002.¹⁹ Other surveys paint a similar picture, showing that in 2001, 13% of First Nations adults living off-reserve were classified as “distressed” according to a standard scale, compared to 8% of other Canadians.²⁰ Results for depression were similar. While 7% of all Canadians had suffered an episode of major depression in 2001, the rate among First Nations living off-reserve was 12%.²¹ Rates among people living on-reserve may be even higher: a 1997 survey in Ontario estimated that 16% of adults in First Nations communities met the criteria for major depression—twice the Canadian average. In addition, the people affected were more likely than other Canadians to find that the depression interfered appreciably with their activities.

(Table 12-2)

According to standard scales used on Statistics Canada surveys, only 3.1% of Inuit suffered a major depressive episode in 2001—well below the national average—and only 6.4% were at high risk of depression.^{22,23} However, these findings are difficult to reconcile with the extremely high suicide rates in most of the Inuit regions and raise the possibility that scales that work well on most North Americans do not give valid results in the Inuit culture. Another possibility is that some depression, especially among men, may not be acknowledged, but manifests itself as alcohol problems, violence or conflict with the law instead.²⁴

Table 12-1 Adults Who Consulted a Professional about Their Mental/Emotional Health in the Past Year	
First Nations groups	
Nova Scotia communities (1997)	12–17%
Manitoba communities (1997)	10% (in lifetime)
First Nations people living off-reserve across Canada (2001)	13%
Inuit	
Inuit throughout Canada (2001)	9%
All Aboriginal	
Aboriginal people living off-reserve (2000–01)	14%
Canadian population as a whole (2001)	8%
<p>Note: Some of the figures above might be higher if more mental health professionals were available in northern and rural areas.</p> <p>Sources NAHO. First Nations and Inuit Regional Health Surveys, 1997: A synthesis of the national and regional reports. Available from: http://www.naho.ca/firstnations/english/first_survey1997.php. P. 48.</p> <p>Statistics Canada (2001d). Custom tabulations from the Canadian Community Health Survey, cycle 1.1. Prepared by Rene Dion, First Nations and Inuit Health Branch, Health Canada; February–March 2004.</p> <p>Statistics Canada, (2001e). Aboriginal Peoples Survey, 2001. Custom tabulations prepared for the First Nations and Inuit Health Branch of Health Canada; February 2004.</p> <p>Statistics Canada (2001c). Canadian Community Health Survey: Off-reserve Aboriginal Profile. Occasional. Cansim Table 105-0112, accessed on June 7, 2005 at: www.statcan.ca/english/freepub/82-576-XIE/free.htm</p>	

Table 12-2 Major Depression among Ontario First Nations (1997) Compared to Canada (1994)						
	Men		Women		Total	
	FN*	Can*	FN	Can	FN	Can
Major depression	13.3%	5.4%	18.4%	9.4%	15.9%	7.5%
The depression interferes with activities 'some' or 'a lot'	24.5%	13.5%	27.2%	17.7%	25.8%	15.7%
<p>*FN = First Nations; CAN = Canada</p> <p>Source: First Nations and Inuit Regional Health Surveys, 1997: A Synthesis of the National and Regional Reports. Table 5-5. Available from: http://www.naho.ca/firstnations/english/pdf/RHS_synthesis_report.pdf.</p>						

Suicide

Rates of suicide and suicidal ideation are high in some First Nations communities and even higher in some Inuit communities. In both populations, rates of completed suicide are higher among males than among females and peak among young adults aged 15–24 years. Because of the young age at which they occur, suicides in First Nations remove many potential years of life—far more than other major health problems such as heart disease or cancer.²⁵

According to the Regional Health Survey 2002/03, 3 in 10 adults (31%) reported having had suicidal thoughts and 1 in 6 (16%) had attempted suicide at some point in their lives. Women were more likely than men to have attempted suicide (18.5% versus 13.1%). Although suicide mortality was higher among boys than girls, 12–17 year-old girls were more likely than boys to report thinking about attempting suicide (39% versus 17%, respectively). Youth with a close family member who committed suicide in the previous 12 months were more likely to have thought about suicide themselves (34% versus 18% of those who did not have a family member commit suicide). Youth who had a parent who attended a residential school were more likely to have thought about suicide than those whose parents had not attended a residential school (26% versus 18%).

Among First Nations communities, suicide rates are twice the national average, and show no signs of decreasing. (Table 12-3) In 2000, the rate was 24 per 100,000 and has shown little change since 1979.²⁶ The high overall rate obscures the considerable variation between different communities and areas. Some areas have had “epidemics” of suicide; others have had few or no suicides for several years. Rates also vary by age group: The rates among First Nations youth (between 15 and 24 years of age) were from 5 times (among boys) to 7 times (among girls) higher than the Canadian population between 1989 and 1993.

