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**An Environmental Scan of Mental Health and
Mental Illness in Atlantic Canada**

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**An Environmental Scan of Mental Health and Mental Illness
in Atlantic Canada**

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Atlantic Regional Office

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The opinions expressed in this publication are those of the author and do not necessarily reflect the views of the Public Health Agency of Canada.

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EXECUTIVE SUMMARY

Much of the recent public and political discourse focused on mental health and mental illness has been informed by the work of the Standing Senate Committee on Social Affairs, Science and Technology which last spring released *Out of the Shadows at Last*.¹

The Senate Committee process provided an opportunity to bring together a number of perspectives, interpretations, and voices on mental health and mental illness within a national context. The document it produced, also known as the Kirby Report, highlighted the need to develop a sustained and coordinated approach to the mental health system in Canada as well as action on underlying issues such as stigma, lack of cohesion, and comprehensiveness.

The report emphasized the importance of building a mental health system based on a wellness, recovery-centred model. It recommended that the principal values guiding the model be choice, community, and integration. Underpinning this approach is the acceptance that social determinants of health play a significant role in understanding mental health and mental illness and in supporting recovery.

As part of its own ongoing work in this area, the Atlantic Regional Office of the Public Health Agency of Canada commissioned this report to provide direction for integrating the Agency's future work related to mental health and social and economic inclusion.

Key components of the research process was a survey of the available literature reflecting regional, provincial, national, and international perspectives; an epidemiological review and analysis; and key informant interviews and analysis.

KEY FINDINGS FROM THE LITERATURE REVIEW

In the Atlantic region, researchers have identified key mental health issues and at-risk populations. The issues include workplace stress, stress arising from food insecurity and poverty, social isolation and exclusion, depression, violence, and poor environmental conditions such as housing and geographic isolation. The populations most at risk for poor mental health status are Aboriginal peoples, youth, elderly, and caregivers.

Researchers have concluded that structural barriers and service deficits in the Atlantic region have contributed to the decline in social supports that enable good mental health. Our literature review identified specific concerns with poverty, unemployment, out-migration, and isolation as factors in understanding mental health and mental illness issues in the region. Specific stressors include working conditions and workplace pressures, food insecurity, poverty, violence, social isolation and exclusion, cultural insensitivity and racism, and poor quality housing.

¹ Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, Ottawa, 2006.

Depression, anxiety, and post-traumatic stress disorder emerged as specific mental health conditions affecting Atlantic Canadians. Specific populations in need of targeted services and intervention include Aboriginal peoples, children, youth, seniors, caregivers, immigrants, women, people with low levels of education, individuals in the Armed Forces (both active and reservists), and those living in rural areas. Suicide intervention is a priority for New Brunswick and for Labrador.

The literature review also identified continuing inequities in accessing services, the absence of integration and coordination in service delivery, and inadequate community supports.

Finally, the literature review identified some emerging issues:

- 1) There is an absence of planning for individuals living with mental illness with respect to their needs as seniors with identified mental illnesses.
- 2) The disproportionate number of Atlantic Canadians in the Armed Forces means an associated risk for post-traumatic stress disorder is likely as a result of recent deployment in Afghanistan.
- 3) The increase in individuals presenting with concurrent disorders for mental illness and addictions and the greater complexity of cases pose significant challenges.

KEY FINDINGS FROM THE EPIDEMIOLOGICAL REVIEW

According to an analysis² of the data collected from the Canadian Community Health Survey - Mental Health and Well-being, there are no appreciable differences at this time between rates of mental health disorders in Atlantic Canada compared to Canada as a whole. Previous researchers have identified the absence of a cohesive health experience in Atlantic Canada.³ There are some trends in Atlantic Canada linked between physical and mental health as well as the influence of factors such as employment, education, culture, gender, and geography.

KEY FINDINGS FROM THE KEY INFORMANTS

The 39 key informants from the four Atlantic provinces presented a wide range of issues, some specific to their province, and others applicable to the whole region. The most frequently cited issue was the impact of the aging population in Atlantic Canada. For example, both Newfoundland and Labrador and Nova Scotia reported more deaths than births in 2006. Other key issues included:

² A. Lesage, H.M. Vasiliadis, M.A. Gagné, S. Dudgeon, N. Kasman, and C. Hay, *Prevalence of Mental Illnesses and Related Service Utilization in Canada: An analysis of the Canadian Community Health Survey*, Canadian Collaborative Mental Health Initiative, Mississauga, 2006. Available at www.ccmhi.ca/en/products/documents/09Prevalence_EN.pdf

³ Karen Hayward and Ronald Colman, *The Tides of Change: Addressing Inequity and Chronic Disease in Atlantic Canada. A Discussion Paper*, prepared for the Population and Public Health Branch, Atlantic Regional Office, Health Canada, Halifax, 2003. Available at www.phac-aspc.gc.ca/canada/regions/atlantic/pdf/Tides_Inequity_and_Chronic_Disease.pdf

- dealing with stigma;
- responding to individuals with concurrent disorders;
- recognizing increasing rates of stress, burnout, anxiety, and depression in the population, often linked with work life issues, but also including resettlement stress;
- anticipating the impact on individuals of deployments in Afghanistan and the risk for increased rates of post-traumatic stress disorder, substance use, and depression;
- dealing with more patients with multiple problems and presenting more complex conditions that are also linked with poverty, lack of affordable housing, social problems, and physical and mental health problems;
- limited resources and increasing demands for other services such as breast cancer screening and care, wait times for hospital and physical procedures, catastrophic drug coverage, and autism interventions;
- developing alternate methods and approaches of delivering services through tele-psychiatry, primary health care, and community services;
- increasing medicalization of issues and the loss of coping skills;
- changing nature of drug use, from street drugs (e.g., moving from marijuana to crystal methamphetamine) to the misuse and abuse of prescription medications such as OxyContin and Percocet;
- challenge of recruiting and maintaining a critical mass of educated mental health service staff;
- establishing competencies and standards of care.

Key informants also described the gaps in mental health as funding, access, and knowledge. Most key informants said more money is needed for the delivery of community-based services, provision of home support, increased income support especially for youth, drug coverage, and infrastructure (housing, staff, training, professional development, and policy development).

Access issues included addressing needs in rural and remote areas, developing alternate forms of service such as telecounselling and tele-psychiatry, and removing the barriers posed by services and materials that do not reflect the diverse linguistic, cultural, and immigrant communities in Atlantic Canada.

Knowledge issues focused on information and understanding. Key informants said there were gaps in knowledge concerning African Canadian women's health, immigrants and mental health, evidence-based decision-making, seniors' mental health and mental illness, treatment for youth, and the development of competencies and standards in mental health services.

Issues related to gaps in understanding focused on stigma and rights-based approaches, integration of philosophical approaches between addictions and mental health, and applying a gendered analysis to mental health and mental illness.

The most consistent opportunity identified was collaboration, with participants suggesting the dismantling of the “silo mentality” that separates mental health and addictions services and encouraging increased information sharing between these and other health programs and social services.

Many informants said increasing coordination was essential, as a means to share information and become more effective in service delivery such as reducing wait times. Non-profit agencies in the mental health sector are also developing collaborative networks.

Other identified opportunities included recognition of the use of population health approaches in health service planning and delivery, the development of provincial mental health and addiction strategies, the publicity the Kirby Report gave to mental health and mental illness in Canada and its place on the national agenda, and the focus on supporting immigration to Atlantic Canada.

The key informants also generally identified priorities in the broad terms of delivery, access, and knowledge.

Issues related to delivery included supporting mental health service providers, establishing competency-based standards for mental health care, developing different models of service provision, developing forensic services, dealing with concurrent disorders, and making the links between mental health and addictions stronger.

Access issues included improving community access to mental health, decreasing inequities in access and attention to mental health issues, focusing on early intervention and promotion of good mental health, offering better service for rural populations that are presently neglected, building coalitions locally and provincially to advocate to government, partnering within systems, sharing the voice of the people worked with, and increasing access to specialized services.

Knowledge issues included building expertise; identifying best practices; sharing available knowledge, expertise, and best practices for mental health; addressing capacity issues for research; communicating effectively about mental health and mental health promotion; and focusing on young people, seniors, immigrants, African Canadians, and Aboriginal peoples.

FUTURE ACTIONS

The mental health issues as captured in this scan are diverse and reflect the concerns and perspectives of the four Atlantic provinces. While there are some issues, such as suicide in Aboriginal communities and disengagement and anger in African Canadian communities, that are specific to geography or constituency, there are also issues that are broader in scope.

Out-migration coupled with low birth rates and rapidly aging populations have been long-standing issues of interest and concern to policy makers. However, there are three other

significant areas to consider for the future with respect to mental health and mental illness. These are:

- the long-term impact of returning Armed Forces personnel to the region,
- the diminishing human resource capacity among mental health service providers, and
- the expanding immigrant base and the diversity of needs and issues brought by this population.

While delivery of health services is the responsibility of each province depending on their needs and their resources, respondents were clear that more collaboration and joint support is necessary, and even essential, to addressing effectively the mental health needs of Atlantic Canadians. Many highlighted the benefits of working together to build creative responses with limited resources.

Although the scan represents a snapshot of mental health in Atlantic Canada today, it supports and extends the knowledge and analysis of previous work and identifies some areas for further action. The evidence collected through the literature supports the priorities identified by the key informants and the epidemiology review. The recommendations reflect the mandate of the Public Health Agency of Canada and its Atlantic Regional Office in building capacity, developing knowledge, and facilitating collaboration. We recommend that the Atlantic Regional Office of the Public Health Agency of Canada implement the following:

- 1) Support research and/or project development focused on innovative models of community-based mental health care service delivery that reflect the principles of population health, best practices, and evidence-based decision-making.
- 2) Support the development of gender-sensitive and culturally and linguistically appropriate mental health promotion materials including French language work.
- 3) Review existing and/or emerging mental health promotion, prevention, and recovery programs to address sensitivity and responsiveness to the concerns and perspectives of young people, seniors, immigrants, African Canadians, Aboriginal peoples, and women.
- 4) Facilitate the building of information/knowledge transfer networks re: new and existing best practices and evidence-based models of mental health services in the Atlantic region.

Throughout the research process, we have found that Atlantic Canadians feel passionate about the issues of mental health and mental illness. Whether they are policy makers, service providers, families, or consumers, the people in this region believe that more needs to be done to help those affected by mental health and mental illness given how these issues impact upon individuals, families, and communities. Despite limited resources, challenging economic environments, and increasingly diverse experiences and needs, there is also hope, creativity, and commitment. The challenges for the future in the region will be to balance priorities,

respect differences, and manage competing agendas so that good mental health is achievable for all Atlantic Canadians.

1. INTRODUCTION

In the past 10 years, there has been significant research, analysis, and effort focused on mental health and mental illness. Some of the actions include enacting new legislation, developing mental health frameworks for policy development, and restructuring health services to bring mental health and addictions programs and personnel together.

As part of its own ongoing work in this area, the Atlantic Regional Office of the Public Health Agency of Canada commissioned this report to provide direction for integrating the Agency's future work related to mental health and social and economic inclusion. The purpose of the scan is to:

1. determine the status of mental health in each of the four Atlantic provinces, including reliable estimates of prevalence, geographic distribution, and the characteristics of the population affected;
2. using a population health approach, analyse the relationship between social and economic inequities and the incidents of mental illness in the region;
3. identify gaps in policy, research, and collaborative mechanisms of program work and recommend possible priorities for the Atlantic Regional Office of the Public Health Agency of Canada as well as for other stakeholders;
4. make recommendations on how stakeholders can work regionally on addressing gaps in research, policy, and programming.

Ultimately, the scan is to assist the Atlantic Regional Office of the Public Health Agency of Canada to develop effective prevention strategies that are grounded in a deep understanding of the pathways between inequity and mental health and mental illness, as well as the role of the community in addressing mental health and mental illness.

1.1 DEFINITIONS

In identifying the priorities⁴ for the scan, the staff of the Agency's Atlantic Regional Office has used the following definitions to guide the research:

Mental health has been defined as *“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.”*⁵ Mental health is viewed as more than the mere absence of mental illness. Mental health is sustained and strengthened by a

⁴ *Request for Proposals: Mental Health and Mental Illness in Atlantic Canada*, Atlantic Regional Office, Public Health Agency of Canada, October 2006.

⁵ *Proceedings from the International Workshop on Mental Health Promotion*, Centre for Health Promotion, University of Toronto, Toronto, 1997.

wide range of factors and influences, from personal health practices to supportive social networks and access to the necessities of life. Access to social and economic supports is key to good mental health.

Mental illnesses take many forms; are usually associated with changes in thinking, mood, and/or behaviour; and are usually accompanied by distress and impaired functioning. Mental illnesses include mood disorders, anxiety disorders, schizophrenia, personality disorders, eating disorders, and addictions such as alcohol abuse, other substance abuse, or gambling. Chronic stress, especially that associated with the workplace, has also been identified as a serious concern.

1.2 REPORT STRUCTURE

This paper features four components:

- 1) an overview of key issues in the policy debates and research analysis focusing on mental health in the last five to ten years;
- 2) an epidemiological analysis to identify key factors and influences on the mental and physical health of people living in Atlantic Canada using the determinants of health model;
- 3) trends and insights gathered from key informants working in a variety of sectors and reflecting multiple perspectives including community, family advocacy, and consumer issues;
- 4) recommendations.

