“Structural Barriers to Accessing Mental Health Care As Experienced By the
Respondents of the Canadian Community Health Survey, Cycle 1.2 Mental Health and
Well-Being”

by

Ashley Marie Towns, B.Sc., McMaster University

A Thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfilment of the requirements for the degree of
Master of Social Work

School of Social Work

Carleton University

Ottawa, Ontario

January, 2010

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Your file *Votre référence*
ISBN: 978-0-494-68625-6
Our file *Notre référence*
ISBN: 978-0-494-68625-6

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submitted by Ashley Marie Towns, B.Sc.

In partial fulfillment of the requirements for
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Karen Schwartz

Thesis Supervisor

Hugh Shewell

Director, School of Social Work
Carleton University

January, 6, 2010

Abstract

Access to mental health care for those experiencing a mental illness is essential, yet access to care is not equal for all. Past research suggests that there are barriers to accessing mental health care (Henderson, 2002; Kessler, Berglund, Bruce, Koch, Laska, Leaf, et al., 2001; Reiger, Narrow, Rae, Manderscheid, Locke & Goodwin, 1993). These include gender (Addis & Mahalik, 2003; Ang, Lim & Tan, 2004), age (Swartz, Wagner, Swanson, Burns, George, & Padgett, 1998), race, (Willie, Rieker, Kramer & Brown, 1995), education level achieved (Wang, Lane, Olfson, Pincus, Wells & Kessler, 2005; Steele, Dewa & Lin, 2007), and income level (Swartz, et al., 1998). By using data from the Canadian Community Health Survey Cycle 1.2 Mental Health and Wellbeing (2001) this study assessed access to mental health care in the Canadian context. Results found that males, youth and seniors, people who achieved lower levels of education and those earning a higher income, did not access mental health care when needed. Other factors affecting access, including, location of services, payment for services, peer support, and access to care from social workers, were also assessed. Understanding the structural barriers preventing access to mental health care makes it possible to improve the mental health care system.

ACKNOWLEDGMENTS

This project would not have been possible without the support of many people. First, I would like to thank Dr. Karen Schwartz, my supervisor, for her continued guidance and help every step of the way. I would also like to thank Ann-Marie O'Brien for her interest in the project and input throughout the process. Also, thank you to my fellow MSW students, who provided me with interesting and intelligent discussion that helped me develop my research. Lastly I would like to thank my family and friends who offered love and support throughout the entire process; this would not have been possible without you.

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Structural barriers to accessing mental health care as experienced by the respondents of the Canadian Community Health Survey, Cycle 1.2 Mental Health and Well-being

Understanding mental illness is very important as it affects people of all ages, races, educational levels and income levels. All Canadians will be affected by mental illness at some point in their lives, whether it is directly or indirectly through the illness of a family member, friend or colleague (Kirby, 2006). In 2002, it was reported that twenty percent of all Canadians will personally experience mental illness at some point during their lives (Health Canada, 2002). Until very recently mental health and mental illness were issues not often spoken about in the public domain because the stigma surrounding mental illness was prominent (Corrigan, Markowitz, & Watson, 2004; Health Canada, 2002; Rusch, Angermeyer & Corrigan, 2005). However, in the more recent years mental health and mental illness have become more visible.

In 2006 Senator Michael Kirby and the Standing Senate Committee on Social Affairs, Science and Technology released the first national mental health report titled *Out of the Shadows at Last* (Kirby, 2006). The report discussed and made recommendations about a variety of issues, including, but not limited to, legal issues, children and youth, seniors, addiction, self-help and peer support, research and telephone mental health hotlines. The report also brought a human face to mental illness and addiction by incorporating the stories of Canadians. This report brought to light many of the important issues that had been hidden and by doing so has made it possible to begin addressing them.

In 2007, as part of the recommendations of the Kirby Report, the Mental Health Commission of Canada (MHCC) was created. The MHCC intends to address some of the other recommendations made by Kirby in 2006. Their three strategic objectives are (1) to develop a national mental health strategy, (2) to conduct a ten year anti-stigma campaign and (3) to build a national knowledge-exchange centre (Kirby, 2008). Most recently the committee has been working to develop a National Mental Health Strategy which is long overdue as Canada is the only G8 country without one. In January 2009 a draft framework for the strategy was released in order to solicit feedback from stakeholders as well as the public (MHCC, 2009). As Canada moves forward with its National Mental Health Strategy it is crucial to gain a more thorough understanding of the factors that affect access to mental health care and services. There is no better time to determine what the problems with the current system are and to start addressing them, than right now.

Social workers have played a substantial role in the mental health field since the early development of service delivery in Canada. In the first half of the twentieth century mental health services were offered in institutions. In the late 1960s de-institutionalization began which eventually led to more and more services being offered in the community as opposed to in an inpatient setting (Nelson, 2006). With these changes came changes in the social workers' role in mental health services. They have gone "from providing social histories and supervising community placements to being a member of an interdisciplinary team or an independent practitioner" (Heinonen & Metteri, 2005).

One of the most important pieces that a social worker can provide in a mental health setting is an understanding of the social context (Heinonen & Metteri, 2005). This

helps all involved go beyond the biomedical perspective in order to understand and address the social inequities and structural issues affecting the situation. Being able to see the social context as well as the individual allows social workers to both help the individual with their own issues as well with structural, public issues.

Like any health issue, access to services is very important. Without seeking care an individual will suffer needlessly and may not realize that they are not alone in their situation. Unlike health services provided in a hospital or by a general practitioner, not all of the outpatient services for mental health are covered by provincial health insurance. For example, a psychologist or other counsellor is not covered by provincial health insurance unless seen while admitted to a hospital. This factor affects who accesses care. If only certain individuals access care this means that there are individuals left out who may need care but can not access it.

In Canada the approach towards health care is that access should be based on need and not the ability to pay. This is the case for most basic health care services, such as those provided by a general practitioner or in a hospital (Canada Health Act, 1984). However, as mentioned above this is not the case with all mental health services. Literature from other countries discusses other possible barriers to mental health care as well. Determining what these barriers are will allow mental health professionals and the MHCC to work towards creating a more efficient and effective mental health system in Canada.

The current study will attempt to determine if structural barriers that affect access to mental health care in other countries have the same effect on access to mental health care services in Canada. The study will look at age, gender, race, education and income to

determine what structural barriers are related to a lack of access to mental health care.

Understanding what the structural barriers are and who is affected will have implications for social work practice and policy.

Theoretical Perspective

Structural Social Work

Structural social work theory will frame this research project as the main purpose is to look at structural barriers that affect access to mental health care. The structural approach to social work was developed in the mid-1970s by the faculty at the School of Social Work at Carleton University, under the leadership of Maurice Moreau (Moreau, 1989). The basis of structural social work is that specific societal contexts cause individual and social problems as opposed to individual issues within the individual (Mullaly, 1997).

The purpose of structural social work is to change the social system and not just the individual (Mullaly, 1997). There are two main goals that structural social workers focus on. These goals are (1) “to alleviate the negative effects on people of an exploitative and alienating social order” and (2) “to transform the conditions and social structures that cause these negative effects”. The focus of this study encompasses the second goal as it aims to determine what the negative effects on individuals are in order to address the social structures and conditions that are affecting individual access to mental health care.