Suicide rates among Inuit are even higher than among First Nations, at 6 to 11 times the Canadian average. In Nunavut, rates are so high that 27% of *all* deaths since 1999 have been suicides.²⁷ In addition, these rates are rising over time. Studies show dramatic increases in Inuit suicide across the north from Alaska to Greenland during the 1970s and 1980s, especially among young males,²⁸ and Canadian Inuit are part of this trend. Rates in Northern Quebec rose fivefold between 1982 and 1996, and unpublished data suggest further increases in recent years.²⁹ Nunavut’s suicide rate—already one of the highest in the world—continues to rise, especially among youth.³⁰ Only Inuit in the Northwest Territories seem to be exempted from this trend.

	Period	Rate per 100,000 population
First Nations throughout Canada	2000	24
All Inuit Regions	1999–2003	135
Canada Total	2001	12

Source: Data for First Nations from Health Canada; Unpublished data provided by the First Nations and Inuit Health Branch; Data for Canada from Statistics Canada; Rates for Inuit based on figures provided by the Nunavut Bureau of Statistics, Inuvialuit Regional Corporation, Nunavik Board of Health and Social Services, and Labrador Inuit Health Commission.

Problematic Use of Alcohol and Drugs

Concern in First Nations and Inuit communities about misuse of alcohol and drugs is widespread. According to surveys in selected regions, three-quarters of all residents feel that substance use is a problem in their community; about one-third state that it is a problem in their own family or household; and approximately one-quarter say that they have a personal problem with alcohol or need to cut back on their drinking.^{31,32} (Table 12-4) Hospitalization statistics from Alberta and British Columbia paint a similar picture, showing that First Nations people—especially men—are admitted to hospital for substance abuse at far higher rates than other provincial residents.^{33,34}

Despite these serious indicators, surveys typically find that lower-than-average proportions of First Nations and Inuit people drink alcohol. According to the Regional Health Survey

2002/03, about two-thirds (66%) of First Nations adults living on-reserve consumed alcohol compared to 76% of the general population. The issue seems to be, then, that those who *do* drink tend to drink heavily. One in 6 (16%) First Nations adults consumed five or more drinks on one occasion on a weekly basis; 2 in 5 youth aged 12–17 years (42%) reported drinking alcohol in the previous year, and 65% of this group had five or more drinks at a time at least once a month.

Cannabis use is also common among First Nations adults (27%). Among youth aged 12–17 years living on-reserve, one-third had used cannabis in the previous year: 48% of 15–17 year-olds and 15% of 12–14 year-olds.

About one-third of respondents (35.4%) reported that there was progress in reducing the amount of alcohol and drug abuse in their community.

Table 12-4 Indications of Problems with Alcohol in First Nations and Inuit Communities		
Feel that alcohol/drug use is a problem in the community	All Inuit (2001)	76–77%
	FN* in Quebec communities (1997)	74%
Alcohol is a problem in the household	FN in Manitoba communities (1997)	>33%
A family member has a drinking problem	Labrador Inuit (1997)	33%
Ever felt that they needed to cut back on drinking, or did cut back	Labrador Inuit, FN in Ontario and Manitoba communities (1997)	77–90%
Need to cut back on drinking at present	Labrador Inuit (1997)	27%
Say that they themselves have a drinking problem	FN in Manitoba communities (1997)	25%
Alcohol affected work or studies in past year	FN in Sask. communities (1997)	15%
Ever attended an alcohol treatment centre	Labrador Inuit	10%
*FN = First Nations Source: Data for Inuit in 2001 are from Statistics Canada 2001b. Remaining data are from NAHO 2004.		

Factors Affecting Mental Health among First Nations and Inuit People

Indicators of mental health and distress vary widely across Aboriginal communities. Some communities are vibrant and healthy while others have high levels of suffering. Several key factors influence individual, family and community mental health and well-being.

Historical Factors and Acculturation

Any consideration of the mental health of First Nations people and Inuit needs to recognize the historical backdrop to the current situation. The changes resulting from contact with Euro-Canadian culture have had a massive impact on communities, on individual and collective identity, and on overall health status. Over time, these changes have included:

- Epidemics of infectious disease;
- Systematic imposition of Christianity and vilification of traditional spirituality;
- Relocation of communities and forced sedentarization whereby formerly nomadic groups were obliged to settle in one location and confined to reserves, reducing their ability to follow and hunt migrating animals, and increasing their reliance on costly manufactured foods;
- Social and political marginalization and bureaucratic control of people's daily lives; and
- Poverty and isolation, along with gradual absorption into global cash economies.^{35,36}

The stresses of cultural suppression and marginalization affect mental health by acting at three levels: community, family, and individual.

- Communities suffer unemployment, poverty, and social disorganisation, which in turn lead to lack of social norms and alienation;
- Families and social support systems are disorganized by rapid modernization and changes in traditional childrearing practices; and
- Individuals suffer loss of self-esteem due to denigration of the culture from which they draw their language and self-definition.³⁷

Together, these stresses often play out as social problems that indicate impaired mental health in any population, whether Aboriginal or non-Aboriginal: violence, family dysfunction, abuse of alcohol or drugs, and physical or sexual abuse.³⁸ Over time, some of these problems may become self-perpetuating.