An annotated bibliography is also attached as Appendix II, highlighting key works on mental health and mental illness.

2. METHODOLOGY

2.1 PHILOSOPHICAL APPROACH

The Atlantic Regional Office of the Public Health Agency of Canada contracted with Martha Muzychka, social policy researcher and consultant based in St. John's, Newfoundland and Labrador, to carry out the scan as specified in its Request for Proposals. The consultant based her methodological approach on several key principles:

- 1) The Atlantic region of Canada has several unique characteristics that offer both challenges and benefits when included in the development of an appropriate research methodology:
 - a. The bilingual nature of Atlantic Canada requires consideration of the unique needs of each of the official language communities.
 - b. Atlantic Canada is a region with a large rural population, where access to basic health services may pose unique challenges not faced by urban dwellers.
 - c. The region faces challenges in its economic environment; many rural and coastal communities are experiencing tremendous changes with out-migration, job loss, and economic uncertainty.
- 2) The research must reflect the needs of other vulnerable populations and be represented in the research process including data collection, interviews, and analysis. The consultant is to apply a gender lens to the interpretation of data and is to seek key informants to describe the issues and concerns of Aboriginal groups (such as Innu, Inuit, Métis, and Mi'kmaq), children and youth, immigrants, and seniors, as mental illness crosses gender, ethnicity, age, and social status.
- 3) The research must reflect population health principles – health determinants, evidence and best practices, and epidemiology. The population health approach incorporates an analysis of the determinants of health. These are economic status, education, employment and working conditions, social networks and social environments, physical environment, healthy child development, personal health practices and coping skills, biology and genetics, and health services.
- 4) The research process must reflect a collaborative, inclusive approach, especially when geared to identifying and recommending actions for implementation at the community level. This collaboration is part of the development process in preparing outlines and action plans for the research, soliciting feedback and incorporating changes into materials, and sharing and discussing conclusions.

2.2 PROJECT MANAGEMENT

Staff at the Atlantic Regional Office of the Public Health Agency of Canada supervised the research with the assistance of an eight-member Advisory Committee consisting of representatives from community-based non-profit agencies, health service providers, and government personnel. A complete list of the Advisory Committee members is provided in the Acknowledgements.

2.3 RESEARCH TOOLS

The consultant used three tools to collect data: a survey of the available literature reflecting regional, provincial, national, and international perspectives; an epidemiological review and analysis; and key informant interviews and analysis. Using these methods offered the researcher an opportunity to triangulate the data and to avoid weaknesses resulting from relying on a single theoretical approach or perspective.

The data collection methods are qualitative, and the consultant used the research principles outlined earlier to guide the selection of materials, surveys, and key informants. Nonetheless, it is important to recognize that this is a descriptive report and as such is limited to the data and individuals available to the researcher within the time frame allocated for the research by the terms of the contract.

2.3.1 Literature review

The consultant recognizes that a great deal of research has been produced in the past 10 to 15 years by a variety of constituents, ranging from academic to community; however, given the volume available, the consultant elected to use references and program materials produced since 2000.

The consultant collected more than 50 references related to mental health and mental illness. References were identified by reviewing current research reports, polling Advisory Committee members for local and provincial materials, and carrying out keyword searches with Internet databases. (Key words included mental health, mental illness, depression, anxiety, mood disorders, statistics, rates, incidence, women, children, youth, seniors, Francophone, Aboriginal peoples, African Canadians, immigrant, Atlantic Canada, Newfoundland, Labrador, Prince Edward Island, Nova Scotia, New Brunswick, and Canada. The consultant also searched by author name once appropriate references were found as a means to seek additional documentation.)

The literature review offered an opportunity to create a context for the key themes that guided the analysis of the epidemiological data and the content generated from the key informant interviews.

As part of the research contract, the consultant also prepared an annotated bibliography focusing almost exclusively on Atlantic Canadian references. This is contained in Appendix II.

2.3.2 Epidemiological review

The consultant identified appropriate sources of data focusing on mental health and mental illness in Canada. Primary sources of data included:

Statistics Canada, *Canadian Community Health Survey – Mental Health and Well-being* (2003) and resulting research reports and documents arising from analysis of data tables

Canadian Collaborative Mental Health Initiative (2006) series of reports including Paper #9, *Prevalence of Mental Illnesses and Related Service Utilization in Canada*

Dr. Douglas May's statistical overview (2005), *Atlantic Canada: the Have Provinces? Health and Wellness & Crime and Safety*, prepared for the Atlantic Summer Institute on Healthy and Safe Communities

Alberta Mental Health Board, *Mental Health Statistics in Your Pocket* (2006)

Public Health Agency of Canada, *The Tides of Change: Addressing Inequity and Chronic Disease in Atlantic Canada* (2003)

Additional data were collected by reviewing reports from Statistics Canada and its newsletter *The Daily* and also from Health Canada and the Public Health Agency of Canada. The consultant organized the data using the determinants of health model with a particular emphasis on collecting data describing previously identified populations and communities of interest in Atlantic Canada.

2.3.3 Key informants survey

The consultant generated a list of possible key informants based on contacts identified through the literature review, by members of the Advisory Committee, staff of the Atlantic Regional Office of the Public Health Agency of Canada, and by key informants themselves. The key informants were first grouped by province and then by theme (population, system representation, language, and issue/concern). The Advisory Committee recommended a minimum of 30 key informant interviews, with the consultant limited to a maximum of 40 because of time and resource constraints.

Of the 39 key informants, three provided responses by e-mail, five participated in two sets of group interviews, and the remainder participated in telephone interviews. Interviews ranged in length from 20 to 45 minutes.

The consultant contracted with Vivat Communications to carry out four of the key informant interviews in French.

Nine other contacts were invited to participate, but they declined due to time constraints or because they were no longer in the position that made them suitable as key informants.

For ease of reporting, the consultant has attributed comments on which there was agreement among all the informants. Where it is useful and offers some scope for additional consideration, the consultant has identified specific comments relating to health providers, communities of interest, and geographic regions.

3. LITERATURE REVIEW

Much of the recent public and political discourse focused on mental health and mental illness has been informed by the work of the Standing Senate Committee on Social Affairs, Science and Technology which last spring released *Out of the Shadows at Last*.⁶

The Senate Committee process provided an opportunity to bring together a number of perspectives, interpretations, and voices on mental health and mental illness within a national context. The document it produced, also known as the Kirby Report, highlighted the need to develop a sustained and coordinated approach to the mental health system in Canada as well as action on underlying issues such as stigma, lack of cohesion, and comprehensiveness.

The report emphasized the importance of building a mental health system based on a wellness, recovery centred model. It recommended that the principal values guiding the model be choice, community, and integration. Underpinning this approach is the acceptance that social determinants of health play a significant role in understanding mental health and mental illness and in supporting recovery.

3.1 COMMUNITIES OF INTEREST

A review of public consultations, carried out in the Atlantic region over a 10-year period, showed that respondents consistently identified mental health, addictions, and mental health promotion as priority issues needing action within the public health mandate of the Agency.⁷ Mental health issues included work place stress, stress arising from food insecurity and poverty, social isolation and exclusion, depression, violence, and poor environmental conditions such as housing and geographic isolation. At risk for poor mental health status were Aboriginal peoples, youth, elderly, and caregivers. The authors concluded that structural barriers and service deficits in the Atlantic region have contributed to the decline in social supports that enable good mental health.

A review of Community Mental Health Survey data focusing on Atlantic Canada also provided similar findings. Starkes et al, in their study of depression,⁸ identified seniors, people with low levels of education, and those living in rural areas as significantly less likely to receive treatment than other populations. These researchers concluded that there was a need to target at-risk populations through public awareness. The researchers noted that if program developers understood better the underlying factors affecting help-seeking, they would be able to facilitate increased access and uptake of mental health support services.

⁶ Standing Senate Committee on Social Affairs, Science and Technology, op. cit.

⁷ Atlantic Networks for Prevention Research, *An Environmental Scan of Health-Related Community Consultations in Atlantic Canada (1995-2005)*, Communities and Health Research Unit, Halifax, 2005. Available at <http://preventionresearch.dal.ca/ScanSummaryFinal.pdf>

⁸ J.M. Starkes, C.C. Poulin, and S.R. Kisely, "Unmet need for the treatment of depression in Atlantic Canada," *Canadian Journal of Psychiatry*, 2005 Sep; 50 (10): 580-90.

New research recently identified the absence of knowledge about immigrants' experience with mental health.⁹ Reitmanova found that existing mental health services are ill-prepared to deal with immigrants living with mental illness or mental health issues. The challenges of language, culture, social isolation, along with the resettlement stress faced by new immigrants, further complicate these issues.

Given the largely rural nature of Atlantic Canada, it is helpful to consider some of the findings reported in *How Healthy Are Rural Canadians*.¹⁰ This study found that while rural Canadians have poorer health status compared to their urban counterparts, they also experience a greater sense of community and belonging.

Rural Canadians experience higher death rates from heart disease, injuries, and suicide. The report identifies higher rates of poverty, unemployment, and isolation as factors related to the higher suicide rate. Other issues compromising the mental health of rural Canadians are lack of control over work and life issues and negative life experiences.

It should be noted that this report, when addressing mental health and mental disorders, focused primarily on suicide in rural populations. There is little, if any, information discussing regional differences. The report acknowledged that some data sets were not sufficient to carry out this level of analysis.

3.2 GENDERED PERSPECTIVES

Reitmanova and Gustafson also identified specific mental health issues for immigrant women.¹¹ In particular, limited social support, financial resources, and access to meaningful employment, coupled with managing multiple social roles and meeting family needs, posed challenges.

Similarly, within African Canadian communities in Nova Scotia, there is a focus on African Canadian women being strong and being present for everyone's needs but their own. Bernard, in her study of African Canadian women and addictions, identified stigma and the absence of personal support as significant issues,¹² while Etowa found that family and community

⁹ Sylvia Reitmanova, *Mental Health of St. John's Immigrants: Concepts, Determinants, and Barriers*, Memorial University of Newfoundland MSc. thesis, April 2006.

¹⁰ Canadian Institute for Health Information, *How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants*, Ottawa, 2006. Available at secure.cihi.ca/cihiweb/products/rural_canadians_2006_report_e.pdf

¹¹ Sylvia Reitmanova and Diana Gustafson, *Concepts and Determinants of St. John's Immigrants' Mental Health*, Report for the Mental Health Decision Makers, Organizations and Service Providers in Newfoundland and Labrador, 2007. Available at www.nlcahr.mun.ca/research/reports_search/Immigrant_mental_health_reitmanova.pdf

¹² Wanda Thomas Bernard, *Including Black Women in Health and Social Policy Development: Winning Over Addictions, Empowering Black Mothers with Addictions to Overcome Triple Jeopardy*, Maritime Centre of Excellence for Women's Health, Halifax, 2001. Available at www.acewh.dal.ca/eng/reports/blackHlthBernard.pdf

responsibilities create stress and pressure, ultimately taking their toll on the women's health.¹³ The African Canadian women in Etowa's research study were reluctant to name their symptoms as depression. The stigma attached to many mental health issues results in isolation and limited support. In Etowa et al,¹⁴ study participants identified racism as a key factor in their experiences of depression and in undermining their efforts to take care of themselves.¹⁵

Researchers for the Elizabeth Fry Society of mainland Nova Scotia reported that providers within the justice system and at the community level were seeing an increasing number of women presenting with mental illness.¹⁶ The qualitative report identified abuse, low self-esteem, and mental illness as key factors for women who had encountered the justice system. Substance use and over-medication were also considerations in understanding the mental health/mental illness issues of this group of women.

3.3 MENTAL ILLNESS AS CHRONIC DISEASE

Researchers reflecting both system and community interests have identified similar concerns and priorities. Jensen and Kisely reported that participants ranked mental health, addictions, and mental health promotion as the priority issues needing action.¹⁷ The authors also described the context for the kinds of challenges and barriers that exist to making a difference, that is,

a lack of funding and resources for public health; challenges in working both across jurisdictions and within sectors; the disconnect between practice, research, and policy; an overall public focus on health care services; and fragmentation within the public health system.

In *The Tides of Change: Addressing Inequity and Chronic Disease in Atlantic Canada*, the authors established the relationship between chronic disease, including mental illness, and social and economic inequities. The authors note:

Because mental and physical illnesses are interconnected, social inequities may influence the progression of chronic diseases through the medium of

¹³ Josephine Etowa and Barbara Keddy, Principal Investigators, *Menopause and Midlife Health of the "Strong Black Woman": African Canadian Women's Perspectives*, Dalhousie University and Health Association of African Canadians, Halifax, 2005. Available at www.haac.ca/downloads/sbwplain.pdf

¹⁴ Josephine Etowa, Barbara Keddy, Julius Egbeyemi, and Felicia Eghan, "Depression: The 'Invisible Gray Fog' Influencing the Midlife Health of African Canadian Women," *International Journal of Mental Health Nursing*, forthcoming Summer 2007.