The primary focus of structural social work is to address oppression (Mullaly, 1997). Oppression occurs when what happens to a person is not due to individual merit or

failure but instead because of the individual's membership in a particular group of people dependent on factors such as race, gender, income, education, or sexual orientation.

Oppressors do not typically set out to oppress others intentionally; instead they see themselves as maintaining the status quo in order to protect the whole of society from a group they deem harmful to the current way of life.

Addressing the societal context that creates oppression is an essential part of structural social work practice. Structural social workers work towards societal transformation that eliminates oppression (Mullaly, 1997). By helping individuals at the same time as encouraging societal transformation, the root cause of the problems is addressed, thus preventing others from suffering.

Structural Social Work and Mental Health

Structural social work and mental health practice are often difficult to reconcile. Structural social work is about empowering individuals and helping them to feel and be in control of their lives, but mental health treatment often requires others to make important decisions for the individual, which takes away from the individual's control. Mental health law and policy authorizes the use of measures that require compulsory treatment when the individual meets the legal requirements, which completely takes away from the individual's ability to control their own life. For example, treatment is often offered in an inpatient setting and in some provinces individuals can be ordered by law to comply with treatment. Mental health service users have reported that treatment, in general, often exacerbates their feelings of powerlessness and lack of control over their own lives (Kirby, 2006). Though mental health care may create structural barriers to full

empowerment or full engagement in society, by identifying these issues, social workers can work toward addressing them. Helping individuals undergoing treatment be empowered so that they can be in control of their lives is part of the role of structural social workers (Schwartz & O'Brien, 2009).

Maurice Moreau, who first conceptualized structural social work, described five tasks of a structural social worker (Moreau, Frosst, Frayne, Hlywa, Leonard, & Rowell, 1993). These five tasks are (1) defence of the client, (2) collectivization of social problems, (3) materialization of social problems, (4) client empowerment, and (5) enhancing the client's power through self change. When a social worker engages in the above listed tasks they can help the client decrease the feelings of powerlessness and loss of control that involuntary treatment often results in. Even for those engaged in voluntary treatment, the social worker can help them understand their issues and feelings in the context of their environment (Moreau, et al, 1993).

There are a variety of structural barriers that can affect an individual's success in their treatment as well as their ability to seek out and engage in treatment. One of the key critiques of the traditional biomedical approach to treatment is that it does not take into consideration or address complex situations that individuals face (Burger & Luckman, 1966). For example, individuals may not be able to afford transportation to the location of their treatment, they may not be able to afford childcare or be able to take the time off of work. Individuals may also feel like treatment is not suitable for their particular needs. By determining the particular structural barriers that prevent access or the characteristics of individuals that do not access mental health care, structural social workers can begin to

focus on strategies to empower individuals and help them to be in control of their treatment options.

LITERATURE REVIEW

Canadian Health Care Ideology

Canadians are very proud of their health care system, a system which provides for Canadians based on need and not the ability to pay, at least in theory (Soroka, 2007). Since the Medical Care Act of 1966 was initiated, and even before that in some provinces, Canada has maintained a universally accessible, publicly funded health care system (Romanow & Marchildon, 2003). In 1984 the Canada Health Act solidified the four principles already established in 1966, public administration, universality, accessibility, and comprehensiveness and added a fifth, portability (CHA, 1984). While these principles work to maintain universal accessibility, the system is not flawless.

The design of the Canadian Health Care system is supposed to provide equitable access to mental health service for all. This means that “citizens get the care they need without consideration of their social status or other personal characteristics such as age, gender, ethnicity or place of residence” (Romanow, 2002). Unfortunately research has indicated that health care services in Canada are not equitable, despite the publicly funded health care system (Romanow, 2002).

Since health care is a finite resource it is understandable that there are waiting times and that not everyone gets the services that they need exactly when they need them. The problem is that certain people are more likely to get the services they need than others and this results in health disparities among individuals (Romanow, 2002). The way in which the health care system works prevents certain individuals or encourages other

individuals to use the system. This results in an inequitable system and creates even greater inequality in society as those with ill health are often unable to work or provide for themselves.

As Martin Luther King once said, “of all the forms of injustice inequality in health care is the most shocking and inhumane” (Medicare, 2008). Essentially, an unequal health care system gives certain people, with particular characteristics, be it money, education or other factors, the right to be healthy, while denying this from other individuals. This is unacceptable and even though our system is equitable in theory it is important to work towards a health care system that is also equitable in practice.

Social Determinants of Health

Many of the structural barriers that affect access to health care have been captured in social determinants of health research. According to Raphael (2004), social determinants of health are defined as the “economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole” (Raphael, 2004, p. 1). In 2002, York University created a list of eleven social determinants of health. These include: Aboriginal status, early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, social safety net, social exclusion, and unemployment and employment security (Raphael, 2004, p.6).

The social determinants of health are widely used to understand why certain people have better health outcomes than others (Raphael, 2008). As mentioned, health care services is one of the social determinants of health. It has been found that certain individuals are less likely to access health care services than others and in turn are more

likely to have worse health outcomes (Raphael, 2004). In Canada, policy dictates that there is universal access to health care, but this is hardly true in practice. Factors that have been found to affect access to health care services are income, gender, race, immigrant status and geography (Raphael, 2004). If an individual does not have access to health care services, health problems left untreated may worsen. When individuals are unable to access adequate health care services, they become more susceptible to disease and unexpected illness. Factors that determine health outcomes, such as access to care, need to be addressed in order to improve the health of individuals.

In the fall of 2008 the World Health Organization (World Health Organization, 2008) released its report on Social Determinants of Health. The report highlights the effect that different factors have on individual health. In response to the report all member states of the WHO committed to improving the determinants of health in order to improve overall health. Social determinants of health are now on the radar screen. They are seen and understood as the key to improving global health.

Access to Health Care

One of the social determinants of health, and the focus of the current study, is access to health care. The link between access to health care services and health is fairly evident, as it is difficult to diagnose and address health care problems without the expertise of health care providers. While access to care is clearly important the other social determinants of health such as housing, education, employment conditions and food security affect access to care greatly and in turn affect health outcomes.

Until the environmental factors that affect health are improved the health care system will only continue to treat the symptoms and never fully address the underlying causes of them. However, preventative action can improve the situation that individuals face. By increasing access to preventative mental health care services more individuals will be able to benefit from preventative action that improves their health outcomes (WHO, 2008).

The WHO document “Closing the Gap in a Generation” provides recommendations on how to improve the mental health care that is currently available (p. 106). Where there is a lack of services the WHO recommends integrating mental health care into primary health services in order to increase the availability of services for individuals (WHO, 2008). Many other recommendations are also made that would increase access to care. For example, reducing the cost of care, initiating anti-stigma campaigns, encouraging family cohesion and peer support, are some of the interventions listed as ways to improve mental health care. By implementing some of the recommendations made by the WHO, a variety of different social determinants of health will be addressed, in turn resulting in increased access to care for individuals with mental health issues.

Mental Illness

Mental illness affects everyone at some point in their life time either directly or indirectly through a family member, friend or colleague. Approximately 20 percent of individuals will directly experience a mental illness at some point in their life. Mental illness is an alteration in “thinking, mood or behaviour associated with significant

distress, impaired functioning over an extended period of time” (Health Canada, 2002, p. 16). A mental illness manifests differently based on the individual, the family and the socio-economic environment.