While recognizing the physiological components of mental illness, Inuit also consider social problems such as substance abuse, addiction, suicide and violence to be symptoms of losses, including culture, lifestyle and self-determination, caused by the imposition of Euro-centric systems and governance models. These "social" symptoms cannot be addressed without also addressing systemic issues (such as education and housing) and governance issues (such as implementation of land claim agreements).³⁹

Residential Schools and the “Sixties Scoop”

Some historical policies—such as the residential schools era and the “Sixties Scoop”—had major impacts on family structure and individual health. Residential schools, which operated from the 1820s through the 1950s,⁴⁰ separated children from their families for long periods.

In the current generation, 20.3% of First Nations adults 18 years of age and over living on-reserve⁴¹ and 13% of Inuit aged 15 years and over⁴² attended these schools.

First Nations survivors of residential schools are aged 40 and older. According to the Regional Health Survey, one-half of First Nations adults living on-reserve said their health and well-being had been negatively affected by the residential school experience, including isolation from family, verbal or emotional abuse, and loss of cultural identity. Over 7 in 10 attendees (71.5%) had witnessed the abuse of others. Personal abuse was reported by many: sexual abuse (32.6%); physical abuse (79.2%); and verbal or emotional abuse (79.3%).

Besides the loss of language and cultural identity and the enforced separation from family, the schools set the stage for family problems by producing generations of people with few parenting skills. Further, the physical and sexual abuse that took place in many schools is thought to have contributed to a trans-generational cycle whereby some of the abused became the abusers.

During the residential schools era, many children who might have required alternative care were housed in the schools. The gradual closing of the schools was one factor contributing to the “Sixties Scoop”, in which large proportions of First Nations children were removed from their families and placed in foster care. Another factor was the lack of parenting

abilities and skills resulting from life in residential schools. This initiative was so extensive that by the end of the 1960s, 30%–40% of the children who were wards of the state were Aboriginal, compared to only 1% in 1959.⁴³

Socio-economic Factors

Disadvantaged circumstances and poor living conditions play a significant role in the mental health of First Nations and Inuit people. Many First Nations and Inuit communities suffer from high unemployment, low income, low education levels and overcrowded housing. These factors in themselves may make mental health problems more likely.

Studies have suggested that disparities in circumstances and lifestyles explained most (but not all) of the differences in depression rates between Aboriginal and non-Aboriginal people in off reserve areas,⁴⁴ and that education and economic security were “critical determinants” of peoples’ ability to make positive changes to their habits, such as quitting smoking, cutting down on drinking, improving diet or exercising.⁴⁵

Family Violence

Violence—whether between family members or in the community at large—is a major problem in some Aboriginal communities. The National Crime Prevention Centre reports that rates of domestic violence are up to 5 times higher than average on First Nation reserves.⁴⁶ Between 1991 and 1999, rates of spousal homicide were 8–18 times higher than in the non-Aboriginal population.⁴⁷

Estimates of the proportion of Aboriginal women exposed to family violence range from a low of 25% to a high of 90% in some northern communities.⁴⁸ According to a Statistics Canada survey in 1999, almost one-half of the spousal violence experienced by Aboriginal women was

severe or life-threatening, such as being beaten, choked, threatened with a gun or sexually assaulted. And during over one-half these incidents, children were present.⁴⁹ This in itself may harm the child's mental health; and insofar as violence is a learned behaviour, it helps to perpetuate the cycle.⁵⁰

In some areas, substantial proportions of Aboriginal children may also experience violence. A survey of Aboriginal people in four large Canadian cities found that 88% had been victims of violence either as children or as adults.⁵¹ In a 1997 survey of Ontario's First Nations communities, 59% of adults reported having experienced physical abuse during childhood. In the current generation of youth, 25% reported instances in which "an adult got so mad that you thought you were going to get badly hurt, or did get hurt," and for 10% this was a repeated occurrence.⁵²

Sexual Abuse and Assault

Little information is available on rates of sexual abuse in Inuit communities. However, a 1991 survey of Inuit in Quebec found that 30% reported at least one episode of sexual abuse.⁵³ And in a country-wide survey in 2001, at least one-third of Inuit adults felt that sexual abuse was a problem in their community.⁵⁴

There is somewhat more information on sexual abuse and assault in First Nations communities. In a 1997 survey of Ontario's First Nations communities, 34% of adults reported having experienced sexual abuse during childhood. The same survey found that 14% of boys and 28% of girls in the current generation of youth 12–17 years of age reported some form of sexual abuse.

In the same vein, rates of sexual assault in First Nations communities were estimated to be at least triple the Canadian average over the

1989–1999 period, based on reports to Statistics Canada's Uniform Crime Reporting System.⁵⁵ These figures are averages across all First Nations communities, suggesting that rates in some communities must be extremely high since other communities have little to no problem with sexual abuse and assault.