¹⁵ See also Focus on Black Women's Health at www.canadian-health-network.ca/servlet/ContentServer?cid=1168525557692&pagename=CHN-RCS/CHNResource/CHNResourcePageTemplate&c=CHNResource

¹⁶ Elizabeth Fry Society of Mainland Nova Scotia, *Women in Nova Scotia, Mental Illness, and the Criminal Justice System: A Qualitative Review*, Halifax, 2005.

¹⁷ Lisa Jensen and Stephen Kisely, *Public Health in Atlantic Canada: A Discussion Paper*, Atlantic Regional Office, Public Health Agency of Canada, Halifax, 2005. Available at www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/PH_Discussion/4_e.html

*mental disorders. Factors such as socio-economic status, family conflict, and work pressures can trigger the onset of mental illness.*¹⁸

This review echoed many of the recommendations highlighted in the report prepared by Citizens for Mental Health.¹⁹ This report was the result of an interactive, collaborative, and consultative approach to identifying national and regional priorities for mental illness and mental health in Canada. Possible areas for action were also offered including research, education, surveillance, standards, service models, and legislation. The results included a focus on networking, building relationships, and greater clarity regarding federal roles and responsibilities. Participants from Atlantic Canada emphasized housing, income support, legal/justice issues, immigration, stigma/public education, lack of appropriate and comprehensive services, and a need to focus on children. The final synthesis approach identified eight priorities: housing, criminal justice, employment, income, culture, immigration/settlement, mental health promotion, and health services. The authors of the report identified its limitations in addressing the specific needs of communities of interest, but, nonetheless, the priority issues it identified can be used to analyze the needs of various populations as required.

3.4 PROVINCIAL CONSIDERATIONS

Within each of the four Atlantic provinces, there have been changes at legislative, policy, and program levels with respect to mental health and mental illness. These changes are varied and reflect different provincial priorities within the region in the last five years.

With the introduction of its new *Mental Health Care and Treatment Act* in December 2006, Newfoundland and Labrador became the most recent province to revise its mental health legislation. In July 2007, the provisions of Nova Scotia's new *Involuntary Psychiatric Treatment Act*, passed in the fall of 2005, will come into effect. Each provides the legal framework for mental health professionals to intervene on behalf of individuals who are deemed to lack the capacity to determine their need for treatment.

All four Atlantic provinces have also developed, to some degree, strategic frameworks that support the identification, development, and implementation of new directions and priorities for mental health and addictions. In Newfoundland and Labrador, the policy framework reflects the Canadian Mental Health Association's framework in valuing mental health, in recognizing consumer and family participation, and in promoting greater responsiveness to changing health and social needs by establishing better connections among all levels and parts of the health and community services system. The province has also developed a provincial poverty-reduction strategy which plans to gradually make available home support for people with severe and persistent mental illness.

¹⁸ Hayward and Colman, op. cit., p. 22.

¹⁹ Citizens for Mental Health, *Mental Health Priorities of the Voluntary Sector: Development of a Framework for Action*, Canadian Mental Health Association, 2004. Available at www.cmha.ca/citizens/citizens_report_ENG_6.pdf

Similarly, the Nova Scotia government identified the development of comprehensive mental health standards, announced in 2003, as its first step in mental health reform. Since then, Nova Scotia has undertaken the development of a monitoring framework to document prevalence and outcomes related to mental health and mental illness.

Also in 2003, the Canadian Mental Health Association in Prince Edward Island began researching the support needs of people with severe and persistent mental illness. The resulting report, *Pain, Perseverance & Passion*, was released in August 2004.²⁰ Since that time, the Prince Edward Island Division of the Canadian Mental Health Association has been working with the provincial government on developing a process for implementing the report's recommendations, particularly with respect to housing and stigma reduction strategies.

One of the key areas for new programming in the Atlantic region has been in the area of suicide prevention. In response to its identified risk for suicide (higher than the national average and the highest in the region), New Brunswick supported a research study in 2003 focused on those factors that led to suicide, in order to identify effective strategies to support individuals and families living with mental illness.²¹ The report proposed making changes through four arcs: governance, intervention, prevention, and evaluation/research.

The New Brunswick study also supported the integration of addictions and mental health approaches to improve rates of treatment and service provision. It is worth noting that all the provinces have experienced restructuring processes within their health systems. One significant outcome has been the focus on bringing policy, program, and staff of both mental health and addictions disciplines together.

Both Nova Scotia and Newfoundland and Labrador have also developed and implemented government-supported suicide intervention strategies, with Newfoundland and Labrador targeting Aboriginal youth (Innu, Inuit, Métis, and Mi'kmaq) as populations at significant risk for suicide. In Prince Edward Island, the Canadian Mental Health Association Division offers "Signals of Suicide," a suicide-prevention program presented by a trained facilitator in grade 9 classrooms throughout the province. The organization also coordinates suicide prevention, intervention, and post-intervention efforts.

3.5 EMERGING ISSUES

Other studies have examined caregiver issues and home support for individuals with severe and persistent mental illness. A Health Canada study prepared by Decima Research of caregivers and their responsibilities for people with mental illness found a gap in services and

²⁰ Canadian Mental Health Association, Prince Edward Island Division, *Pain, Perseverance & Passion: A Report on the Support Needs of Individuals with Severe and Persistent Mental Illness on Prince Edward Island*, 2004. Available at www.gov.pe.ca/photos/original/hss_mentalh_rep.pdf

²¹ Monique Seguin, Alain Lesage, Gustavo Turecki, France Daigle, and Andrée Guy, *Research Project on Deaths by Suicide in New Brunswick between April 2002 and May 2003*, Douglas Hospital Research Centre and Government of New Brunswick, 2005. Available at www.gnb.ca/0055/pdf/3182-e.pdf

support.²² The researchers identified caregiver stress as a significant impact of managing care responsibilities, as well as the inability to cope with care demands and the lack of regular respite. While the authors undertook a gender analysis of the data, their report did not provide a regional analysis of the data collected.

The Health Canada study supports some of the conclusions made in a study undertaken for the Canadian Mental Health Association into home support for people with mental illness.²³ In this study, Parent and Anderson reported on the outcomes of three pilot projects that explored delivery issues, identified practice guidelines, and examined policy implications in Newfoundland and Labrador, Alberta, and Ontario. The study reported several key findings including the need for increased family support.

The Canadian Forces Mental Health Survey, a supplement to the Canadian Community Health Survey, found that there were higher prevalence rates for depression, alcohol dependence, and panic disorder among Armed Forces personnel compared to the prevalence rate in the Canadian population at large.^{24 25} In another study, Mitchell examined the impact this will have for social work practice in the future.²⁶

With the economic situation in Atlantic Canada being less robust than other parts of Canada, many young people are finding employment with the Armed Forces. In the most recent deployment to Afghanistan, more than half of the 2,500 deployed were from Atlantic Canada.²⁷

American service personnel returning from Iraq and Afghanistan are reporting high rates of substance abuse, post-traumatic stress disorder, and other mental health problems.^{28 29} Work is now under way to prepare the supports and services needed to manage the anticipated increase in the number of military personnel from the Atlantic region, along with their families, presenting with mental health and addiction issues.

²² Decima Research Inc., *Informal/Family Caregivers in Canada: Caring for Someone with a Mental Illness*, prepared for Health Canada, 2004. Available at

www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2004-mental-care-soins/index_e.html

²³ Karen Parent and Malcolm Anderson, *Home Care & People With Psychiatric Disabilities: Needs & Issues*, Canadian Mental Health Association, Toronto, 2000.

²⁴ Statistics Canada, *Canadian Forces Mental Health Survey*, Ottawa, 2003.

²⁵ Deniz Fikretoglu, Alain Brunet, Stéphane Guay, and David Pedlar, "Mental Health Treatment Seeking By Military Members With Post-Traumatic Stress Disorder: Findings on Rates, Characteristics and Predictors From a Nationally Representative Canadian Military Sample," *Canadian Journal of Psychiatry*, Vol 52, No 2, 2007.

²⁶ Daphne Mitchell, "The military: special issues for social workers," *The Advocate*, Journal of the Alberta College of Social Workers, Fall 2006: 22-23.

²⁷ CBC News On-Line, "IN DEPTH Afghanistan: Atlantic Canada's role," January 29, 2007. Available at www.cbc.ca/canada/new-brunswick/background/afghanistan-atlantic/

²⁸ Karen Seal, Daniel Bertenthal, Christian R. Miner, Saunak Sen, and Charles Marmar, "Bringing the War Back Home: Mental Health Disorders Among 103,788 US Veterans Returning From Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities," *Archives of Internal Medicine*, 167:476-482, 2007.

²⁹ CBC News On-Line, "Mental Health Woes Afflict Almost a Third of Iraq, Afghan Vets," March 12, 2007. Available at www.cbc.ca/cp/HealthScout/070312/6031208AU.html

3.6 SUMMARY

In conclusion, the review of available literature examining Atlantic Canada identified specific concerns with poverty, unemployment, out-migration, and isolation as factors in understanding mental health and mental illness issues in the region.

Specific stressors include working conditions and workplace pressures, food insecurity, poverty, violence, social isolation and exclusion, cultural insensitivity and racism, and poor quality housing.

Depression, anxiety, and post-traumatic stress disorder have emerged as specific mental health conditions affecting Atlantic Canadians. Specific populations in need of targeted services and intervention include Aboriginal peoples, children, youth, seniors, caregivers, immigrants, women, people with low levels of education, individuals in the Armed Forces (both active and reservists), and those living in rural areas. Suicide intervention is a priority for New Brunswick and for Labrador.

The literature review identified continuing inequities in accessing services, the absence of integration and coordination in service delivery, and inadequate community supports.

The literature review also identified some emerging issues:

- 1) There is an absence of planning for individuals living with mental illness with respect to their needs as seniors with identified mental illnesses.
- 2) The disproportionate number of Atlantic Canadians in the Armed Forces means an associated risk for post-traumatic stress disorder is likely as a result of recent deployment in Afghanistan.
- 3) The increase in individuals presenting with concurrent disorders for mental illness and addictions and the greater complexity of cases poses significant challenges.

4. EPIDEMIOLOGICAL REVIEW

4.1 PREVALENCE

According to the analysis³⁰ of the data collected from the Canadian Community Health Survey - Mental Health and Well-being, there are no appreciable differences at this time between rates of mental health disorders in Atlantic Canada compared to Canada as a whole.³¹

While there appears to be a slightly lower rate of depression noted in Atlantic Canada (3.6 %), compared to 4.8% for the Canadian average, people in some parts of Atlantic Canada (Nova Scotia and New Brunswick) are at a higher risk to become depressed. New Brunswick has a higher suicide rate than the Canadian average, although, on average, fewer Atlantic Canadians commit suicide than Canadians who live in other parts of the country.^{32 33} Please see Appendix V for a detailed profile summarized from *The Tides of Change*³⁴ concerning specific mental health trends in Atlantic Canada, with provincial breakdowns.

4.2 HEALTH DETERMINANTS

In *The Tides of Change*, Hayward and Colman note that, “*there is no single health profile in Atlantic Canada.*”³⁵ In *Atlantic Canada Snapshot*, the authors note, “*Atlantic Canada is not one homogenized region. Rather it is four diverse, yet interconnected, economies and cultures. Each has its own unique needs and opportunities.*”³⁶ The authors suggest social and economic inequities, growing urban-rural splits, cultural differences, and social processes that affect the conditions of people’s lives are at the root of these differences.

The differences that influence an individual’s health and well-being are what are termed the determinants of health. Health Canada has identified 12 determinants of health: income and social status, social support networks, education, employment and working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender, and culture.

As a way of understanding how mental health and mental illnesses play out in Atlantic Canada, we can use the determinants of health model to collect and review health information

³⁰ A. Lesage et al., op. cit.

³¹ The Canadian Community Health Survey organized mental health disorders in five categories: depression, social phobia, panic disorder, mania, and agoraphobia. The survey also looked at rates of drug and alcohol dependence. The survey was based on self-reported data.

³² Dalhousie University, *Atlantic Canada Snapshot*, Faculty of Medicine, Halifax, 2006. Available at www.strategicplan.medicine.dal.ca/documents.htm

³³ Douglas May, *Atlantic Canada: The Have Provinces? Health and Wellness & Crime and Safety*, prepared for the Atlantic Summer Institute on Healthy and Safe Communities, Memorial University of Newfoundland and Newfoundland and Labrador Statistics Agency, 2005.

³⁴ Hayward and Colman, op. cit.

³⁵ Ibid.

³⁶ Dalhousie University, op. cit.

from this region. Using a population health lens allows us to re-interpret data to identify trends and to track changes that may influence the development and prevalence of mental health and associated issues.

4.2.1 Income and social status

Income and social status are the biggest single predictors of overall health. The more money one has, the more likely one is to be healthy.

- Almost 16 % of Atlantic Canadians have incomes below Statistics Canada's low income cutoff; however real disposable income is increasing in Atlantic Canada.³⁷
- Canadians as a whole live longer than Atlantic Canadians.³⁸
- A far greater proportion of African Canadians (almost four times as many) in Nova Scotia live in poverty compared to those of European heritage.³⁹
- Natural resources drive the largely rural economy of Atlantic Canada; the seasonal workers on which it depends are often under-educated, have lower incomes, are aging, and are declining in numbers due to out-migration.⁴⁰

4.2.2 Social support networks

The more support and help one receives from family and friends to solve one's problems, the more in control and healthier one feels.