Mental illness can take many different forms. Some of the main categories of illness include mood disorders, such as depression and mania, schizophrenia, anxiety disorders, personality disorders and eating disorders. In a study from the United States it was found that 54 percent of individuals with a mental illness also experience another mental illness or addiction. Alcohol or drug addiction occurs frequently with mental illness, as these substances are often used to self-medicate in an attempt to deal with the mental illness.

As mentioned, mental illness directly affects approximately 20 percent of the population. These individuals can be of any age and from any culture and socioeconomic background. Despite the fact that mental illness can affect anyone, it does tend to affect certain people more often than others (Health Canada, 2002). The Canadian Community Health Survey – Cycle 1.2 – Mental Health and Well-being (2002) (CCHS 1.2) gathered data about who is affected by mental illness. This will be discussed further in the results section of this paper.

It has been found that, in developed countries, mental illness accounts for four of the ten main causes of disability (Health Canada, 2002). Globally, depression has been ranked as the fourth leading cause of burden on society (Ali, 2002). This shows that not only does mental illness affect individuals and families, but it also has an economic impact in terms of productivity losses and health care costs. It was estimated in 1996/97 that the economic impact of mental illness in Canada is 14.4 billion dollars (Statistics

Canada, 1999). The burden of mental illness has only increased in the last decade.

Helping individuals to get the help they need to treat their mental illness will help decrease the hours of lost productivity, the costs on the mental health system and overall decrease the expense.

As previously mentioned mental illness is often not something that is out in the open. One of the main reasons that mental illness is not openly discussed or addressed is because of the widespread stigma and discrimination that comes along with it. Stigma often arises from superstition, lack of knowledge and empathy, old belief systems, fear and lack of knowledge (Health Canada, 2002). Education is one the major factors that can help prevent discrimination and decrease the stigma surrounding mental illness.

Developing and enforcing policies that address discrimination against those with mental illnesses is another way to decrease stigma. The Kirby Report (2006) lists the steps that can be taken to begin reducing stigma and help those who suffer from mental illness. As the recommendations from the Kirby Report begin to be addressed by the mental health community, including the MHCC, the situation will start to improve.

Mental Health Legislation

In 1983 the Canadian Charter of Rights and Freedoms was established. This legislation was significant in the mental health field because it meant that individuals who were mentally ill now had the same rights as everyone else. In particular, section seven of the Charter of Rights and Freedoms grants the right to life, liberty and security of the person to everyone. Shortly after the Charter of Rights and Freedoms was enacted, the Psychiatric Patient's Advocate Office (PPAO) was established in Ontario. The PPAO

was the first and largest provincial mental health advocacy program in Canada and was established to protect the legal and civil rights of inpatients in psychiatric hospitals (Psychiatric Patient Advocate Office, 2009). Over time, the PPAO has also come to protect the rights of those in mental health units of general hospitals and those being considered for a community treatment order.

The Charter of Rights and Freedoms and the PPAO have had a major impact on mental health legislation in Canada. Since health is of provincial jurisdiction in Canada, legislation is different in the different provinces and territories (Kirby, 2006). Mental health legislation “encompasses civil commitment (including involuntary hospitalization and various forms of mandatory outpatient treatment), decision making for mentally incapable individuals, and the protection and disclosure of clinical records” (Canadian Psychiatric Association, 2005). Mental health legislation is required because some individuals are prevented from making capable decisions due to their mental health condition. This legislation makes it possible for others to make decisions on behalf of the individual who has a mental illness and it ensures that the best possible decisions are made. Mental health legislation is required to “strike a balance between a citizen’s right to live safely in society and a person’s right to liberty and autonomy” (Canadian Psychiatric Association, 2005). Due to this, all mental health legislation in Canada must be compatible with the Charter of Rights and Freedoms.

Mental Health Care System

The origins of mental illness are vast and complex, and treatment for mental illness needs to reflect this. There is a variety of different treatment methods and

professionals that can help with mental illness. For maximum effectiveness the individual needs to be actively involved with their treatment and should have the ability to access services where they are needed (Health Canada, 2002). Treatment locations are often broken down into two different areas, the community and the institution.

In the late 1800s institutions were established in Canada in order to confine people with mental health problems who did not fit into regular society (Nelson, 2006). At this time there were no other options for treatment. Individuals were hospitalized and rarely left the hospital to go back to their families and communities. There were many problems with institutions including countless reports of abuse due to immense power imbalances between patients and staff (Nelson, 2006). As well, unethical research was often conducted, taking advantage of vulnerable patients (Burstow & Weitz, 1988).

In the early 1960s the deinstitutionalization movement began, moving those who had been hospitalized with mental illness, from the hospital or institution, into the community. This movement began for a few reasons. The cost of keeping patients hospitalized was starting to increase and was not sustainable (Nelson, 2006). As well, around the same time, the Canadian welfare system was being strengthened, creating a support system for those who were mentally ill, living in the community. A push to protect human rights in the 1960s also contributed to deinstitutionalization (Nelson, 2006). The limitations of institutions were no longer being tolerated. Instead a focus on community treatment was starting to take precedence.

The theory behind community treatment was that costs could be contained and individuals would be able to take part in society with the appropriate supports at their fingertips. Unfortunately, in the 1960s when individuals were being released from

institutions, the necessary services were not funded and not available to the majority of individuals. This left many people with mental illness in “psychiatric ghettos” (Nelson, 2006). Support outside the hospitals consisted mainly of medication which was inadequate without proper monitoring and emotional support. Many individuals were faced with economic, social and interpersonal problems. A study which followed individuals released from two different hospitals in Toronto, Canada found that six months after being released from the hospital, 33 percent had been readmitted to hospital, only 38 percent were employed, 68 percent reported moderate to severe difficulties in social functioning and 20 percent were living in inadequate housing (Goering, Wasylenki, Farkas, Lancee & Freeman, 1984).

The community mental health system is still drastically underfunded. Many treatment programs are working toward a more community oriented system that allows for clients to be empowered and take control of their treatment. By providing treatment in the community, the intention is to provide individuals with seamless care regardless of where they are. An example of this type of care is ACT Teams (Nelson, 2006). ACT teams are committed to accepting the consumer’s point of view with respect to their treatment options (Nelson, 2006). By allowing individuals to access the treatment of their choice in the community, research shows that they are more satisfied with their progress (Krupa, Eastabrook, Hern, Lee, North, Percy, Von Briesen & Wing, 2005; Redco, Durbin, Wasylenki & Krupa, 2004).

Overall, mental health services can be provided by a wide variety of professionals and other individuals. The majority of individuals seek mental health care in the primary health care system. However, general practitioners are typically the first point of access

into the mental health care system. General practitioners are unable to address mental illness because it requires a lengthy process that is not supported by the current payment schedule of general practitioners. The primary health care system is designed to deal with physical health problems in a fast and efficient manner; however it does not accommodate mental health problems (Romanow & Marchildon, 2003). General practitioners often recognize severe mental illness and refer their patients to the appropriate specialists, typically a psychiatrist (Romanow & Marchildon, 2003). Care can also be informally sought from other medical doctors and nurses. At times doctors will refer patients to psychologists, or individuals will seek out the services of psychologists on their own (Romanow & Marchildon, 2003). Social workers, religious advisors, counsellors and other health professionals can also encounter mental health issues from their service users.