Cultural Strengths and Protective Factors

Despite the documented stresses associated with Euro-Canadian culture contact, it would be an oversimplification to assume that these stresses always lead to mental health problems.

Many Aboriginal communities have protective factors against mental health problems and suicide, such as ways of living on the land⁵⁶ and strong social networks.

Many First Nations and Inuit people continue to live in extended-family households, and have extensive networks of friends and kin around them (although these networks can be a source of stress as well as support).

People living off-reserve often maintain ties with their own or other communities and return to the community at times for support and sustenance. Inuit also continue to have a strong family orientation in which people feel that they can always turn to their families if they need help.⁵⁷

Further, many people draw strength from their traditions and culture. In a series of interviews with First Nations people living in Vancouver's downtown Eastside, Van Uchelen tried to identify the dimensions of wellness—the factors that people saw as keeping them strong. The themes that emerged appeared to be strongly related to First Nations values and traditions:

- Having a sense of community;
- Identity—knowing who you are as a First Nations person;
- Traditions as a source of strength;
- Contribution—helping/giving to others;
- Spirituality;
- Living in a good way (e.g. courtesy, honesty, self-esteem); and
- Coming through hardship.⁵⁸

Finally, community characteristics—such as the level of a community’s control over its own affairs—appear to be related to mental health. Suicide is much less common in First Nations communities that have cultural facilities, that manage their own health, education and police services, and that are actively pursuing self-government and control of their traditional lands.^{59, 60}

The recent trend for communities to assert increasing control over their own affairs through, for example, healing circles, restorative justice, mediation circles and cultural teaching to prevent violence, may also be associated with better mental health.

Factors Affecting Children and Youth

A recent report from the Sal’i’shan Institute for the British Columbia Ministry of Children and Family Development, entitled “The Mental Health and Well-being of Aboriginal Children and Youth: Guidance for new Approaches and Services”,⁶¹ outlines some of the factors influencing the health and well-being of children and youth.

“The concern with serious problems (for children and youth) such as suicide, violence, and alcohol and substance abuse must expand beyond a focus on treatment and risk reduction to a broader approach that promotes individual, family and community healing.”

Promoting the mental health of Aboriginal children and youth is both a family and a community responsibility. Many families have the resources to provide a safe, loving and stimulating environment for their children to grow up in. Others are strapped with difficulties including addictions, poverty and a lack of education/training.

Some children grow up in communities with extended family networks, a sense of collective responsibility, connections to ancestors and elders, and services to assist those with problems. Others grow up in communities that are fragmented, without hope, and that lack basic health services. Communities with high problematic substance use leads to fetal alcohol syndrome and fetal alcohol effects that influences learning ability and illegal behaviour that results in time in prison.

Some of the main factors that influence the mental health of children and youth, and the development of suicide, abuse, and problematic alcohol and substance abuse are as follows:

Positive Factors

- Connections among the young and the old as the elders pass along their stories and wisdom.
- Community-based healing initiatives that nurture autonomy of will and spirit, sharing, spirituality, respect, honour, compassion and cultural pride support healing and good mental health.
- Youth pursuing higher education to expand knowledge and skills.

Negative Factors

- Residential schools have left a generation of parents who are disconnected from their roots and culture and who did not have effective role models for their own parenting. Many of the graduates of residential schools repeat the oppressive, controlling and abusive patterns they were exposed to as children in these schools.
- Multi-generational losses have disrupted the extended family network that supports the raising of children and youth. Some of these losses come from the residential school experience and others from colonization.

- In some communities, collective responsibility for children and youth has been replaced by an individualistic perspective. Collectivism is defined by cooperation, emotional attachment to others, concern with other's opinions and attention to family and relatives. Individualism is defined by independence, autonomy, emotional detachment from others and competition.
- Social racism and oppression contribute to lateral violence and a sense of hopelessness and isolation.
- Too many young people believe that the only place they can live is on-reserve. This doesn't encourage them to pursue further education which opens other doors.
- Inadequate culturally appropriate services and lack of recognition of the need for change among agencies providing services.
- Lack of adequate housing.
- Economic development that gives families stability and youth opportunity.

Many families and communities are raising strong, healthy children and youth. There are many opportunities to expand this circle for more children and youth by focusing on community-level interventions, promoting leadership and training, providing mentoring and support, fostering links within and between communities, and supporting ongoing capacity building.

Prevention and Treatment of Mental Illnesses in Aboriginal Populations

Culturally-adapted Approaches to Mental Health Problems

As described in the preceding sections, Aboriginal mental health has some distinct features. First, Aboriginal people are likely to have a more holistic view of mental wellness as a state of “balance” with family, community and the larger environment. Second, many of the mental health problems afflicting Aboriginal communities today are believed to be the result of forced acculturation policies, both historical and ongoing.