- Canadians rely primarily on health professionals as opposed to self-help groups for assistance with managing mental health issues. Newfoundland and Labrador reported the lowest rate of usage of self-help of all provinces, while Prince Edward Island reported the highest rate among the four provinces in Atlantic Canada.⁴¹
- Atlantic Canadians report having high levels of social support; women are more likely to report having social support than men in all four provinces.⁴²
- On average, nearly 40% of Canadians, including those living in Atlantic Canada, with a self-reported mental health disorder said they used mental health services.⁴³

4.2.3 Education and Literacy

Higher levels of education are connected to better work opportunities and increased salary. These offer more choices and provide a person with more control over their life circumstances, thus leading to better health.

³⁷ May, op. cit.

³⁸ Ibid.

³⁹ Hayward and Colman, op. cit.

⁴⁰ Dalhousie University, op. cit.

⁴¹ Lesage et al., op. cit., p. 6.

⁴² May, op. cit., p. 22.

⁴³ Lesage et al., op. cit., p. i.

- There are fewer Atlantic Canadians with bachelors degrees compared to the rest of Canada, and there are more Atlantic Canadians whose highest level of education achieved is grade 9 or lower.⁴⁴
- The Public Health Agency of Canada reports that people with low or limited literacy skills may experience higher stress levels. They may also have limited self-confidence, feel isolated, and may have a limited range of choices and fewer resources with which to cope with stress in their lives.⁴⁵

4.2.4 Employment/working conditions

The more control one has in one's work life, the less stress associated with one's job, and the better the rate of pay, the more likely one is to be healthier and live longer.

- According to April 2007 Statistics Canada figures, the Atlantic region has a high unemployment rate, at about 9.4%, compared to 6.1% for the Canadian average. Within the region, Newfoundland and Labrador has the highest unemployment rate at 12.9%, followed by Prince Edward Island at 9.4%. Both Nova Scotia and New Brunswick have rates slightly higher than the national average at 8% and 7.3% respectively.⁴⁶
- Unemployment rates among youth aged 15-24 (April 2007 figures) range from 24.5% in Newfoundland and Labrador to 14.7% in Nova Scotia, 14.5% in Prince Edward Island, and 11.8% in New Brunswick, compared to the Canadian average of 11.5%.⁴⁷
- Due to the seasonal and uncertain nature of employment in the region, many Atlantic Canadians work less hours per year than other Canadians. Newfoundlanders and Labradorians and Prince Edward Islanders report working the least number of hours. However, when Atlantic Canadians are working, they work more hours per week.⁴⁸
- In Canada as a whole, 17% of all self-reported incidents of violent victimization occurred in the workplace; Newfoundland and Labrador reported a 40 % incident rate.⁴⁹
- People who described most of their workdays as stressful were more likely than people in less stressful working conditions to have had a depressive illness in the previous 12 months.⁵⁰

⁴⁴ May, op. cit.

⁴⁵ Public Health Agency of Canada, *What is Literacy? Fact Sheet*, Ottawa, 2003. Available at www.phac-aspc.gc.ca/ph-sp/phdd/literacy/facts.html

⁴⁶ Statistics Canada, "Labour Force Survey, April 2007," *The Daily*, Ottawa, May 11, 2007. Available at www.statcan.ca/Daily/English/070511/d070511.pdf

⁴⁷ Statistics Canada, "Labour force survey estimates, by sex and age group, seasonally adjusted and unadjusted, monthly, CANSIM Table 282-0087, May 2007.

⁴⁸ May, op. cit.

⁴⁹ Statistics Canada, "Study: Criminal victimization in the workplace," *The Daily*, February 16, 2007. Available at www.statcan.ca/Daily/English/070216/d070216a.htm

⁵⁰ H. Gilmour and S. Patten, "Depression and work impairment," *Health Reports*, Statistics Canada, Vol 18, No 1, February 2007.

- While 9% of nurses across Canada experienced depression, only 5% in Newfoundland and Labrador and 6% in Prince Edward Island did. Nova Scotia and New Brunswick nurses experienced depression at rates on par with the national average.⁵¹
- A qualitative study of 25 women working in call centres in Nova Scotia reported that the women experienced low energy, depression, irritability, disrupted eating and sleep patterns, and poor overall mood. Women also reported conflicts in family relationships, lack of time to meet personal needs or for leisure activities, as well as conflicts with care giving responsibilities.⁵²

4.2.5 Social environments

Community belonging is linked to an individual's self-perceived health status. When one feels connected and involved with one's community, one is more likely to feel supported and to feel healthy.

- Nearly two-thirds of those who feel a very strong or somewhat strong sense of community belonging report excellent or very good general health. In contrast, only half of those with a very weak sense of belonging view their general health as favourable as those with a strong sense of community belonging. Atlantic Canadians report the highest sense of community belonging (75% average compared to 64.1% for Canada as a whole) with Newfoundland and Labrador reporting the highest rates in the country.⁵³
- Population loss is high in Atlantic Canada because of the declining birth rate and out-migration. As a result, the region also has a rapidly increasing population of seniors;⁵⁴ Newfoundland and Labrador and New Brunswick have more people leaving than coming in.⁵⁵
- Capital cities in each Atlantic Canadian province expanded by 50,000 people between 1995 and 2004, despite an overall drop in the region's population.⁵⁶
- Between 42% and 55% of Atlantic Canadians live in rural areas. The national average is 20%.⁵⁷

⁵¹ Statistics Canada, *The Daily*, February 16, 2007, op. cit.

⁵² Carol Putnam, Anne Fenety, and Charlotte Loppie, *Who's on the Line? Women in Call Centres Talk about Their Work and Its Impact on Their Health and Well-being*, Atlantic Centre of Excellence for Women's Health, Halifax, 2000.

⁵³ Lesage et al., op. cit.

⁵⁴ Dalhousie University, op. cit.

⁵⁵ May, op. cit.

⁵⁶ Dalhousie University, op.cit.

⁵⁷ Ibid.

4.2.6 Physical environments

Poor physical environments result in poor health. Clean air, water and soil, and safe housing, workplaces, and roadways are some environmental factors that can affect health.

- Atlantic Canadians are more likely to own their own homes compared to Canadians elsewhere.⁵⁸
- The homeless with mental illness are more vulnerable than the homeless without mental illness.⁵⁹

4.2.7 Personal health practices and coping skills

How one looks after oneself physically and mentally affects how well one can maintain one's overall health and well-being. Knowing how to cope with stress, live a healthy lifestyle, and make healthy choices are skills that lead to good personal health. Living and working in communities that support good health also have an effect on how well one can maintain one's health.

- 18.47% of Atlantic Canadians report experiencing life stress, compared to 24.4 % of Canadians as a whole.⁶⁰
- 24.1% of Atlantic Canadians report smoking daily or occasionally, compared to 22.9% of Canadians as a whole.⁶¹
- Almost 28 % of Atlantic Canadians have five or more drinks on occasion, compared to 20.7% of Canadians on average.⁶²
- Atlantic Canadians have higher rates of diabetes compared to the national average.⁶³
- New Brunswick has higher than average mortality rates from cancer and heart disease.⁶⁴

4.2.8 Healthy child development

A healthy beginning in childhood can help one maintain good health as an adult. For example, a mother's nutrition in pregnancy can affect a person's health later on. Early childhood experiences with learning, socialization, and family are also key influences.

- Children in Atlantic Canada are more likely to grow up in more supportive environments, that is, with parents using a rational parenting style than those in the

⁵⁸ May, op. cit.

⁵⁹ Canadian Mental Health Association, *Homelessness and People with Serious Mental Illness*, Fact Sheet, January 31, 2003.

⁶⁰ Statistics Canada, *Canadian Community Health Survey – Mental Health and Well-being*, Ottawa, 2003, updated 2004.

⁶¹ Ibid.

⁶² Ibid.

⁶³ Dalhousie University, op. cit.

⁶⁴ Ibid.

rest of Canada. Nova Scotia is the exception, displaying the highest rate of parents using a punitive approach.⁶⁵

- Between 17% and 31% of children in Atlantic Canada live in poverty, compared to the national average (16.9%). In Newfoundland and Labrador, the number of children living in poverty is almost double the national average.⁶⁶
- 25% of deaths among youth aged 15-24 is due to suicide, a rate second only to car accidents. More teenagers and young adults die of suicide than die from cancer, heart disease, AIDS, pneumonia, influenza, birth defects, and stroke combined. More than 90% of children and adolescents who die by suicide have a mental disorder. Suicide attempts peak during mid-adolescence, and the mortality from suicide increases steadily through the teen years.⁶⁷
- Rural male youth are at higher risk for suicide than urban male youth.⁶⁸
- Only one in five children who needs mental health services receives them.⁶⁹
- Atlantic Canada has more seniors and fewer youth than any other part of Canada.⁷⁰

4.2.9 Biology and genetic endowment

One's biology and genetic makeup determine one's physical health. While one cannot change one's genetic profile, the choices one makes can influence how certain genetic tendencies will affect one's overall health.

- Rates of diabetes are higher in Atlantic Canada compared to the rest of Canada, with Newfoundland and Labrador having the highest rates. The rates are increasing: in New Brunswick, for example, the rates have doubled between 1994 and 2003.⁷¹
- Newfoundland and Labrador has the highest rate of heart disease in Canada.⁷²
- Depressed men are more likely to die from cardiac disease than depressed women.⁷³
- The instance of suicide among men 80 years of age and older is the highest of all age groups in Canada.⁷⁴

⁶⁵ May, op. cit.

⁶⁶ Ibid.

⁶⁷ Canadian Mental Health Association, *Evidence Summary on Suicide*, Toronto, 2004. Available at www.suicideinfo.ca/csp/assets/Senate_SummaryofEvidence.pdf

⁶⁸ Laura Armstrong, *Youth Suicide: It's Time to Get Involved*, Canadian Institutes for Health Research, 2006.

⁶⁹ Canadian Mental Health Association, *Background: Mental Health and Mental Illness*, no date. Available at www.cmha.ca/data/1/rec_docs/155_mental_illnessENG.pdf

⁷⁰ May, op. cit.

⁷¹ Ibid.

⁷² Ibid.

⁷³ Andrew Sherwood, James A. Blumenthal, Ranak Trivedi, Kristy S. Johnson, Christopher M. O'Connor, Kirkwood F. Adams Jr., Carla Sueta Dupree, Robert A. Waugh, Daniel R. Bensimhon, Laura Gauden, Robert H. Christenson, Gary G. Koch, and Alan L. Hinderliter, "Relationship of Depression to Death or Hospitalization in Patients With Heart Failure," *Archives of Internal Medicine*, 167:367-373, 2007.

⁷⁴ Canadian Mental Health Association, *Evidence Summary on Suicide*, op. cit.

- Depressed women are 73 % more likely to have heart attacks or other cardiac diseases than women who are not depressed.⁷⁵
- The risk of heart disease increases greatly in postmenopausal women.⁷⁶

4.2.10 Health services

Generally speaking, health services have a small role in determining a person's overall health status. Health services which do have an effect on health and well-being are those that help people maintain health or that help in recovery after illness or injury.

- On average, 8.75% of Atlantic Canadians report visiting a health care provider for mental health reasons, compared to 9.5 % of Canadians generally.⁷⁷
- The highest use of general practitioners for help with mental health issues is in Nova Scotia, and the lowest use is in Prince Edward Island.⁷⁸
- Accessing self-help programs and supports ranked fifth and the lowest in all provinces for individuals using services to cope with mental health issues. However, in the Atlantic region, the highest use of self-help is in Prince Edward Island, and the lowest use is in Newfoundland and Labrador.⁷⁹
- More people in Nova Scotia reported seeing a psychiatrist than individuals in any other Atlantic province.⁸⁰
- People in New Brunswick are more likely to use specialty mental health services compared to Prince Edward Island and Newfoundland and Labrador, with the latter featuring the lowest use of specialty mental health services.⁸¹
- On average, about 40% of people with mental health issues report seeking help. When we look at specific groups, we see that only 25% of youth seek help, and within that population, young male youth are least likely to seek help.⁸²
- Nova Scotia ranks second in Canada for psychiatric hospitalization.⁸³

4.2.11 Gender

One's health status may be different because of one's gender. Women are more likely to experience violence, poverty, and single parenthood, while men are more likely to die young, because of injuries, heart disease or cancer, or suicide.

⁷⁵ Ibid.

⁷⁶ Bill Wilkerson, *Depression and Heart Disease: A Dynamic Workplace Health Risk*, presentation, The Ontario Chamber of Commerce Economic Summit Mental Health and Productivity, June 2005.

⁷⁷ Lesage et al., op. cit.

⁷⁸ Ibid.

⁷⁹ Ibid.

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² Ibid.

⁸³ Ronald Colman, *The Cost of Chronic Disease in Nova Scotia*, GPI Atlantic, Halifax, 2002.