Understanding which service providers to approach with mental health issues can be confusing. Professionals who do not undergo general medical training or who are not specialized in mental health care may not be able to provide adequate support. The CCHS 1.2 lists professionals who Canadians approach with mental health concerns, including those not equipped to deal with mental illness. This included anyone from medical doctors who are not specialized in mental illness to other professionals such as physiotherapists, acupuncturists and energy specialists. This gap in the mental health system can result in individuals falling through the cracks when they are unsure of whom to access or are improperly diagnosed by a professional who is inadequately trained in mental health. Addressing these gaps is important to improving access to mental health

services and in turn improving the mental health status of Canadians. When individuals are unable to access the appropriate care, they may resort to others for help.

The Role of Social Workers in the Mental Health Care System

Social workers play an invaluable role in the mental health system. Typically, mental illness is dealt with in the health care system. This is problematic because, while they are intricately linked, there are many important differences between physical health and mental health. In the case of mental health understanding and dealing with the environment or context in which an individual lives is essential. Dealing with the environment is the social workers niche, although this was not always the case.

As the mental health care system changed from an institutionally based system to one that emphasizes community care, the role of the social worker changed. Initially social workers were responsible for gathering social histories from patients and supervising community placements. Now social workers are an integral part of interdisciplinary teams (Canadian Association of Social Workers, 2001). Some of the key roles that a social worker plays includes, but is not limited to, ensuring that environmental or contextual factors in the individuals lives are addressed, the provision of therapeutic services, responsibility for working with the individual's family or support system and in capacity building (CASW, 2001).

An article by Renouf and Bland (2005) highlighted four key issues for social work practice in the mental health field. These issues were "(1) the need to establish a viable paradigm for practice, (2) a more positive response to the challenge of evidence based practice models, (3) a national agenda for education and training and (4) the importance

of working collaboratively with consumers and families in a way that values their human rights and the experience of mental illness” (Renouf & Bland, 2005). Determining barriers to accessing mental health care will help social workers move forward on all of these issues. By determining who is unable to access mental health social workers can improve their practice.

Barriers to Accessing Mental Health Care

As mentioned, access to mental health care is far from equal for all Canadians in need of care. Studies from outside of Canada have demonstrated this and even a few studies within certain regions of Canada have found similar results. Research shows that nearly one in five people are affected by a mental disorder each year and 60 to 75 percent do not access mental health care (Henderson, 2002; Kessler, Berglund, Bruce, Koch, Laska, Leaf, et al., 2001; Reiger, Narrow, Rae, Manderscheid, Locke & Goodwin, 1993). There are many social determinants of health, but for the current study the most important factors, for which there is also data available, are gender, age, race, income and education.

Gender

There are differences in the rates that men and women access mental health care. It has consistently been found that females are more likely to access mental health care than males (Addis & Mahalik, 2003; Ang, Lim & Tan, 2004; Morgan, Ness & Robinson, 2003; Vogel & Wester, 2003). A study by Mackenzie, Gekoski & Knox (2006), surveyed men and women of different age groups regarding their past use or likelihood of

future use of mental health services from a variety of service providers. The study found that while there was no difference in help seeking behaviour between the sexes when seeking care from a general practitioner, women were more likely to seek specialized mental health care. It was thought that females would be more likely to seek mental health care because of their openness to help seeking and acknowledgement of psychological problems (Mackenzie et al., 2006).

The finding that women are more likely to use mental health services as opposed to speaking to their general practitioner is not consistent in the literature. A study by Wang, Lane, Olfson, Pincus, Wells & Kessler (2005) found that men were more likely to seek specialty mental health care than women were. The authors of this study hypothesized that there may be a greater willingness for General Practitioners to treat female's mental health issues themselves as opposed to referring them to speciality care. This difference in access makes it far more likely that males will receive adequate mental health care as opposed to females (Wang et al., 2005).

According to Canadian hospitalization data men and women are hospitalized for different disorders at different rates. Women are hospitalized more often for depression, bipolar disorder, anxiety disorders, eating disorders and personality disorders¹ (Health Canada, 2002). Men, 15 to 49 years old, are hospitalized significantly more often than women for schizophrenia. A document from Health Canada (2002) reporting this data recommends more research assessing at whether the disorder manifests differently in men and women requiring more males to be hospitalized than females. Some research

¹ More men over the age of 75 are hospitalized for personality disorders than women over the age of 75, but this is significantly less than those hospitalized for personality disorders in other age groups, for which females are more likely to be hospitalized.

suggests that men are hospitalized more often than women because they are perceived as more dangerous, whether they truly are or not (Willie, Rieker, Kramer & Brown, 1995). Further research with regards to hospitalization data is required to determine if males and females are receiving different levels of care.

With exception to the Canadian hospitalization data, the studies discussed above are from the United States. With the differences in the health care system in the United States and Canada it is important to understand the differences in access between males and females in the Canadian context. It appears that for Canadians, women are hospitalized more often for a variety of disorders; this may be an effect of their access to other forms of speciality care. Clarifying the differences in access to mental health care between males and females is essential in order to determine if there are structural barriers creating differential access to care. Understanding what these differences are will help to make changes and improve access for all in the future.

Age

Previous studies looking at access to mental health care have found a pattern in the age of respondents (Swartz, Wagner, Swanson, Burns, George, & Padgett, 1998). Studies show that individuals aged 25 to 44 are more likely to access mental health care than other age groups (Mackenzie, et al., 2006; Swartz et. al., 1998). As this group of individuals accesses care more often than others, there are some challenges that those outside this age range face in accessing mental health care.

The majority of literature on age and access to mental health care seems to highlight issues with children and youth, as well as the elderly. In the United States

policy discussion regarding access to mental health care for children and adolescents often emphasizes the lack of service use for this age group (Kataoka, Zhang, & Wells, 2002). An American study by Kataoka, Zhang and Wells (2002) that looked at data from three nationally representative household surveys to determine rates of use of mental health services by children and adolescents (ages 3 to 17) who were in need of mental health care, found that of those 6 to 17 years of age who were in need of mental health care almost 80 percent did not receive these services. These findings are intensified for Latino children and those who are uninsured.

Other studies have also found that access to mental health care is limited for children and adolescents. Despite a self reported need for mental health services adolescents often forego care (Elliott & Larson, 2004; Klein, McNulty & Flatau, 1998; Zimmer-Gembeck, Alexander & Nystrom, 1997). It has been found that in the United States one in ten children suffer from a mental illness severe enough to cause impairment, yet fewer than one in five of these children actually receive services for their mental illness (US Department of Health and Human Service, 1999). There are a variety of social, psychological, economic and structural factors that can result in adolescents not accessing needed mental health care. Samargia, Saewyc & Elliott (2006) looked at self-reported reasons why adolescents did not access mental health care when they thought they needed it. The most commonly reported reasons were that they thought the problem would go away and they did not want their parents to know about it. Other issues that were reported by the adolescents surveyed included waiting lists for care, lack of parental consent, transportation issues, an inability to pay for services and a lack of knowledge about where or how to access services (Samargia, et al., 2006).