As a result, the prevention and treatment programs developed by Aboriginal groups similarly tend to focus on social causes and to adopt culturally-grounded approaches^{62,63} and the orientation to individual therapy is weaker than in “western” approaches.

“Culture and spirituality may be more effective as a framework for treatment than conventional approaches... family and community are central to individual ability to reclaim a rightful place of balance and harmony.”⁶⁴

Approaches developed by Aboriginal communities also tend to emphasize research that identifies the strengths of families and communities and programs that build on these strengths. This is seen as the most effective

approach and an antidote to the damage done by much of the existing “deficiency-oriented” research that emphasizes the problems of First Nations and Inuit communities but does not describe their strengths.

“You can’t do it for us, you can only do it with us”⁶⁵

First Nations and Inuit communities are determined to come up with their own solutions, rather than continue to have Euro-Canadian models imposed on them without their input and consent. Communities want to be in control of the process and decide what is best for their own residents, although outside help may be welcome and many communities employ a mix of “traditional” and “western” therapies. This assertion of community control may, in itself, be beneficial in terms of its effects on mental health.

“Community development and local control of health services are needed, not only to make services responsive to local needs but also to promote the sense of individual and collective efficacy and pride that contribute to positive mental health. Ultimately, political efforts to restore Aboriginal rights, settle land claims, and redistribute power through various forms of self-government hold the keys to healthy communities.”⁶⁶

Example: Promoting Good Mental Health in Labrador

What might a community-run program look like? One example is the program run by the Department of Health and Social Development, Nunatsiavut Government, (formerly the Labrador Inuit Health Commission that provides services to seven communities in Labrador (of which five are coastal communities accessible only by plane, boat or snowmobile). In 1996, the Commission signed a formal “transfer” agreement with the federal government; prior to this, community health services were delivered under more restrictive annual funding agreements with Health Canada. The Department operates with a holistic Community Health Plan that has seven core areas, three of which play a direct role in promoting mental wellness: Mental Health, Addictions and Child Development.

The Mental Health program employs counsellors, psychologists and mental health workers at both community and regional levels, and offers:

- Counselling and support;
- Support groups;
- Crisis response;
- Public awareness;
- Cultural events and family activities; and
- Youth programming.

Specific activities include an after-school program for children aged 6–12 years, a structured Youth Program, counselling and suicide-prevention programs (including the White Stone Prevention Program developed by the RCMP). The Commission also runs a Residential Schools Healing Project.

The Addictions program addresses alcohol, drugs, solvents, tobacco and problem gambling. It offers a mix of “western” and culture-based approaches, including:

- Public-awareness activities like school visits and workshops;
- Counselling and referral for treatment;
- A five-week residential therapy program at Saputjivik Treatment Centre in North West River; and
- Land-based treatment for families, to help people relearn or enhance traditional ways of living.

The Child Care program offers after-school activities in all communities, and maintains child care centres in five of them. It also runs Child Development Preschool Play Groups and Parent and Tot Groups in all communities, with the intent of promoting the development of healthy families and children.

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Examples: Collaborative Mental Health Care

The following are brief descriptions of First Nations collaborative mental health care initiatives in Canada

Dilico Ojibway First Nations

Mental health services are provided to thirteen First Nations by family physicians, nurse practitioners and mental health clinicians. Psychologists and psychiatrists are also available for consultation. Telepsychiatry services are provided with specialists from the Hospital for Sick Children (Toronto) and local hospitals. Assessments are adapted to employ First Nations perspectives.

Muskiki Mental Health Program

The Muskiki Mental Health Program provides services to 5,000 First Nations people on reserve. Counselling and other services incorporate Medicine Wheel teachings. A traditional co-ordinator-medicine healer visits three times per year.

Waadziwin (Health Is in Our Hands) Health Access Centre, Mental Health Program, Fort Frances, Ontario

The centre serves local First Nations, fly-in services, off reserve and Métis. Services are provided by an interdisciplinary team, including family physicians, nurse practitioners, mental health workers, FAS/FAE co-ordinator, traditional healer, etc. A psychologist and psychiatrist are available on a consultation basis.

Source: Canadian Collaborative Mental Health Initiative. Establishing collaborative initiatives between mental health and primary care services for Aboriginal peoples. 2006. Available at: <http://www.ccmhi.ca/en/products/toolkits/providers.htm>

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GLOSSARY

Agoraphobia

For the purpose of CCHS 1.2 – Mental Health and Well-being, Agoraphobia is a fear and avoidance of being in places or situations from which escape might be difficult or in which help may not be available. Feared situations include being outside the home alone, being in a crowd or standing in a line, being on a bridge, and travelling in a bus, train or automobile. Situations may be endured with distress that can include dizziness, sweating, chest pain, nausea, feelings of helplessness or detachment, or feeling that the body or environment is unreal. Agoraphobia may occur alone or be accompanied by panic disorder.¹

Alcohol Dependence

Alcohol dependence is defined as tolerance, withdrawal, or loss of control or social or physical problems related to alcohol use.