- Women more likely to consult a mental health care provider than men.⁸⁴
- Men are more likely than women to commit suicide in Canada; in Newfoundland and Labrador, the rate is seven times higher for men than for women and is five times higher in Nova Scotia and New Brunswick.⁸⁵
- Single mothers are more likely to suffer higher rates of mental distress and depression.⁸⁶

4.2.12 Culture

Culture is a factor in overall health and well-being. If one's culture is not valued nor respected, if one experiences racism and discrimination, or if one is unable to access services which are culturally and linguistically appropriate, then one's overall health status will be affected.

- New immigrants and members of visible minorities are at high risk for poverty and increased heart disease.⁸⁷
- Racial and cultural minorities are also particularly vulnerable to exclusion.⁸⁸
- Suicide rates in Canada's Aboriginal populations are two to three times higher than the rates of suicide in the non-Aboriginal population, and the rates are five to six times higher among Aboriginal youth.⁸⁹
- Some researchers have found evidence to support the preservation of culture, self-government, and self-determination as a means of eliminating or preventing youth suicide in certain Aboriginal peoples/cultural groups.^{90 91}
- Across Canada, more than half of the Aboriginal population lives in urban centres; in Atlantic Canada, most Aboriginal peoples live in rural communities.⁹²

4.3 SUMMARY

Previous researchers have identified the absence of a cohesive health experience in Atlantic Canada.⁹³ There are some trends in Atlantic Canada linked to physical and mental health as well as the influence of external factors such as employment, education, culture, gender, and

⁸⁴ Lesage et al., op. cit.

⁸⁵ May, op. cit.

⁸⁶ Cara Tannenbaum, *Towards a Better Understanding of Women's Mental Health and Its Indicators*, Centre de recherche de l'Institut universitaire de gériatrie de Montréal, 2006. Summary available at www.hc-sc.gc.ca/sr-sr/finance/hprp-prpms/results-resultats/2006-tannenbaum_e.html

⁸⁷ Michael Mirolla, *The Cost of Chronic Disease in Canada*, Chronic Disease Prevention Alliance, Ottawa, 2004, p. 67.

⁸⁸ Ibid.

⁸⁹ Health Canada, *Acting On What We Know: Preventing Youth Suicide in First Nations*, Ottawa, 2005. Available at www.hc-sc.gc.ca/fnih-spni/pubs/suicide/prev_youth-jeunes/index_e.html

⁹⁰ Canadian Mental Health Association, *Evidence Summary on Suicide*, op. cit.

⁹¹ Health Canada, *Acting On What We Know*, op. cit.

⁹² Hayward and Colman, op. cit.

⁹³ Ibid.

geography. However, there is limited statistical information on each province due to the low sample numbers in some areas. This makes it challenging to develop analyses that are generalizable to the populations at large in each province. However, by looking at these data from the determinants of health model, we can see there are multiple factors that influence health and well-being. More importantly perhaps, the data can lead program developers and policy makers to more awareness of the context in which Atlantic Canadians are living and the factors that may affect the desired outcomes for their mental health and well-being.

5. KEY INFORMANTS

The 39 key informants from the four Atlantic provinces presented a wide range of issues, some specific to their province and others applicable to the whole region. The key informants represented a variety of perspectives: community, health services/institutional, academic, government, policy, and advocacy. See Appendix III for a list of the key informants involved in this scan and Appendix IV for the questions they were asked.

In the interviews, the key informants tended to group mental health issues into three main areas: funding, access, and knowledge. Most key informants said more money was needed for delivery of community-based services, the provision of home support, increased income support especially for youth, for drug coverage, and to support infrastructure (housing, staff, training, professional development, and policy development).

For ease of reporting, we have summarized the responses of key informants by question, and then by theme, as appropriate.

5.1 WHAT ARE THE CURRENT ISSUES RELATING TO MENTAL HEALTH AND MENTAL ILLNESS?

5.1.1 Income and social status

Many key informants highlighted the impact living in poverty has on individuals with mental illness. They also highlighted the role stigma plays in creating poor social status for people with mental illness. Participants also identified stigma as a key factor in accessing services and later in reintegrating into the community, post-treatment. For example, stigma was cited as an underlying cause supporting the “re-criminalization” of mental illness and addictions through actions such as enforced treatment and imprisonment.

5.1.2 Social support networks and social environments

Key issues in this category focused on the role of the family as a support system for patients, what improvements could be made including addressing the needs of family involved in an individual’s care, and how to increase family awareness so they can deal with the family member living with a mental illness.

5.1.3 Employment and working conditions

Several key informants noted that training, education, recruitment, and retention for mental health professionals were areas of concern. Some were concerned about the impact of retirement on the current pool of staff, and the need to support incoming staff, many of whom having little “field” knowledge before starting work.

Others highlighted that lack of employment and attendant low income or income insecurity create barriers for youth and immigrants. This creates additional stress and/or prevents access to services and benefits such as drug coverage. For immigrants, double standards and credentialing mean they have difficulty in gaining meaningful work unless their background meets a knowledge gap (e.g., individuals with science backgrounds are fast tracked compared to those coming from the humanities or social sciences).

5.1.4 Physical environments

The lack of affordable housing that is clean, safe and within reach of health services is an area of concern. Home ownership is high in rural areas, yet out-migration means communities are becoming depopulated. Urban environments are also changing: one informant noted that even within cities, downtown areas are becoming cold, impersonal, and unsafe environments. The move to suburban communities where there might be affordable housing means that transportation to centralized services poses challenges. One informant noted that aging institutional infrastructures mean there is no space for future growth. Furthermore, mental health program administrators found that dealing with crumbling buildings, which require extensive renovations, mean less time devoted to program development.

Other informants noted that there is a need to define the economic and geographic constraints more clearly; in their work, they see a divide between urban, suburban, rural, and remote areas within Atlantic Canada. Some areas are experiencing booming economies; while the attendant wealth offers some opportunities, for others living with low or limited incomes, it means higher prices for housing, transportation, and other life necessities. There was also recognition that certain environmental issues, such as the Sydney Tar Ponds, create stress in communities.

5.1.5 Personal health practices and coping skills

Most informants reported working on issues deeply connected to increased public awareness and education. Many noted that in spite of increased awareness, there is still a lack of information about available services, as well as inability to recognize that what is being experienced is a mental health or mental illness issue. A number of informants said, *“People don’t know where to turn to for help.”* Another said, *“... even if they do know, they have limited skills in navigating through the healthcare system,”* while a third said, *“... there isn’t any individual and system advocacy for people with mental illness.”* A number of informants reported the presence of life stresses, work-family balance issues, and increased anxiety.

“I see stress with kids, parents, teachers. There’s not enough time and resources to do what you need to do.”

5.1.6 Health issues

Informants connected with front-line staff noted an increase in the number of clients presenting with concurrent disorders. These could be the result of better assessments as more

training becomes available and health professionals become better equipped to recognize them. Several informants noted that staff are reporting increases in clients with depression, anxiety, and post-traumatic stress disorder.

5.1.7 Health services

Most informants highlighted the need to reorient mental health services in a number of areas. Informants focused on increasing funding, improving access, developing supportive services such as post-hospital transition and reintegration in the community, providing treatment services in the community, addressing coordination issues, and recognizing the particular needs of communities of interest such as immigrants, Francophones, and Aboriginal peoples.

“When you are sick you are not bilingual.”

Several informants noted that integration of addictions and mental health was important. One informant said, *“It’s not a done deal; we see it in different ways, so there’s still a fair bit of work to bring them together. There’s a perception out there that this [integration] is heresy.”*

Reduced financial support from government and different interpretations of what community means complicate the issue of community access. Access issues include examining the role of psychiatrists in the delivery of mental health services. There is also reduced access to psychiatric services because there are fewer psychiatrists. Key informants noted that there is a greater reliance on family doctors or the emergency department as a way to receive services. There is also a perception that because service delivery is fragmented, it is more difficult to work together as a team. Many informants noted that clients seem to go from one program to another.

“All of a sudden, health authorities are seen as community. We need to see that community based is not just where the physical plant is located but also the philosophy behind the service being delivered.”

5.1.8 Forensic issues

A key concern is the continued ability to manage requests from the courts for forensic services, as this is an area with increasing demands for evaluation and support. Informants reported forensic services as an area where there are still barriers to understanding the links between mental illness and the criminal justice system. There is also a focus on making the links among substance use, addictions, and mental illness. In New Brunswick, there are agreements between the provincial Department of Health and the Correctional Service of Canada to expedite the provision of mental health services to offenders being released from provincial and federal jails. Work in this area focuses on putting these components into practice; however, while regional health authorities are supportive, limited resources challenge their abilities to meet community and institutional expectations.

5.1.9 Culture

Key informants from the Aboriginal peoples, African Canadians, immigrant, and Francophone communities identified challenges posed by living in a culture that is largely white and English. Racism, discrimination, and insensitivity play out in different ways in each community. Issues focus on clashes between cultural and religious values, the absence of multicultural and multilingual staff, the use of inappropriate therapeutic approaches, and the absence of linguistically diverse materials.

Informants from Aboriginal peoples and African Canadian communities noted that many in their communities are dealing with historical trauma and unresolved grief from racism and oppression. This context both exacerbates and contributes to mental health issues. For example, several informants noted that African Canadian youth express their anger and depression in external ways such as vandalism, crime, and gang violence, while Aboriginal youth express their pain internally through suicide.

“Our [Aboriginal] youth are in a mental space so terrible, that the only escape is suicide. We need to bring the light in, bring hope. We need to tell the kids there’s another way.”

5.1.10 Francophones

Francophone issues identified by the key informants focused on access, service provision, and information. While New Brunswick’s Acadian Peninsula has services available in French, many Francophones in the Atlantic region do not enjoy the same access. As there are sometimes delays in receiving French translations, ready access to appropriate French-language materials is not always consistent. Some informants noted that certain Francophone areas are poorer economically, and this can translate into social exclusion because of diminished social status. Finally, some areas also have had trouble in recruiting French-speaking health personnel, including French-speaking or bilingual psychiatrists in rural areas.

5.1.11 Youth

Informants highlighted the lack of services for youth, including appropriate housing and income support. Some informants noted their concerns about young people’s use of anti-depressants, especially certain medications that can allow them to act on suicidal feelings.⁹⁴ Informants whose work focuses on youth noted the sense of alienation and detachment young people feel. One informant said Aboriginal youth feel the loss of identity in their communities, and they question where they belong and what relationships they have there.

⁹⁴ While there have been concerns that children and adolescents are at risk for increased suicidal ideation while taking anti-depressants, the Federal Drug Administration in the United States announced in May 2007 that it would expand its warning to include youth aged 18-24 years

5.1.12 Seniors

The comments of the key informants on mental health issues for seniors focused on two areas: seniors who experience mental health issues once they reach a certain age, and seniors who had previously been diagnosed with a mental illness. With the former, issues include the onset of depression because of grief and loss, post-retirement stress, and the development of addictions including use of street drugs, prescription misuse, and gambling.

One informant noted, *“The more I delve into [senior’s mental health], with help from others, the more concerned I become. People are not noticing signs and symptoms related to depression; they’re minimizing them – there’s too much of he’s old. Well, he may be old, but if he is depressed, he should be treated. Given our limited resources, we need to figure out what needs to be done in long term care.”*

Another informant said, *“If you are 50 or 60 you have mental health issues, but past that and you are dementing. Health care providers don’t look to see if there’s anything else. For example, there’s a lack of understanding that as a person ages, drugs metabolize differently. [Lack of knowledge] means providers often prescribe drugs inappropriately to seniors.”*

According to the informants, there appears to be little discussion regarding the needs of individuals who have been previously diagnosed with mental illness, and who are aging. One informant noted that individuals living with a mental illness often have interrupted work patterns, resulting in few, if any, pension benefits. There is also little planning or awareness of what might be needed in terms of long-term care supportive services or for coping with the challenges of aging and managing a mental illness.

5.2 WHAT ARE THE EMERGING ISSUES?

Key informants described emerging issues in different ways. The most frequently cited issue was the impact of the aging population in Atlantic Canada. Both Newfoundland and Labrador and Nova Scotia reported more deaths than births in 2006. Other key areas included:

- Dealing with stigma: *“[It] is still so huge – if we can’t deal with stigma, then people will always be uncomfortable, people don’t want to be labeled.”*
- Responding to individuals with concurrent disorders – seeing people who are coming to treatment for one or the other and have both.
- Recognizing increasing rates of stress, burnout, anxiety, and depression in the population, often linked with work life issues, but also including resettlement stress.

“Over the last 20 years, we have compartmentalized and silo’d programs. We need to get back to our first priority – putting clients first, not the services.”