Not only is there a lack of access for youth in general but a Canadian case study demonstrates the lack of access for youth who are in correctional facilities. Ashley Smith was a nineteen year old woman from New Brunswick who had been incarcerated in provincial and federal prisons from the time she was thirteen. Ashley was mentally ill and ended up taking her own life while incarcerated (New Brunswick Ombudsman and Child and Youth Advocate, 2008). This incidence highlighted the lack of access to appropriate mental health care for youth who are in correctional facilities. A report from the New Brunswick Office of the Ombudsman and Child and Youth Advocate highlights the importance of improving the understanding of mental illness and behavioural disorders among youth. In the case of Ashley Smith, she was denied access to mental health care because she was sentenced to serve custodial time in a correctional facility. Again, it was recommended that those working with children and youth be educated to recognize mental health issues and be able to advocate for access to the appropriate care.

Access to mental health care for youth is not only an issue in Canada and the United States but globally as well. In 2007, the Lancet published an entire series on Global Mental Health. Included in this series was a look at the mental health of young people. It was reported that most mental health needs in adolescents, even in high income countries, go unmet (Patel, Fisher, Hetrick, & McGarry, 2007). Key challenges to addressing access to health care for youth worldwide include a shortage of mental health professionals, a low capacity and willingness of non-specialized health care professionals to provide quality mental health care or advice to adolescents and the stigma associated with mental disorder (Patel, et al., 2007). It is particularly important for adolescents to receive the necessary mental health care in order to allow them to “fulfill their potential

and contribute fully to the development of their communities” (Patel, et al., 2007, p. 1302).

On the other end of the spectrum there also appears to be issues with access to mental health care. Studies have found that the elderly have lower rates of access to mental health care than those in other age categories (Robins & Reiger, 1991). However, this study does not look at access to mental health care in the general medical sector, which is often where the elderly receive treatment for mental illness. This is the case as, they typically have comorbid physical and functional impairments which bring them to a general practitioner more often and which makes it more difficult for them to participate in other forms of mental health care (Burns & Taube, 1990; Padgett et al., in press).

Many other studies, including a report from the Surgeon General in the United States, indicate that mental health services are underutilized by the elderly (Bartels, Horn, Sharkey, & Levine, 1997; US Department of Health and Human Services, 1999). Access to assessment and treatment by speciality mental health providers has been indicated as especially poor (US Department of Health and Human Services, 1999). It was found that fewer than three percent of elderly people see a mental health professional for treatment, which is the lowest rate for all adult age groups (Olfson & Pincus, 1996). As described above, the elderly tend to seek mental health treatment in primary care settings which is challenging because it is not always equipped to adequately deal with mental illness (Kaplan, Adamek & Calderon, 1999).

While the findings on how individuals at different life stages access mental health care seem to be consistent, there is a considerable gap in understanding if the patterns seen in the United States are similar in Canada. The current study will seek to determine

if the patterns found in the United States are the same in Canada and will discuss implications for these patterns in the Canadian context.

Race

Like age and gender, previous research has found that individuals from different races access mental health care at different rates as well. For lack of a better term race is being used to describe a variety of factors that are all related to race. These factors include language spoken, immigrant status, length of time in Canada, and country of birth. While these factors do not indicate race, together they address some of the factors related to race that affect access to health care. Research has found that there are differences between these two groups of individuals including the need for and access to mental health care.

Specifically in terms of mental health care, research in the United States has found that those of a minority race are more likely to be diagnosed with a mental illness but less likely to access mental health care (Willie, et al., 1995). It has been hypothesized that those of a minority race potentially access mental health care less often than others for three reasons (1) they drop out of services because it does not meet their needs, (2) institutional policy may in some way, obvious or hidden, restrict those who most need care from receiving treatment and/or (3) psychotherapists and other professionals may reject minority clients (Willie, et al., 1995). In regards to the third point, previous research has found that people of color are often diagnosed with more serious mental illness such as schizophrenia or bipolar disorder (Willie, et al., 1995). They are also more likely to be hospitalized and seen as violent. These differences affect the quality of care

received and in turn the likelihood that individuals of a minority race will access mental health care.

Research done by Statistics Canada has found that immigrants to Canada are healthier than Canadian-born citizens (Ali, 2002). More recent immigrants to Canada had lower rates of depression and alcohol dependence than Canadian-born citizens; however immigrants who had been in Canada for ten or more years had rates of depression and alcohol dependence equal to Canadian-born citizens.

Despite reports of immigrants being healthier than Canadian-born citizens this is not the case for all immigrants, especially those who have been in Canada for ten or more years, and it certainly does not seem to be the case for all individuals of a minority race. An American study that looked at barriers to using mental health services in the US found that those of Caucasian decent are more likely to access mental health care than those of other races (Swartz, et al., 1998). Swartz and colleagues (1998) noted that African Americans were more likely to experience higher rates of involuntary hospitalization. If different people have unequal access to certain types of care, voluntary or involuntary, there is the risk that not every individual is receiving the same level of adequate care. With the American health care system it is found that those of a minority race tend to access private care less often than those of Caucasian decent. In Canada, technically most health care is public, but certain mental health care services are not entirely public. It would be interesting to determine if Swartz findings hold true in the Canadian context.

In the Canadian context it is important to understand access to mental health care for Aboriginal peoples. Unfortunately, this issue can not be addressed to the fullest extent in the current study because the Canadian Community Health Survey 1.2 did not survey

Aboriginals on reserve or individuals in remote and isolated locations. Since the study also did not ask respondents what their race or ethnicity was directly it is not possible to look at access to mental health care for Aboriginals off reserve. In terms of the current study, this limitation is extremely unfortunate; however it is possible to address the current status of literature on this topic.

Previous studies have indicated that Aboriginals bear a disproportionate burden of illness in Canada. This includes mental illness (Tookenay, 1996). Qualitative studies have found that the collective exposure of Aboriginal people to forced assimilation policies is the prime cause of poor mental health (Kirmayer, Simpson & Cargo, 2003). The most prominent example of causes of poor mental health is the residential school experience (Kirmayer, et al., 2003). This experience of forced assimilation has had lasting effects on Aboriginal communities. This includes, “the structural effects of disrupting families and communities; the transmission of explicit models and ideologies of parenting based on experiences of punitive institutional settings; patterns of emotional responding that reflect the lack of warmth and intimacy in childhood; repetition of physical and sexual abuse; loss of knowledge, language and tradition; systematic devaluing of Aboriginal identity; and paradoxically, essentialising Aboriginal identity by treating it as something intrinsic to the person, static and incapable of change” (Kirmayer, et al., 2003, p. s18).

The most prominent mental health issue facing Aboriginal communities is suicide. Rates of suicide among Aboriginal youth are three to six times greater than the general population (Kirmayer, et al., 2003). Unfortunately data on rates of psychiatric disorders in Aboriginal populations are non-existent, but they are expected to be higher than that of the general population (Kirmayer, et al., 2003).