Alcohol dependence for the purposes of this report was measured by the questionnaire using the Alcohol Dependence Scale (Short Form Score), which is based on a subset of items from the Composite International Diagnostic Interview (CIDI) developed by Kessler and Mroczek (University of Michigan). The CIDI is a structured diagnostic instrument that provides diagnostic estimates according to criteria of the DSM-III-R classification for psychoactive substance user disorder.^{1,2}

Diagnostic and Statistical Manual of Mental Disorders (DSM)

DSM is an internationally recognized classification of mental disorders with several versions. Mental conditions or problems found in the CCHS 1.2 are partially coded either to DSM-IV or DSM-III-R.

Disability-Adjusted Life Year (DALY)

DALYs are the sum of years of life lost (YLL) to the disease and years of life lived with disability (YLD).³ DALY is a health gap measure developed for the WHO Global Burden of Disease to estimate the burden of a disease on a defined population. DALYs are measured in terms of mortality and morbidity. Morbidity is weighted to reflect the severity of the condition.

Eating Attitudes Test Index Score

A measure of the extent of the symptoms and concerns characteristic of eating disorders. In the CCHS Mental Health and Well-being Survey, 2002, Cycle 1.2, 2 screening questions were used to assess past 12 months and lifetime concerns with eating attitudes and behaviours. Those with positive responses to these screening questions were asked all of the questions in the Eating Attitudes Test (EAT-26). Higher scores indicate a higher level of eating disorder. EAT-26 is a widely used standardized measure of the extent of symptoms and concerns characteristic of eating disorders developed by Dr. David M. Garner.⁴ It does not yield a specific diagnosis.¹

Highest Level of Education – Respondent, 4 Levels

- Less than secondary school graduation
- Secondary school graduation, no post-secondary education
- Some post-secondary education
- Post-secondary degree/diploma¹

Illicit Drug Dependence – 12 Months

Respondents to the CCHS Mental Health and Well-being Survey, 2002, Cycle 1.2 met the criteria for illicit drug dependence if they reported a maladaptive pattern of drug use, leading to clinically significant impairment or distress, as manifested by three or more of the following six symptoms, all exhibited within the same 12-month period:

1. Tolerance, as defined by a need for markedly increased amounts of the drug to achieve intoxication or desired effect or by markedly diminished effect with continued use of the same amount of drug;
2. Withdrawal, as manifested by withdrawal syndrome or by taking the same (or a closely related) substance to relieve or avoid withdrawal symptoms;
3. The drug is often taken in larger amounts or over a longer period than was intended or drugs are used even though respondents promised not to;
4. A great deal of time is spent in activities necessary to obtain the drug (e.g. visiting multiple doctors or driving long distances), using the drug or recovering from its effects;
5. Important social, occupational or recreational activities are given up because of drug use;
6. The drug use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the drug.

Income Adequacy

This variable classifies the total household income into 5 categories based on total household income and the number of people living in the household.¹

Lowest Income	< \$10,000 if 1 to 4 people < \$15,000 if 5+ people
Lower Middle Income	\$10,000 to \$14,999 if 1 or 2 \$10,000 to \$19,999 if 3 or 4 \$15,000 to \$29,999 if 5+
Middle Income	\$15,000 to \$29,999 if 1 or 2 \$20,000 to \$39,999 if 3 or 4 \$30,000 to \$59,999 if 5+
Upper Middle Income	\$30,000 to \$59,999 if 1 or 2 \$40,000 to \$79,999 if 3 or 4 \$60,000 to \$79,999 if 5+
Highest Income	≥ \$60,000 if 1 or 2 ≥ \$80,000 if 3+

Level of Interference

Respondents to the CCHS Mental Health and Well-being Survey, 2002, Cycle 1.2 indicated on a scale of 0–10 how much they felt that their illness interfered with their home responsibilities, responsibilities at school or work, their ability to form and maintain close relationships, or their social life.¹

Major Depressive Episode – Lifetime

Respondents to the CCHS Mental Health and Well-being Survey, 2002, Cycle 1.2 met the CCHS 1.2/WMH-CIDI criteria for lifetime major depressive episode if they reported:

1. Two weeks or longer of depressed mood or loss of interest or pleasure and at least five symptoms associated with depression which represent a change in functioning;
2. That symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning; and
3. That symptoms are not better accounted for by bereavement, or symptoms last more than two months, or the symptoms are characterised by a marked functional impairment, preoccupation with worthlessness, suicidal ideation or psychomotor retardation.¹

Major Depressive Episode – Past 12 Months

Respondents to the CCHS Mental Health and Well-being Survey, 2002, Cycle 1.2 met the CCHS 1.2/WMH-CIDI criteria for major depressive episode in the 12 months prior to the interview if they reported:

1. Meeting the criteria for lifetime major depressive episode;
2. Having a depressive episode in the 12 months prior to the interview; and
3. Clinically significant distress or impairment in social, occupational or other important areas of functioning.¹

Mania – Lifetime

Respondents to the CCHS Mental Health and Well-being Survey, 2002, Cycle 1.2 met the lifetime CCHS 1.2/WMH-CIDI criteria for Mania if they reported:

1. A distinct period of abnormally and persistently elevated, expansive or irritable mood lasting at least one week;
2. Three or more of seven symptoms (or four or more if mood is only irritable) were present during the mood disturbance. Symptoms are inflated self-esteem or grandiosity; decreased need for sleep, more talkative than usual; flight of ideas or racing thoughts; distractibility; increase in goal-oriented activity or psychomotor agitation; and excessive involvement in pleasurable activities with high potential for painful consequences;
3. Marked impairment in normal daily activities, occupational functioning or usual social activities or relationships with others; or mood disturbance includes psychotic features; or mood disturbance severe enough to require hospitalization.¹

Mania – Past 12 Months

Respondents to the CCHS Mental Health and Well-being Survey, 2002, Cycle 1.2 met the CCHS 1.2/WMH-CIDI criteria for mania in the 12 months prior to the interview if they reported:

1. Meeting the criteria for lifetime manic episode;
2. Having had a manic episode in the 12 months prior to the interview; and

3. Clinically significant distress or impairment in social, occupational or other important areas of functioning.¹

Panic Disorder – Lifetime

This variable identifies whether the respondent meets the diagnostic criteria for lifetime Panic Disorder. The criteria are met if the respondent reported:

The CCHS 1.2/WMH-CIDI criteria for lifetime Panic Disorder were met if the respondent to the CCHS Mental Health and Well-being Survey, 2002, Cycle 1.2 reported:

1. 4 or more recurrent unexpected panic attacks; and
2. At least one of the attacks have been followed by one month or more of worry about having additional attacks, worry about the consequences of the attacks or changes in behaviour related to the attacks.¹

Panic Disorder – Past 12 Months

Respondents to the CCHS Mental Health and Well-being Survey, 2002, Cycle 1.2 met the CCHS 1.2/WMH-CIDI criteria for panic disorder in the 12 months prior to interview if they reported:

1. Meeting the criteria for lifetime panic disorder;
2. Having had a panic attack in the 12 months prior to interview; and
3. Significant emotional distress during a panic attack in the 12 months prior to interview.¹

Physical Activity Index

Statistics Canada calculates energy expenditures from responses to a series of questions on activities and uses these values to categorize individuals as follows.

Active	Those who averaged 3.0+ kcal/kg/day of energy expenditure. This is approximately the amount of exercise that is required for cardiovascular health benefit.
Moderate	Those who averaged 1.5–2.9 kcal/kg/day. They might experience some health benefits but probably little cardiovascular benefit.
Inactive	Those with an energy expenditure < 1.5 kcal/kg/day

These categories have been used for various national surveys beginning with the 1981 Canada Fitness Survey.⁵ The active category definition originated from a 1985 review which identified the optimal exercise dose for cardiovascular health benefit as 2–4 kcal/kg/day (an average of 3 kcal/kg/day).^{1,6}

Social Phobia – Lifetime

Respondents to the CCHS Mental Health and Well-being Survey, 2002, Cycle 1.2 met the CCHS 1.2/WMH-CIDI criteria for lifetime Social Phobia if they reported:

1. A marked and persistent fear of one or more social or performance situations in which they were exposed to unfamiliar people or to possible scrutiny by others and fear of acting in a way (or show anxiety symptoms) that would be humiliating or embarrassing;
2. That exposure to the feared social situation(s) almost invariably provoked anxiety;
3. That they recognized that their fear was excessive or unreasonable;
4. That the feared social or performance situation(s) were avoided or that the feared social or performance situation(s) were endured with intense anxiety or distress;

5. Significant interference with their normal routine, occupational or academic functioning, or social activities or relationships; and
6. That they were 18 of age or older the last time they strongly feared or avoided a social or performance situation or that they strongly feared or avoided a social or performance situation for longer than six months.¹

Social Phobia – Past 12 Months

Respondents to the CCHS Mental Health and Well-being Survey, 2002, Cycle 1.2 met the CCHS 1.2/WMH-CIDI criteria for social phobia in the 12 months prior to the interview if they reported:

1. Meeting the criteria for lifetime social phobia;
2. Fearing or avoiding social or performance situation(s) in the 12 months prior to the interview; and
3. Clinically significant distress or impairment in social, occupational or other important areas of functioning.¹

Social Support

The Medical Outcomes Study Social Support Survey⁷ provides indicators of four categories of Social Support. 19 functional support items cover five dimensions:

- Emotional support – the expression of positive affect, empathetic understanding and the encouragement of expressions of feelings.
- Informational support – the offering of advice, information, guidance or feedback.
- Tangible support – the provision of material aid or behavioural assistance.
- Positive social interaction – the availability of other persons to do fun things with you.
- Affection – involving expressions of love and affection