- Anticipating the impact on individuals from military deployments in Afghanistan and the risk for increased rates of post-traumatic stress disorder, substance use, and depression.
- Dealing with more patients with multiple problems and presenting more complex conditions that are also linked with poverty, lack of affordable housing, social problems, and physical and mental health problems.
- Limited resources and increasing demands for other services, such as breast cancer screening and care, wait times for hospital and physician procedures, catastrophic drug coverage, and autism interventions: *“Some have good outcomes and others we don't know. How do we make ethical decisions?”*
- Developing alternate methods and approaches of delivering services through tele-psychiatry, primary health care, and community services.
- Increasing medicalization of issues and the loss of coping skills: *“I am troubled by the medicalization of so many things. Everything is seen as depression or anxiety when [often] it is a response to everyday stresses in their lives.”*
- Changing nature of drug use, from street drugs (e.g., moving from marijuana to crystal methamphetamine) to the misuse and abuse of prescription medications such as OxyContin and Percocet. One informant observed that younger generations are more open to drug use; however, there is also a lack of understanding among youth as to how drug use could make mental health issues worse. A few key informants noted that youth often use drugs as a means to self-medicate, especially among Aboriginal youth struggling to cope with significant issues in their communities.
- Recruiting and maintaining a critical mass of educated mental health service staff is, and will be, a challenge: *“We have well trained staff, seasoned veterans who will be moving out of the job market. Who is coming up? The newbies, yet we will still need the experts to provide specialized and quality services.”*
- Establishing competencies and standards of care: *“Training in institutions has been eroded in the discipline, [with the result that] new staff doesn't get as well trained before going into the field, and there's no money to support ongoing training.”*

5.3 WHAT HAS CHANGED IN THE REGION?

5.3.1 Life patterns

In Atlantic Canada, there are fewer job opportunities compared to other parts of Canada. Jobs are seen as less stable. When and where there are jobs, especially in the non-profit and health service delivery sector, they are often seen as specialized and requiring doing more with less. The economic situation is considered insecure, with a number of initiatives based on resource development and market interests, and that in turn brings a lot of instability. The not-for-profit sectors are seeing increasing numbers of people seeking service because they have nowhere else to go in the formal health system.

Families are frustrated, trying to reach out and get supports wherever they can. Out-migration breaks up families, and there are fewer relatives around to help. Economic misery brings stress and anxiety. This has an impact on young people – schools are further away, parents are less involved in school life. Youth are lost in bigger schools, and life is more difficult for them.

“Kids leave for school in the dark and come home in the dark.”

In Aboriginal communities, youth are a very significant demographic: *“They are the majority and that will define everything. [Aboriginal youth] are considered ‘stuck’ as adolescents – they haven’t had the rituals and ceremonies to bring them into the community and help them accept their responsibilities as adults.”*

The population is aging. Ten years ago the population was younger. Informants reported a shift in attitude: *“Ten years ago we were emptying institutions, today we are re-opening beds.”* Informants also reported more willingness to accept the illness and the treatments, especially among youth with multiple issues. Said one key informant from the health sector, *“There was a time when everyone expected everything to happen at the mental hospital, and once you got inside you never got better. Today people don’t want to come to the hospital for everything, they want more local access, they want other health services closer to their communities, not in [the regional centre].”*

While more community services exist today, people feel that the increase in the number of patients with multiple problems changes the dynamics for the service. One informant reported their organization recognized that their HIV/AIDS clients had mental health issues and tried to address them as part of the holistic approach they had adopted over time. Nonetheless, even at capacity, the staff felt they were being pushed to add yet another service dimension without the corresponding financial support for this added work.

5.3.2 Visibility

Participants expressed that today there is a clear move to listen to the experience of people who are living with and managing mental illness. Another change has been the shift from a clinical focus to the empirical experience of people in the field. Some feel strongly that research has influenced policies and the treatment of mental illness.

Another aspect of increased visibility is that there are more opportunities to become involved and be valued as an advocate: *“Ten years ago, I was full of anger at the system, now I feel like I am part of the team, and the professionals there value my opinion. We developed a handbook, and I feel I am a part of that team, and I am proud of what I have done with that.”*

Others noted that increased visibility has brought its own set of problems because it has revealed the superficial understanding of mental illness and its dynamics within health, social services, and justice systems.

5.3.3 Kinds of illnesses and issues

Key informants reported that there is more anxiety and depression because of pressure and stress in individual lives. Health professionals say cases are becoming more complex, and there are new substance issues to deal with. Many say that the number of patients with multiple problems is on the rise. There are lengthy wait lists, and the reasons are varied: sometimes, wait lists are a result of increased awareness and demand for services, sometimes the wait lists are evidence of fewer resources to respond to need.

Others noted philosophical shifts in policy, program, and government approaches: *“We have moved full circle from abstinence, to harm reduction, back to abstinence again.”* Alternatively, there are others who see welcome changes in practice and approach: *“We are shifting from mental illness to mental wellness.”*

5.4 WHERE ARE THE GAPS?

Key informants described the gaps in mental health as funding, access, and knowledge. Most key informants said more money is needed to support delivery of community-based services, to provide home support, and to increase income support, especially for youth, and for drug coverage and infrastructure (housing, staff, training and professional development, and policy development).

For example, one informant noted, *“There’s an imbalance of money going to acute care and psychiatric services in hospitals and there’s a lack of money for community services such as those provided by the [Canadian Mental Health Association].”* Another said, *“There are only short term funding options, here for two years and then they are gone. The attitude is we’ll pour money in now and then choose something new in five years.”*

Access issues included addressing needs in rural and remote areas, developing alternate forms of service such as telecounselling and tele-psychiatry, and removing the barriers posed by services and materials that do not reflect the diverse linguistic, cultural, and immigrant communities in Atlantic Canada.

Knowledge issues focused on information and understanding. Key informants said there were gaps in knowledge concerning African Canadian women’s health, immigrants and mental health, evidence-based decision making, seniors’ mental health and mental illness, treatment for youth, and the development of competencies and standards in mental health services.

Issues related to gaps in understanding focused on stigma reduction and rights-based approaches, integration of philosophical approaches between addictions and mental health, and applying a gendered analysis to mental health and mental illness.

- *“There’s an absence of the gendered analysis regarding mental health. There’s a gender blindness that distresses me. Women are working in this field as social workers and*

psychologists, and they are burning out. Women are providing unpaid care as the family caregivers.”

- *“One important absence of post recovery rights for people with mental illness is recognition that people with mental illness are entitled to have access to services – housing, employment and education. There is a lack of recognition that people with persistent mental illness have the same right to enjoy what those who don’t have mental illnesses do.”*
- *“The mental health consumer often lives a life of poverty. Clearly, we haven’t provided or responded to the needs of the socially marginalized. It’s a terrible gap – I think a lot of mental health problems are caused by that or are made worse by that.”*

5.5 WHAT ARE THE OPPORTUNITIES?

The most consistent opportunity identified was collaboration, from removing the “silo mentality” that separates mental health and addictions services to sharing information between these and other health programs and social services.

Many informants said increasing coordination, as a means to share information and become more effective with service delivery such as reducing wait times, was essential. *“There’s greater interest in sharing resources; we have to do things differently, we share clients, we need to focus on what we do well.”*

Similarly, non-profit agencies in the mental health sector are also developing collaborative networks. *“There’s so much to do that everything is an opportunity. There are so many gaps, there are opportunities for innovation and improvement, if there were serious efforts made to address these problems.”*

“Visibility does give some leverage on resources. If you can get [systems] to see the links, you can piggy back the resources.”

Other opportunities identified included recognition of the use of population health approaches in health service planning and delivery, the development of provincial mental health and addiction strategies, the publicity the Kirby Report has given to mental health and mental illness in Canada and its place on the national agenda, and the focus on supporting immigration to Atlantic Canada.

5.6 WHAT ARE THE PRIORITIES?

The key informants generally identified the priorities in broad terms. The consultant has grouped them into three main categories: delivery, access, and knowledge.

DELIVERY	ACCESS	KNOWLEDGE
<ul style="list-style-type: none"> • Support mental health service providers 	<ul style="list-style-type: none"> • Improve community access to mental health services and community-based supports 	<ul style="list-style-type: none"> • Share available knowledge, expertise, best practices for mental health
<ul style="list-style-type: none"> • Establish competency-based standards for care in mental health 	<ul style="list-style-type: none"> • Decrease inequities in access and attend to mental health issues 	<ul style="list-style-type: none"> • Address capacity issues for research
<ul style="list-style-type: none"> • Develop different models of providing service 	<ul style="list-style-type: none"> • Offer better service for rural populations that are presently neglected 	<ul style="list-style-type: none"> • Build expertise among mental health professionals
<ul style="list-style-type: none"> • Develop forensic services 	<ul style="list-style-type: none"> • Build coalitions locally and provincially to advocate to government 	<ul style="list-style-type: none"> • Identify best practices
<ul style="list-style-type: none"> • Deal with concurrent disorders 	<ul style="list-style-type: none"> • Increase collaboration within systems to share the voices of clients affected by mental health and mental illness issues 	<ul style="list-style-type: none"> • Promote the value of early intervention, development of coping skills, and prevention in mental health
<ul style="list-style-type: none"> • Make the links stronger between mental health and addictions 	<ul style="list-style-type: none"> • Increase access to specialized mental health services 	<ul style="list-style-type: none"> • Focus on young people, seniors, immigrants, African Canadians, Aboriginal peoples

There were some variations among the local, regional, and provincial levels with respect to particular priorities for mental health. However, the key informants consistently identified collaboration and sharing as a means to achieve the desired outcomes from the identified priorities at all levels. This included the sharing of resources to assist the development of new programs and the sharing of information regarding programs, policies, and research about mental health and mental illness.

6. FUTURE ACTIONS

The mental health issues as captured in this scan are diverse and reflect the concerns and perspectives of the four Atlantic provinces. While there are some issues, such as suicide in Aboriginal communities and disengagement and anger in African Canadian communities that are specific to geography or constituency, there are also issues that are broader in scope.

Out-migration coupled with low birth rates and rapidly aging populations have been long-standing issues of interest and concern to policy makers in the Atlantic region. However, there are three other significant areas to consider for the future with respect to mental health and mental illness. These are:

- the long-term impact of returning Armed Forces personnel to the region,
- the diminishing human resource capacity among mental health service providers, and
- the expanding immigrant base and the diversity of needs and issues brought by this population.

While delivery of health services is the responsibility of each province depending on their needs and their resources, respondents were clear that more collaboration and joint support is necessary, and even essential, to addressing effectively the mental health needs of Atlantic Canadians. Many highlighted the benefits of working together to build creative responses with limited resources.

For instance, respondents identified the housing and support model offered by the Stella Burry Corporation in St. John's as an example of an innovative approach to responding to the shelter needs of people living with severe and persistent mental illness. Other examples of programs that could be shared across the regions included the "Changing Minds" education and training program of the Canadian Mental Health Association, Newfoundland and Labrador Division.

6.1 RECOMMENDATIONS

Although this scan represents a snapshot of mental health in Atlantic Canada today, it supports and extends the knowledge and analysis of previous work and identifies some areas for further action. The evidence collected through the literature supports the priorities identified by the key informants and the epidemiology review.

As noted earlier, respondents strongly support efforts to work regionally on addressing gaps in research, policy, and programming and to build on the information collected and the trends identified in this scan.

The recommendations reflect the mandate of the Public Health Agency of Canada and its Atlantic Regional Office in building capacity, developing knowledge, and facilitating collaboration. We recommend that the Atlantic Regional Office of the Public Health Agency of Canada implement the following:

Building community capacity

- 1) Support research and/or project development focused on innovative models of community-based mental health care service delivery that reflect the principles of population health, best practices, and evidence-based decision-making.

Developing knowledge

- 2) Support the development of gender-sensitive and culturally and linguistically appropriate mental health promotion materials including French language work.
- 3) Review existing and/or emerging mental health promotion, prevention, and recovery programs to address sensitivity and responsiveness to the concerns and perspectives of young people, seniors, immigrants, African Canadians, Aboriginal peoples, and women.

Facilitating collaboration

- 4) Facilitate the building of information/knowledge transfer networks re: new and existing best practices and evidence-based models of mental health services in the Atlantic region.

6.2 CONCLUSION

Throughout the research process, we have found that Atlantic Canadians feel passionate about the issues of mental health and mental illness. Whether they are policy makers, service providers, families, or consumers, the people in this region believe that more needs to be done to help those affected by mental health and mental illness, given how these issues impact upon individuals, families, and communities. Despite limited resources, challenging economic environments, and increasingly diverse experiences and needs, there is also hope, creativity, and commitment. The challenges for the future in the Atlantic region will be to balance priorities, respect differences, and manage competing agendas so that good mental health is achievable for all Atlantic Canadians.

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Appendix II: ANNOTATED BIBLIOGRAPHY

1. **Alberta Mental Health Board, *Mental Health Statistics in your Pocket*, Edmonton, 2006.** This text surveys provincial, national, and international data sets to organize and compare the economic impact of mental illness on Canadian society. The focus is on understanding the prevalence and nature of mental illness and identifying how and where mental health resources are used. The document frames its analysis on three planks: the burden of mental illness, the commitment of resources, and the performance of health systems in dealing with mental illness and mental health issues. The report provides comparative data across all provinces where available, thus permitting an analysis of the Atlantic region in relation to the rest of the country. Of particular interest is how the report examines the relationships among consumers, providers, and systems in cash terms and in relation to the effect of mental illness on individuals (out-of-pocket costs, insurance claims, etc).
2. **Atlantic Networks for Prevention Research, *An Environmental Scan of Health-Related Community Consultations in Atlantic Canada (1995-2005)*, Communities and Health Research Unit, Atlantic Networks for Prevention Research, Halifax, 2005.** This summary document synthesizes the results of a series of health-focused consultations carried over a 10-year period in Atlantic Canada. The primary health issues identified were mental health and mental illness followed by workplace health and safety, physical safety, respiratory problems, obesity, and poor nutrition. Mental health issues included work place stress, stress arising from food insecurity and poverty, social isolation and exclusion, depression, violence, and poor environmental conditions such as housing and geographic isolation. Several groups were highlighted as being at risk for poor mental health status: Aboriginal peoples, youth, elderly, and caregivers. The authors concluded that structural barriers and service deficits in the Atlantic region contributed to the decline in social supports that enable good mental health.
3. **Canadian Alliance on Mental Illness and Mental Health, *Framework for Action on Mental Health and Mental Illness*, 2006.** This document summarizes key points from the Kirby Report (2004) and identifies the critical areas for action as access, stigma, and national standards. The report uses a population health approach: for example, it notes that the absence of community supports and income support are barriers to recovery from mental health issues. The authors also carried out a comparative analysis of Canada's mental health service model with other countries in the Commonwealth: the United Kingdom, Australia, and New Zealand. The authors recommend that Canada become an international leader in mental health reform by focusing on leadership at the federal and provincial levels, establishing national data and surveillance processes, carrying out research, and implementing mental health promotion initiatives.