Access to mental health care is different for individuals who identify as Aboriginal. They have different cultural assumptions and traditions that affect the way they understand mental illness and the way that they treat it. There is currently a lack of culturally appropriate services to address mental health issues experienced by Aboriginal individuals (Blackstock, 2008). The impact of Western mental health treatment for Aboriginals has not been great. In order to develop culturally appropriate treatment for the mental health issues of Aboriginals, it is important to acknowledge and understand the differences in the world view of Aboriginal people and non-Aboriginal people (Blackstock, 2008). Further research in the area of Aboriginal mental health care is required in order to have a better understanding of what kind of help would benefit them and how to go about encouraging culturally appropriate care.

Overall, race or ethnicity seems to play a large role in access to mental health care in other countries. It is important to determine if there are structural barriers in place that prevent individuals of a minority race from accessing the adequate and necessary care. By determining if there are barriers in place and what these barriers are they can begin to be broken down in order to achieve equal access to mental health care for all.

Education and Income

Like age, gender and race, level of education achieved and household income have been found to affect access to mental health care. In some studies, socioeconomic status, or a combination of education and income level, was used to better understand who accesses mental health care. In other studies education and income were measured

separately and found to have different levels of association with access to mental health care.

In terms of education, an American study used survey data to determine the characteristics of individuals that accessed mental health care more frequently than others. This study found that low education was a factor that predicted a lack of access to mental health care (Wang, et al., 2005). In the same study it was also found that individuals with a higher education were more likely, not only to receive care, but also to receive more adequate care than those with a low education (Wang, et al., 2005).

These findings were similar to another American study by Swartz and colleagues (1998). Again using survey data, it was found that those who have achieved a higher level of education are more likely to access mental health care; leaving those with a lower education without the necessary mental health services they require (Swartz, et al., 1998). This particular study also measured socioeconomic status by looking at a combination of educational level, occupational status and household income. It was found that a higher income alone predicted greater access to mental health care. When income was combined with education to measure socioeconomic status, a positive correlation was also found (Swartz, et al., 1998).

Since the health care systems in the United States and Canada differ greatly, it is important to understand how income and education affect access to mental health care in the Canadian context. A Canadian study used survey data to look at individuals, over the age of 17 who were diagnosed with an affective disorder and/ or an anxiety disorder to determine their ability to access mental health care based on their educational level, income level and a combination of the two (Steele, Dewa, & Lin, 2007). It was found

that for each additional level of education achieved individuals were more likely to see a professional about their mental health. Income, as well as the income education interaction, did not have a significant affect on access to mental health care.

These results show the effect that education has on access to mental health care. The authors of the study addressed the fact that the causes for the inequity in access to mental health care are multi-faceted (Steele, et al., 2007). They recommended further research to better understand if increased access to mental health care is due to the individual who has achieved a higher level of education or the health care providers increased willingness to treat individuals who were more educated. Determining what the inequities are helps in determining the causes and in the end addressing why certain individuals are more likely to access mental health care than others.

Differences in Access to Health Care by Location

It is important to look at Canada as a whole to understand the national situation; however the situation may be very different across Canada. Health care has been determined to be a provincial matter, which means that there are different systems across the country that could result in very different outcomes. Even within the provinces, there are differences when accessing mental health care based on if you are accessing care in a rural or urban location.

Rural versus Urban

Canadians live in urban and rural locations and as with physical health care there are differences in access to mental health care in these different locations. Remote and

isolated locations are less likely to have quality mental health care and where there is care, the range is limited (Ryan Nicholls, 2004; Shelton & Frank, 1995). Living in a rural area seems to be a barrier to mental health care in itself.

Previous research has found that individuals living in rural and remote communities have poorer health status and greater need for primary health care than those living in urban areas (Romanow, 2002). Due to a lack of access to health care services those living in rural and remote communities have poorer health outcomes as well. The reason for poorer health outcomes is attributed to the insufficient number of health care providers in rural and remote communities (Romanow, 2002).

Primary health care providers have pointed out one of the biggest challenges in rural and remote communities. The challenge is reconciling a need for individuals to take responsibility for their own mental health care and the traditional approach to mental health care, where the individual passively receives care from mental health care providers (Ryan-Nicolls & Haggerty, 2007). Until there is access to an increased number of mental health professionals in rural and remote communities it is crucial to determine how to address the lack of care that individuals in these communities receive.

Unfortunately, the Canadian Community Health Survey Cycle 1.2 Mental Health and Well-being did not survey individuals in rural, remote and isolated communities, so analyses in the current study do not include these regions. Since these regions include many Canadians it is important to incorporate information in order to have a truly complete understanding of access to mental health care in Canada. Further study is important to better understand the needs in these communities in order to improve the quality, and in most cases quantity, of services available in these communities.

Provincial Differences

A study conducted by Vasiliadis, Lesage, Adair and Boyer (2005) used the Canadian Community Health Survey 1.2 to determine provincial differences in mental health service use. By looking at the prevalence rates of health services use for mental health reasons in the previous twelve months, the authors determined the rates of mental health service use by province. It was found that Nova Scotia and British Columbia had the highest rates of mental health service use. Newfoundland and Labrador and Prince Edward Island had the lowest rates of mental health service use. In all provinces the need for mental health care predicted service use and access due to the level of need being relatively equitable across the provinces. Overall the study recommended further research to better understand the individual determinants that predict the differences in the type of services used across the provinces (Vasiliadis, et al., 2005).

***Exploring Access
Peer Support***

Often individuals access support for mental health care from a variety of different sources, not just professionals. There are telephone help lines, internet support groups and peer support meetings, along with more informal types of peer support such as that provided by family and friends. Research has shown that peer support can often enhance the positive affects of professional help, specifically for patients with cancer, schizophrenia and substance dependence (Emrick, Tonigan, Montgomery & Little, 1993; Humphreys, 1997; Humphreys, Moos & Finney, 1995; Humphreys, Moos & Finney, 1996; Klein, Cnaan & Whitecraft, 1998; Rogers, Bauman & Metzger, 1985).

In a study by Hunkler and colleagues (2000) the effect of peer support and nursing telehealth care were analyzed for patients receiving primary health care treatment for depression. It was found that nurse telehealth care enhanced primary health care. Patients who accessed nurse telehealth care had improved mental function and treatment satisfaction when assessed at six weeks and six months, post contact, compared with their counterparts who only received primary health care. When peer support from an individual who had successfully overcome an episode of major depression, was included along with primary health care and the nurse telehealth care, there was no additional improvement (Hunkler, Meresman, Hargreaves, Fireman, Berman, Kirsch, Groebe, Hurt, et al., 2000). It would have been interesting to know if the peer support had an affect on mental functioning and satisfaction without the nurse telehealth care, in order to better understand its true impact on treatment.

Internet support groups have become more and more popular in recent years. They can take the form of mailing lists, newsgroups, discussion forums or live chatrooms. A study by Eysenbach, Powell, Englesakis, Rizo, & Stern (2004) found that in April 2004 Yahoo!Groups listed close to 25000 electronic support groups in the health and wellness section. The number of groups has only increased since. The study by Eysenbach and colleagues sought to determine if online support groups provided a positive impact on treatment. They were unable to find evidence of the health benefits from belonging to an online support community. As online peer support is often combined with other methods of support and treatment it was difficult to determine the impact of online support groups alone (Eysenbach, Powell, Englesakis, Rizo, & Stern, 2004).