Empirical analysis indicated that emotional and informational support items should be scored together.¹

WMH-CIDI (World Mental Health version of the Composite International Diagnostic Interview)

The WMH-CIDI instrument, as part of the WMH2000 Project (World Mental Health 2000) is a World Health Organization worldwide initiative to assess the prevalence rates of various mental disorders in multiple countries. This was modified for the needs of CCHS 1.2. The WMH-CIDI is a standardized instrument for assessment of mental disorders and conditions according to an operationalization of the definitions and criteria of DSM-IV and ICD-10.¹

Years Lived with Disability (YLD)

Component of the DALY that measures the years of healthy life lost through living in states of less than full health.³

Endnotes

- ¹ Statistics Canada. Canadian Community Health Survey. Cycle 1.2. Derived Variable Specifications.
- ² Kessler RC, Andrews G, Mroczek D, Ustun B, Wittchen H-U. The World Health Organization Composite International Diagnostic Interview Short-Form (CIDI-SF). *Int J Methods Psychiatr Research*. 1998;7:172-85.
- ³ <http://www.phac-aspc.gc.ca/phi-isp/glossary.html>
- ⁴ Garner DM, Olmsted MP, Bohr Y, Garfinkel PE. The Eating Attitudes Test: psychometric features and clinical correlates. *Psychological Medicine*. 1982;12:871-8.
- ⁵ Stephens T, Craig CL, Ferris BF. Adult physical activity in Canada: Findings from The Canada Fitness Survey I. *Can J Public Health*. 1986;77:285-90.
- ⁶ Haskell WL, Montoye HJ, Orentstein D. Physical activity and exercise to achieve health-related components of physical fitness. *Public Health Reports*. 1985;100:202-12.
- ⁷ Sherbourne CD, Stewart AL. The MOS Social Support Survey. *Soc Sci Med*. 1991;12(6):705-14.

RESOURCES

The following organizations provide information on Mental Health and Mental Illness:

Alzheimer Society of Canada	www.alzheimer.ca
Ami Québec: Alliance for the Mentally Ill Inc.	www.amiquebec.org
Anxiety Disorders Association of Canada	www.anxietycanada.ca
Canadian Academy of Child and Adolescent Psychiatry	www.canacad.org
Canadian Alliance on Mental Illness and Mental Health	www.camimh.ca
Canadian Association for Suicide Prevention	www.suicideprevention.ca
Canadian Association of Occupational Therapists	www.caot.ca
Canadian Association of Social Workers	www.casw-acts.ca
Canadian Centre on Substance Abuse	www.ccsa.ca
Canadian Coalition for Seniors' Mental Health	www.ccsmh.ca
Canadian Collaborative Mental Health Initiative	www.ccmhi.ca
CCMHI Toolkits:	www.ccmhi.ca/en/products/toolkits.html
Canadian Council of Professional Psychology Programs	www.ccppp.ca
Canadian Health Network	www.canadian-health-network.ca/1mental_health.html
Canadian Institute for Health Information	www.cihi.ca
Canadian Institutes of Health Research – Institute of Neurosciences, Mental Health and Addiction	www.cihr-irsc.gc.ca/e/8602.html
Canadian Medical Association	www.cma.ca
Canadian Mental Health Association	www.cmha.ca
Canadian Partnership for Responsible Gambling	www.cprg.ca
Canadian Psychiatric Association	www.cpa-apc.org

Canadian Psychiatric Research Foundation	www.cprf.ca
Canadian Psychological Association	www.cpa.ca
Canadian Register of Health Service Providers in Psychology	www.crhsp.ca
Centers for Disease Control and Prevention (United States)	www.cdc.gov
Centre for Addiction and Mental Health	www.camh.net
Centre for Suicide Prevention	www.suicideinfo.ca
The College of Family Physicians of Canada	www.cfpc.ca
Health Canada	www.hc-sc.gc.ca
Mental Health Canada	www.mentalhealthcanada.com
Mental Health at Work	cgsst.fsa.ulaval.ca/sante/eng/default.asp
Mental Health Works	www.mentalhealthworks.ca
Mind Your Mind	www.mindyourmind.ca
Mood Disorders Society of Canada	www.mooddisorderscanada.ca
National Eating Disorder Information Centre	www.nedic.ca
National Network for Mental Health	www.nnmh.ca
Psychosocial Rehabilitation Canada	www.psrrpscanada.ca
Public Health Agency of Canada – Mental Health	www.phac-aspc.gc.ca/mh-sm/mentalhealth
Registered Psychiatric Nurses Association of Canada	www.psychiatricnurse.ca [site of Manitoba nurses]
Responsible Gambling Council	www.responsiblegambling.org
Schizophrenia Society of Canada	www.schizophrenia.ca
Statistics Canada	www.statscan.ca