4. **Canadian Institute for Health Information. *How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants*, Ottawa, 2006.** The key purpose of this report is to provide a comprehensive analysis of the health status of rural Canadians and to foster understanding of their particular health needs. The report finds that rural Canadians, while having poorer health status compared to their urban counterparts, also experience a greater sense of community and belonging. Rural Canadians experience higher death rates from heart disease, injuries, and suicide. The report identifies higher rates of poverty, unemployment, and isolation as factors related to the higher suicide rate among rural Canadians. Other issues compromising the mental health of rural Canadians are lack of control over work and life issues and negative life experiences. However, the researchers noted that their data analysis found no significant difference in the prevalence of mental disorders between rural and urban areas. They qualified their remarks by noting their data were based on self-reported data collected by the Canadian Community Health Survey. The report, in addressing mental health and mental disorders, is focused primarily on suicide in rural populations but contains no information discussing regional differences, if any. The report acknowledges that some data sets were not sufficient to carry out this level of analysis.

5. **Canadian Mental Health Association, Prince Edward Island Division, *Pain, Perseverance & Passion: A Report on the Support Needs of Individuals with Severe and Persistent Mental Illness on Prince Edward Island*, 2004.** The authors of this study collected data to identify key priorities for intervention and program development. Data were collected from individuals, family members, and service providers. The report presents quantitative and qualitative data collected through interviews and focus groups, resulting in a particularly rich description of the needs and experiences of individuals living with severe and persistent mental illness in Prince Edward Island. The priorities for action focus on services, education, and income support. Secondary considerations include home support, financial assistance for education, and oral health care. The report highlights the need for appropriate information, timely referrals, and education regarding stigma.

6. **Cape Breton Wellness Centre, University College of Cape Breton, *Raising the Roof: Developing a Youth Sexuality Education Program while Adopting a Mental Health Promotion Approach*, Health Canada, Ottawa, 1999.** This report documents the results of a mental health promotion project designed for youth in Cape Breton, an area of Atlantic Canada facing considerable challenges economically. The report builds on earlier analyses identifying youth as a key population at risk for diminished mental health as a result of community pressures and stressors. The project tactics highlight knowledge gathering and information sharing as well as safety and respect for youth participants. The results have demonstrated improvements in feelings of confidence and empowerment among teens with respect to choices and decision-making.

7. **Citizens for Mental Health, *Mental Health Priorities of the Voluntary Sector: Development of a Framework for Action*, Canadian Mental Health Association, 2004.** This report is the result of an interactive, collaborative, and consultative approach to identifying national and regional priorities for mental illness and mental health in Canada. The consultations focused on two questions: what are the main issues and how should they be dealt with federally. Possible areas for action were suggested, including research, education, surveillance, standards, service models, and legislation. The results include a focus on networking, building relationships, and greater clarity regarding federal roles and responsibilities. In Atlantic Canada these include housing, income support, legal/justice issues, immigration, stigma/public education, lack of appropriate and comprehensive services, and a need to focus on children. The final synthesis approach identifies three ideals, 11 guiding principles, and eight priorities: housing, criminal justice, employment, income, culture, immigration/settlement, mental health promotion, and health services. The authors of the report note its limitations in addressing the specific needs of communities of interest, but, nonetheless, the priority issues identified can be used to analyze the needs of various populations as required.
8. **Decima Research Inc., *Informal/Family Caregivers in Canada: Caring for Someone with a Mental Illness*, prepared for Health Canada, 2004.** This document examines the experience of caregivers looking after family members living with a mental illness. The purpose was to create a profile of this particular caregiving experience, including the caregiver, the recipient, and the type of care provided. The study identifies a gap in support and assistance with caregiving responsibilities associated with this population. The study also identifies caregiver stress as a significant impact of managing care responsibilities, as well as the inability to cope with care demands and the lack of regular respite. While the authors undertook a gender analysis of the data, their report does not provide a regional analysis of the data collected.
9. **Elizabeth Fry Society of Mainland Nova Scotia, *Women in Nova Scotia, Mental Illness, and the Criminal Justice System: A Qualitative Review*, Halifax, 2005.** This report offers an insightful and gendered examination of the criminalization of mental health issues. Based on key informant interviews, and supported by an extensive literature review, the report finds that women are misdiagnosed or undiagnosed, and subsequently they fall through gaps in the health and justice systems. A key issue for women is access to supportive services while reintegrating into the community post-incarceration. The researchers conclude that women-centred mental health approaches should provide continuity of care, options for women-only programs and services, and recognition of women's roles as mothers and caregivers.
10. **Etowa, Josephine, Barbara Keddy, Julius Egbeyemi, and Felicia Eghan, "Depression: The "Invisible Gray Fog" Influencing the Midlife Health of Black Women," *International Journal of Mental Health Nursing*, forthcoming Summer 2007.** Etowa et al find that family and community responsibilities create stress and pressure, ultimately taking a toll on the women's health. African Canadian women are

reluctant to name their symptoms as depression. The stigma attached to many mental health issues results in isolation and limited support. In this paper, racism was identified by respondents as a key factor in their experiences of depression and in undermining their efforts to take care of themselves.

11. **Foulem, Ghislaine, *Repercussions of Poverty and of the Crisis in the Fisheries on the Health of Young People in the Acadian Peninsula*, prepared for the Population and Public Health Branch, Atlantic Regional Office, Health Canada, Halifax, 2000.** This report profiles youth on the Acadian Peninsula of New Brunswick and their experiences growing up and living in an economically challenged environment where out-migration is a significant concern. Youth reported concerns with self-esteem and suicide, although they noted fear, stigma, lack of knowledge in dealing with suicide, and being unable to give voice to their feelings about this issue were factors preventing them from making any changes. The researchers conclude that the involvement of youth in planning and carrying out the study provided more useful data, as youth felt more involved and freer to share their experiences and ideas.
12. **Gilmour, H. and S. Patten, “Depression and work impairment,” *Health Reports, Statistics Canada, Vol 18. No 1, February 2007.*** Increasing interest in understanding the impact depression poses on productivity and the individual in terms of work performance prompted the researchers to undertake an in-depth analysis of data collected from the Canadian Community Health Survey. The researchers find that factors such as gender, income status, type of occupation, chronic illness, addictions issues, or anxiety disorders are present in those workers reporting episodes of depression. The researchers note that symptoms of depression can negatively affect job performance leading to other complications including safety concerns. A limitation of the study is the reliance on self-reported data, as opposed to workplace observation by the researchers for the assessment of impairment. The researchers conclude that workplace support, sensitivity to work schedules, and job satisfaction may positively affect outcomes in cases where workers are affected by depressive episodes.
13. **Government of Newfoundland and Labrador, *Working Together For Mental Health: A Provincial Policy Framework for Mental Health and Addictions Services in Newfoundland and Labrador*, St. John’s, 2005.** This document sets out a comprehensive strategy for the mental health and addictions system in Newfoundland and Labrador. The policy framework supports consumer and family participation and promotes greater responsiveness to their changing health and social needs by establishing better connections among all levels and parts of the health and community services system. The strategy identifies five key directions: enhancing prevention and early intervention, involving consumers and significant others, building bridges for better access, providing quality mental health and addictions, and, demonstrating accountability.

14. **Hayward, Karen and Ronald Colman, *The Tides of Change: Addressing Inequity and Chronic Disease in Atlantic Canada. A Discussion Paper*, prepared for the Population and Public Health Branch, Atlantic Regional Office, Health Canada, Halifax, 2003.** This report provides a significant review of population health issues in the Atlantic region. It makes the links among inequities, chronic disease, and health outcomes. The researchers show how education, adequate income, and social support can mitigate the impacts of poverty, exclusion, and disease. The researchers support a shift in focus from individual strategies to dealing with social and economic root causes. The report presents evidence, identifies patterns, and presents trends in illness in the region. Perhaps the strongest part of this report is its identification and promotion of the Atlantic region's strengths and capacity, described as "*the strong network of social supports in this region [that] contribute to a decent, caring society which values social justice, decency, and equity.*"
15. **Health Canada, *Best Practices: Concurrent Mental Health and Substance Use Disorders*, Ottawa, 2002.** This report focuses on addressing knowledge and practice issues related to the dual diagnosis of mental illness and addictions; thus its primary audience are managers or practitioners in the field. The report examines how to define the parameters of dual diagnosis and associated practice issues, the implications of integrated treatment approaches, and the framework for best practice guidelines including screening, assessment, and treatment/support protocols. The report identifies alternative strategies and suggestions for future research. The recommendations focus on implementing changes at the service delivery and system levels within or across specialized substance abuse or mental health programs.
16. **Health Canada, *Telemental health in Canada: A status report*, 2004.** Health Canada notes that telemental health services, unlike other telehealth services, is focused more on clinical services rather than educational or administrative services. Further, the researchers conclude that program developers must recognize the complexity of service implementation and delivery. The report identifies several key lessons arising from implementation: careful planning is critical; uptake is gradual and the project can take several years to fulfill its potential; evaluation should be built into every program or initiative and should be adequately funded; many mental telehealth projects have found that real economies of scale are possible, although more information is required to make accurate comparisons for cost-effectiveness; there are demonstrated benefits to clients and providers, but patients are more easily converted than providers; telehealth programs can be creative responses to limited access and professional staff shortages, but can also limit growth; and a comprehensive, multi-faceted strategy for managing change is crucial to success. The Health Canada report discusses provincial and territorial experiences with telemental health. The report notes that although Newfoundland and Labrador has been a leader in implementing telehealth services, integration within the health system continues to be a challenge.
17. **Jensen, Lisa and Stephen Kisely, *Public Health in Atlantic Canada: A Discussion Paper*, prepared for the Atlantic Regional Office, Public Health Agency of Canada, Halifax, 2005.** This paper studies the public health environment in Atlantic

Canada through a literature review and stakeholder survey. The report is a meta analysis of key public health issues and challenges in the region. With respect to mental health, the researchers identify some gaps; for example, healthy living initiatives are sometimes narrowly defined and ignore mental health components. Respondents identified mental health, addictions, and mental health promotion as priority issues needing action within the public health mandate of the Public Health Agency of Canada. The value of this report lies in its broad view of population health through an Atlantic Canadian lens. It is most useful in setting the context for the kinds of challenges and barriers that exist to making a difference, e.g., “*a lack of funding and resources for public health; challenges in working both across jurisdictions and within sectors; the disconnect between practice, research, and policy; an overall public focus on health care services; and fragmentation within the public health system.*”

18. **Lesage, A., H.M.Vasiliadis, M.A. Gagné, S. Dudgeon, N. Kasman, and C. Hay, *Prevalence of Mental Illnesses and Related Service Utilization in Canada: An analysis of the Canadian Community Health Survey, Canadian Collaborative Health Initiative, Mississauga, 2006.*** This report is included as a source document for the epidemiological analysis of this environmental scan. It analyses self-reported data collected through the Canadian Community Health Survey, with national and provincial comparisons. In its descriptive analysis of the data, the authors conclude that it is stigma, and not necessarily lack of access to services, which inhibits individuals from seeking help.

19. **May, Douglas, *Atlantic Canada: The Have Provinces? Health and Wellness & Crime and Safety*, prepared for the Atlantic Summer Institute on Healthy and Safe Communities, Memorial University of Newfoundland and Newfoundland and Labrador Statistics Agency, 2005.** Like the Jensen and Kisely report, this document offers an overview of Atlantic Canadian issues and provides a unique statistical analysis of the Atlantic region’s strengths in addressing issues related to health, wellness, crime, and safety. The author is an economist who was instrumental in developing the Community Accounts web-based data clearinghouse. Dr. May uses a strengths-based approach to identify social indicators which promote Atlantic Canada as a “have” region as opposed to a “have-not” one. In this report, Dr. May addresses mental health on two levels – disease and social impact (familial/community relationships) – and discusses the connections to crime and safety. The paper also discusses the value of social capital as a key indicator for “have” status and recommends further analysis and study of the implications for the Atlantic region.