In the studies reviewed by Eysenbach and colleagues no negative effects of online support groups were reported. However, other studies have reported negative aspects such as hoaxes, spam, encouragement of suicide, and privacy issues (Ebbinghouse, 1998; Eysenbach, & Till, 2001; Golant, Winzelberg, Lieberman, States, Berman, Levy, et al., 2003). While there are inherent risks with seeking support over the internet, there can also be positive impacts. For example, online support groups provide 24 hour, 7 day a week access for individuals. As well, they have been found to support self-education and encourage patient's initiative and assertiveness when seeking professional care. They also provide members with an opportunity to share their stories, and give and receive advice and help other people (Ferguson, 2004). Further research is required to determine if the positive impacts outweigh the negative ones and if there are improved health outcomes for those that use online support groups.

Overall, there are a variety of methods of accessing peer support groups. Whether it be online, over the telephone or by meeting face-to-face with individuals who have similar experiences, individuals around the world seek mental health care from sources other than just health professionals. When assessing access to mental health care it is important to look at peer support, to better understand how people deal with mental health issues.

Payment

While health care in Canada is generally covered by provincial health insurance, not all mental health services are covered by provincial health care in Canada. Because of the Canada Health Act (1984) hospital services and primary care physicians are generally favoured by provincial health insurance systems, which has resulted in a lack of emphasis

on mental health services (Romanow & Marchildon, 2003). Currently, most severe mental health disorders are treated by psychiatrists, with a referral from a primary care physician.

Psychiatrists often treat mental illness with medication and drugless therapies seem to be uncommon (Romanow & Marchildon, 2003). Drugless therapies are uncommon because psychologists or social workers who provide this type of care are rarely consulted as they are not part of provincial health insurance systems and thus require individuals to pay for the service out of their own pocket or use private medical insurance. When individuals are able to access this type of care, it is often because they have well paying jobs that include these services in employee assistant programs, or have employee health insurance that helps pay the majority of the costs.

This system often leaves less severe mental illness undiagnosed and untreated by family physicians that are unable to spend the requisite amount of time to adequately address mental illness. Family physician services are covered by provincial health insurance and thus do not require individuals to pay for services out of their own pocket, however if they are not receiving the appropriate services to treat their mental illness, their problems will not be resolved.

Other services that can address or treat mental illness are not always covered by provincial health insurance. As mentioned, psychologists are not covered by provincial health insurance, unless employed by a hospital or community mental health clinic (Romanow & Marchildon, 2003). The same is the case for other professionals, such as counsellors, hypnotists, dieticians, or relaxation experts, among others. When individuals access care outside of the primary health care system or hospitals, they risk having to pay

for services out of their own pocket. When this happens individuals do not have access to care based on need, but rather on the ability to pay for services. While this is less of a problem in Canada, since certain services are covered by the provincial health insurance system, not all services are, it may still be a factor in accessing mental health care. The current study intends to determine if inability to pay for services is a barrier to accessing mental health care.

As is evident from the current state of the literature, access to mental health care is complex. There are many factors that affect an individual's ability to access care. The current study will explore access to mental health care from the Canadian perspective.

METHODOLOGY

Hypotheses

The current study uses data from the Canadian Community Health Survey Cycle 1.2 – Mental Health and Well-being (2002) to explore need for and access to mental health care in Canada. Based on the literature available to date, many hypotheses have been developed based on expectations for access to mental health care in Canada.

1. *Need and Access* – Based on past literature it is likely that not all respondents in need of mental health care were able to access that care. By looking at structural barriers indicated in the literature to be key factors in accessing health care a better understanding of gaps in the system will be achieved.

- a. Gender – According to literature from other countries women access mental health care more often than males (Addis & Mahalik, 2003; Ang, et al., 2004; Morgan, et al., 2003; Vogel & Wester, 2003; Mackenzie, et al., 2006). This is

often due to stigma, which occurs in Canada as well. Thus it is hypothesized that Canadian men will access mental health care less than women.

- b. Age – Nearly half of all mental health related hospital admissions were of individuals aged 25 to 44 years (Health Canada, 2002). Another quarter of the hospitalizations were individuals between the ages of 45 and 64 years (Health Canada, 2002). Individuals aged 25 to 44 years are more likely to access all types of mental health care (Swartz et. al., 1998; Mackenzie, et al., 2006).
- c. Race – Past research has indicated that those of minority races are less likely to access mental health care despite displaying a greater need for it (Willie, et al., 1995). It is hypothesized that the effect that is prevalent in other countries will be similar in Canada where those of a minority race will be less likely to access mental health care.
- d. Income – Previous research of a small geographic region of Canada has found that income is not a factor that affects access to mental health care (Steele, et al., 2007). It is likely that the current research will indicate the same finding as many health services in Canada are covered by universal public health insurance. Not all services are covered though, this research project will look specifically at the type of mental health care accessed, be it a general practitioner, a social worker, a psychiatrist or a psychologist. It is hypothesized that the services that require out of pocket funding, such as a psychologist, will not be accessed by those with lower income as often as those with a higher income.

- e. Education – Previous research has indicated that those who have achieved a higher level of education are more likely to access mental health care than those who have not (Steele, et al., 2007; Willie, et al., 1995). It is likely that this pattern will also be seen in Canada.

2. *Exploring Access* – As mentioned, it is unlikely that all respondents in need of mental health care will be able to access it. If the findings for section one of this paper confirm what the literature has said, it will be useful to explore access to mental health care in further detail. As this section is exploratory, specific hypotheses have not been developed.

- a. Location of services – the community approach is being supported and encouraged more and more in the last few years. If practice follows theory, community resources should be used more frequently than institution. It will be interesting to observe if community based services are used more often than institutional based services.
- b. Professional or peer support – Based on the literature, peer support is commonly used for health issues, including mental health issues. This study will go further than the state of the current literature and determine what types of peer support are used most often.
- c. Out of pocket payment – With Canada's health care system it is expected that not many individuals are paying for health services out of pocket. However, many mental health services are not covered by provincial health insurance

such as therapy sessions with a psychologist or social worker, outside of the hospital.

- d. **Barriers to Accessing Care** as assessed by the CCHS 1.2 – Previous research asking these particular questions has not been done in Canada. The information that this analysis will provide is important as it will provide a service users perspective on why they were unable to access mental health care.
- e. **Accessing Mental Health Care from a Social Worker** – As discussed, social workers play an integral role in mental health care for many individuals. Understanding who accesses social work services will help improve the services that are provided. It also brings to light who does not access social work services and who might benefit from these services.

Secondary Analysis of Data

A secondary analysis of data was chosen to investigate the research questions because substantial national data on the topic of mental health has been collected by Statistics Canada. The Canadian Community Health Survey includes questions that provide data to answer the questions being asked in this study. Conducting a secondary analysis also allows for a substantial amount of data. Since the sample size is so large, it makes it possible to generate the data to the majority of the population, with a few exceptions depending on who was surveyed.