20. **Mirolla, Michael, *The Cost of Chronic Disease in Canada, Chronic Disease Prevention Alliance, Ottawa, 2004.*** This comprehensive report offers an extensive analysis of the costs of chronic disease in Canada. Of particular value is the chapter examining the costs of mental illness; the links between chronic stress, considered the most costly of “modifiable” risk factors; the incidence of diseases such as hypertension, heart disease, and cancer for example; and the benefits of psychosocial interventions in mental illness. The author argues that mental illness can precede

physical issues and conversely, that good mental health can facilitate healing and the development of well-being following a physical illness. The report examines the changing trends in data and looks at mental health and social well-being data from Atlantic Canada collected through the Canadian Community Health Survey. The author concludes that investment in mental health will have visible positive effects on costs related to chronic disease.

21. **Nova Scotia Department of Health, *Our Peace of Mind: Mental Health Promotion, Prevention and Advocacy Strategy and Framework for Nova Scotia, Halifax, 2004.*** The Nova Scotia framework focuses on prevention, promotion, and advocacy of mental and emotional health. The document offers a service model and a process and templates to implement promotion, prevention, and advocacy activities. The framework examines specific issues related to mental health promotion, stigma, suicide prevention, and implementation. There is an extensive collection of appendices presenting profiles and needs of target populations, literature from other sectors and jurisdictions, regional data, suicide intervention models, and risk factors.

22. **Parent, Karen and Malcolm Anderson, *Home Care & People With Psychiatric Disabilities: Needs & Issues, Canadian Mental Health Association, Toronto, 2000.*** In 2000, the Canadian Mental Health Association carried out three pilot projects providing home support to people with mental illness to explore delivery issues, to identify practice guidelines, and to examine policy implications. St. John's was one of the three sites; the other two were in Alberta and Ontario. The study reports several key findings: access to home support for this sector is limited to non-existent; existing services are not appropriate; awareness of available services is absent; support for families is needed; home support can make a difference; a brokerage model can improve access to service; non-traditional service delivery models have the potential to enhance the preventative and maintenance functions of home care; integration can improve service; integration and outreach work well in rural communities; housing, homelessness, and home care are intertwined; home care providers could increase service levels if resources were available to support their capacity to serve people with mental illness; safety concerns need to be addressed; and leadership and direction are needed at the political and ministerial levels. The report makes 10 recommendations based on these findings and also identifies policy implications for national standards and housing.

23. **Population Mental Health Monitoring Working Group, *Establishing A Mental Health Monitoring Framework: Phase 1 Report, prepared for the Mental Health Steering Committee of Nova Scotia, Halifax, 2002.*** This report presents baseline data on the mental health of Nova Scotians and offers a beginning for a monitoring framework to document prevalence and outcomes related to mental health and mental illness. The proposed framework addresses sources of data; the development of mental health indicators; collection of best practices; identification and recommendations related to effective tools for monitoring; identification of "end-users" of the data collected; and the development of an action plan for implementation. In its review of

existing data, the report also provides additional information relating to outcomes of the Stirling County longitudinal study on mental health.

24. **“Random Samples: Stirling County’s Golden Years,” *Harvard Public Health Review*, Winter 2002.** This article profiles the key components of an American longitudinal study of mental health in a Nova Scotia community. The study, which began in 1952, has expanded its sample on two occasions, providing a profile of the prevalence of mental illness across generations and populations within the sample. As an example, the article notes that while the incidence of depression has remained consistent during the duration of the study, its distribution in the population has changed. The authors identify gender differences in depression: 83 % of men described as depressed experienced catastrophic effects (e.g., remaining chronically depressed), compared to 43 % of women with depression.

25. **Reitmanova, Sylvia, *Mental Health of St. John’s Immigrants: Concepts, Determinants, and Barriers*, Memorial University of Newfoundland MSc. thesis, April 2006.** This thesis uses a small sample of research subjects to develop a preliminary understanding of the immigrant experience of mental health and mental illness in Newfoundland and Labrador. The absence of knowledge about this experience, coupled with the challenges of language, culture and social upheaval, has meant existing mental health services are ill-prepared to address the needs of immigrants living with mental illness or mental health issues. The researcher applied a population health approach to her analysis and examined the impacts of isolation, unemployment, and poverty as factors contributing to the development of mental health/mental illness issues in this population. The researcher makes recommendations for further work in this area, including improvements in service delivery, identification of support programs, and awareness of the barriers preventing immigrants from seeking treatment and assistance.

26. **Seguin, Monique, Alain Lesage, Gustavo Turecki, France Daigle, and Andrée Guy, *Research Project on Deaths by Suicide in New Brunswick Between April 2002 and May 2003*, Douglas Hospital Research Centre and Government of New Brunswick, 2005.** In response to a high suicide rate in New Brunswick, the authors looked at those factors leading to suicide in order to identify effective strategies to support individuals and families living with mental illness. The key findings of the study include noting that suicide victims had long-term mental health issues which could have been managed more effectively when they accessed services; that almost two-thirds experienced significant addictions at the time of their deaths; almost three-quarters had struggled with addictions issues throughout their lives; almost 70 % of victims experienced an affective disorder such as depression at the time of their deaths; mental health and addictions services are not well-equipped to support individuals with multiple, complex issues because of systemic barriers which inhibit collaboration and coordination; and while awareness of suicidal ideation among victims was high, facilitating help seeking or therapeutic intervention was low. The report proposes making changes through four trajectories: governance, intervention,

prevention, and evaluation/research. The report also supports integration of addictions and mental health approaches to improve rates of treatment and service provision.

27. **Standing Senate Committee on Agriculture and Forestry, *Understanding Freefall: The Challenge of the Rural Poor*, Ottawa, 2006.** This report documents the situation of rural Canadians who are poor, using the agricultural sector as its lens for analysis. Mental health issues relate to access to services – rural residents seeking help must travel greater distances to urban centres to get help – and isolation. Further, the report identifies farm men as increasingly facing challenges to maintaining good mental health as a consequence of rural (farm) decline. The report is particularly useful in its efforts to define and describe rural Canada to effect a common understanding of that experience.

28. **Starkes, J.M., C.C. Poulin, and S.R. Kisely, “Unmet need for the treatment of depression in Atlantic Canada,” *Canadian Journal of Psychiatry*, Sep; 50 (10):580-90, 2005.** The researchers used material collected from the Canadian Community Health Survey to explore the prevalence of depression and to identify any patterns in the use of mental health services among certain populations. Previous research indicated that most people experiencing depression do not receive treatment even though it is available. The researchers examined the factors related to untreated depression in the Atlantic region. Key observations include: women, singles (widowed, separated, or divorced), people with low incomes, and individuals with two or more medical issues face a higher risk for depression; only 40% of people with probable depression reported any contact with a service provider; and less than 25% reported receiving appropriate levels of care. The researchers identify seniors, people with low levels of education, and those living in rural areas, as significantly less likely to receive treatment as other populations. The researchers conclude that there is a need to target at-risk populations through public awareness and to increase access to services through improved understanding about the underlying factors affecting help seeking.

Appendix III: KEY INFORMANTS LIST

Sharon Barnes, Mental Health Consultant, Department of Health and Community Services, Government of Newfoundland and Labrador

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Barbara Broom, Clinical Nurse Specialist, Mental Health, Children and Youth, Atlantic Regional Office, First Nations and Inuit Health Branch, Health Canada, Nova Scotia

Ted Callanan, Faculty of Medicine, Memorial University of Newfoundland, Newfoundland and Labrador

John Campbell, Director, Mental Health and Addiction Services, Annapolis Valley Health, Nova Scotia

Jeanne-Mance Chiaisson, Acadian Peninsula (French) Program Manager, New Brunswick

Geoff Chaulk, Executive Director, Canadian Mental Health Association, Newfoundland and Labrador Division

Elizabeth Church, School Psychology, Department of Education, Mount Saint Vincent University, Nova Scotia

Bertrand Collin, Director of CMHS, Addiction Services, New Brunswick

Mike Egan, Veterans Affairs Canada, Prince Edward Island

Josephine Etowa, School of Nursing, Dalhousie University, Nova Scotia

Bianca Horner, Department of Psychiatry, Dalhousie University, Nova Scotia

Jean Hughes, Professor, School of Nursing, Dalhousie University, Nova Scotia

Danny Jardine, Regional Manager, Health Region 2 Supported Employment and Housing, Long-Term Mental Health Services, New Brunswick

Archie Kaiser, Professor, Law and Psychiatry, Dalhousie University, Nova Scotia

Stanley Kutcher, Sun Life Chair in Adolescent Mental Health, Dalhousie University/IWK Health Centre, Nova Scotia

Eugène Leblanc, Activity Centre Director and Publisher of *Our Voice* consumer newspaper, New Brunswick

Rosanne LeBlanc, Manager, Drug Strategy and Controlled Substances Program, Atlantic Regional Office, Healthy Environments and Consumer Safety Branch, Health Canada, Nova Scotia

Anne-Marie Leger, Senior Policy Analyst, Atlantic Regional Office, Health Policy Branch, Health Canada, Nova Scotia

Jane MacDonald, Safe Environments Liaison Officer, Atlantic Regional Office, Healthy Environments and Consumer Safety Branch, Health Canada, Nova Scotia

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Barbara Martin, New Brunswick Aboriginal Women

Debbie Sue Martin, Director, Mental Health and Addictions, Department of Health and Community Services, Government of Newfoundland and Labrador

Phyllis Marsh-Jarvis, President, Health Association of African Canadians, and Co-Chair, Southeastern Community Health Board, Nova Scotia

Thomas Mills, Director of Public Prosecutions, Department of Justice, Government of Newfoundland and Labrador

Karen Moores, Social Worker, Military Family Resource Centre, Newfoundland and Labrador

Sheila Morrison, Family Advocate, Nova Scotia

Roy Muise, Consumer Advocate, Self-Help Connection, Nova Scotia

Josephine Muxlow, Clinical Nurse Specialist, Adult Mental Health, Nova Scotia

Donna Phillips, Executive Director, Elizabeth Fry Society, Nova Scotia

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Linda Smith, Executive Director, Mental Health, Children's Services and Addictions Treatment, Government of Nova Scotia

Carol Tooton, Executive Director, Canadian Mental Health Association, Nova Scotia Division

Deborah Warren, SIDA-AIDS Moncton, New Brunswick

Gwen Watts, Director, Mental Health and Addictions, Health Labrador

Barb Whitenect, Director, Addiction and Mental Health Services, New Brunswick

Appendix IV: KEY INFORMANTS QUESTIONNAIRE

- 1) Tell me about the three most important issues you are facing today in your work that relate to mental health/mental illness.
- 2) What do you think are the emerging issues for mental health and mental illness in the Atlantic Region?
- 3) What can you tell me about these issues that make them different from issues you worked on five years ago? Ten years ago?
- 4) What are the gaps? What are the opportunities?
- 5) What are the mental health priorities for your organization? Your community? Your province? The Atlantic Region?

**Appendix V: ATLANTIC MENTAL HEALTH PROFILE
SUMMARIZED FROM *THE TIDES OF CHANGE*⁹⁵**

There is a distinct split in mental health status among the four Atlantic provinces, with Newfoundland and Labrador and Prince Edward Island having higher levels of mental health than the Canadian average, and Nova Scotia and New Brunswick having lower levels.

Newfoundland and Labrador and Prince Edward Island report high levels of mental well-being and low levels of chronic stress. In 2001, high stress was 40% less common among residents of Newfoundland and Labrador than among other Canadians. In Prince Edward Island, chronic stress levels were 23% lower than the national average.

Residents of Newfoundland and Labrador are 30% more likely than other Canadians to report high levels of psychological well-being. Prince Edward Island has a rate of psychological well-being 17% higher than the national rate. In contrast, both Nova Scotia and New Brunswick have lower levels of psychological well-being than other Canadians.

Across Canada, 7.1% of the population is considered to be likely to become depressed. This rate of risk for depression is lower in Newfoundland and Labrador (4.7%) and in Prince Edward Island (5.8%). The rate is higher in both Nova Scotia (8.7%) and New Brunswick (7.7%). The regions with the highest risk of depression in Atlantic Canada are in Nova Scotia – Colchester, Cumberland, and East Hants counties (11.6%) and Cape Breton (9.8%) – and in the Moncton region of New Brunswick (10.7%).

Newfoundland and Labrador, Prince Edward Island, and Nova Scotia all have suicide rates lower than the Canadian average of 12.9 per 100,000 people, but these rates conceal some differences within provinces. Newfoundland and Labrador's low provincial average of 7.3 per 100,000 conceals a very high rate of suicide in Labrador (19.2 per 100,000) where Aboriginal peoples make up 28.7% of the population. Prince Edward Island's suicide rate of 11.0 per 100,000 hides an urban-rural split: the rate is higher in urban Charlottetown and Summerside (14.1) than in the rural areas of the province (8.3). At 11.6 per 100,000, Nova Scotia's suicide rate is also lower than the national average.

New Brunswick's suicide rate of 13.4 per 100,000 is higher than the national average, and it, too, masks an urban-rural difference. However, in New Brunswick, in contrast to Prince Edward Island, the rates are higher in rural areas than in urban: Saint John (9.2), Fredericton (10.6), and Moncton (12.3) are all below the national average, while the Edmundston area in the western part of the province (24.9) and the Campbellton area in northern New Brunswick (22.8) have the highest rates of suicide in the Atlantic region.

⁹⁵ Hayward and Colman, op. cit.