While a secondary analysis of data is the appropriate research method for the current study and has many benefits there are also limitations. The majority of limitations

with a secondary analysis of data are a result of the data collection process, or survey (Kiecolt & Nathan, 1985). For example, without a thorough understanding of the data being used it may be difficult to ensure compatibility with the current research objectives. If the primary and secondary research objectives are significantly different the data may not be able to achieve the objectives of the secondary analysis. This limitation will not significantly affect the current study as the purpose of the primary data collection was to gather data to aid in analysis of a variety of health related topics. A considerable amount of information about the data files is available so a complete understanding of the data collection process, potential errors made and other important factors also help ensure the validity of the data.

Another limitation of survey research that affects a secondary analysis of data is the sampling method itself. Since surveys are often conducted over the phone participants must have a home address and telephone in order to be contacted. This leaves out an entire portion of the population. In terms of the current study, it leaves out a population of individuals, who according to past research, are highly likely to have mental health issues and are least likely to be able to access services, such as those who are homeless (Raphael, 2004). Other portions of the population that are often left out are rural and remote communities and those living on reserve. Past research has found that these individuals are likely to have less access to health care services (Raphael, 2004). By leaving out certain populations it is not possible to generalize data to all individuals or regions across the country. For the current study this limitation means that problems with accessing mental health care will likely be under reported.

Canadian Community Health Survey Cycle 1.2 – Mental Health and Well-being

The Canadian Community Health Survey Cycle 1.2 – Mental Health and Well-being (CCHS 1,2) “is a cross-sectional survey that collects information related to health status, health care utilization and health determinants for the Canadian population” (Statistics Canada, 2004, p. 1). The survey was established by the Canadian Institute for Health Information (CIHI), Statistics Canada and Health Canada who created the National Health Information Roadmap in order to address concerns cited by the National Task Force on Health Information (1991). The purpose of the CCHS 1.2 is to “follow through on the mandate of collecting reliable, relevant information on health services, health status, and health issues of importance to Canadians – at the regional, provincial and national level – and disseminating this information to the public” (Statistics Canada, 2004, p. 3).

The data collection period for the CCHS spans two years. During the first year of the survey cycle the general population health survey is administered to a large sample. The second year of data collection focuses on a smaller survey designed to collect provincial level information on a focused health topic.

During the first cycle of the survey, 2001-2002, mental health was the focused topic. The primary objectives of the cycles were to “provide timely, reliable, cross-sectional estimates of mental health determinants, mental health status and mental health system utilization across Canada; determine prevalence rates of selected mental disorders to assess the impact of burden of illness; juxtapose access and utilization of mental health services with respect to perceived needs; and assess the disabilities associated with

mental health problems to individuals and society” (Statistics Canada, 2004, p.4). With these objectives in mind the interview tool was designed.

In order to determine what aspects of mental health and well-being were to be captured in the survey extensive consultations were conducted. The priority areas of the survey were established through consultations with the Mental Health Expert Group (assembled for the survey) and the Population Health Advisory Committee, as well as through contact with the World Health Organization, academia, federal and provincial governments, consumers and professional associations.

Once the survey questions had been established the interview was drafted. The content was partly based on a selection of mental disorders from the World Mental Health – Composite International Diagnostic Interview Instrument (WMH-CIDI) (Statistics Canada, 2004, p. 6). Among other things, the survey is designed to screen respondents for various mental health disorders by asking screening questions, and then if the individual was flagged, they are administered a modified version of the WMH-CIDI or another similar diagnostic interview. For the current research project the mental disorders used were depression, mania, social phobia, agoraphobia, alcohol dependence, illicit drug use, gambling and eating disorders.

The WMH-CIDI is a “lay administered psychiatric interview that generates a profile of those with a disorder according to the definitions of the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition” (Statistics Canada, 2004, p. 10). The survey was modified to meet the needs of the Mental Health Cycle of the Canadian Community Health Survey and was named CCHS 1.2/WMH-CIDI. It was created based

on other health surveys such as the National Population Health Survey, the Health Promotion Survey and the Canadian Community Health Survey Cycle 1.1.

Between May and December 2002, the survey was administered to “persons aged 15 or older, living in private occupied dwellings” in the ten provinces (Statistics Canada, 2004, p. 1). The sample of people surveyed “excludes individuals living on Indian reserves and on Crown Lands, Health care institution residents, full-time members of the Canadian Armed Forces, and residents of certain remote regions” (Statistics Canada, 2004, p. 1).

The survey was administered across Canada, with exception to the above listed regions or populations. In order to provide accurate data from each province the sample of respondents was allocated among provinces proportionally to the square root of the estimated population in each province.

As was mentioned, the age range was 15 years old and older. The selection of respondents was designed to ensure an over-representation of young persons, aged 15 to 24, and seniors, aged 65 years and older. This strategy was designed to “consider user needs, cost, design efficiency, response burden and operational constraints” (Statistics Canada, 2004, p.34).

The questionnaire was administered using computer-assisted interviewing techniques. This technique makes administering the survey very efficient for several reasons. First, the survey is customized as it is administered in order to fit the respondent and skips questions that are not applicable to the respondent. It also checks for inconsistent answers and provides prompts on screen when an entry is invalid, which significantly decreases entry errors.

The interviewers had “specialized training on mental illness and how to conduct difficult interviews for interviewers, careful planning of collection periods and interviewer assignment sizes, addition of staff in key areas, and the decision to allow limited data collection by telephone” (Statistics Canada, 2004, p. 42). Having interviewers prepared to adequately respond to the information they get is important, especially when dealing with mental health issues. Overall there was a 77 percent national response rate, which is typical of this type of national survey (Statistics Canada, 2004). After going through a formal review process to ensure that a respondent could not be identified by their file, the data are made available by remote access for public use by Statistics Canada.

Data Analysis

All statistical analyses were conducted using SPSS Version 17. In order to gain a preliminary sense of the data basic frequencies and percentages were calculated for a variety of factors related to need for and access to mental health care. Once preliminary trends were established, the significance of these trends was assessed. Since the majority of the data was nominal level statistical analyses were limited. Chi square tests were used to determine whether a particular factor was significantly associated with need or access. Using the Bonferroni correction was considered in order to correct for false positives, as there are many comparisons being made; however, the significance (p) values were so small that this was deemed unnecessary. Frequencies and percentages of respondents in each category were used to understand the results of the chi square tests.

Key Terms and Definitions

There are a variety of terms used throughout the current study that need to be defined and operationalized. The definitions of these terms are dependent on the information available in the CCHS 1.2. The following are the key terms defined for the purposes of this study:

Gender – Gender was recorded in the survey by asking respondents whether they were male or female. Respondents could also indicate that they preferred not to answer the question. No response option was given for transgendered individuals.

Age – Refers to the age range of the respondent. Age was initially recorded in the following categories: 15 to 19, 20 to 24, 45 to 29, 30 to 34, 35 to 39, 40 to 44, 45 to 49, 50 to 54, 55 to 59, 60 to 64, 65 to 69, 70 to 74, 75 to 79 and 80 years or older. For the purposes of this study the age ranges were collapsed to better reflect similar research studies, as discussed in the literature review (Swartz et. al., 1998; Mackenzie, et al., 2006). The collapsed age ranges include: 15 to 24, 25 to 44, 45 to 64 and 65 years and older.

Race – Unfortunately the CCHS 1.2 did not directly ask individuals about their race or ethnicity, however it is possible to gain an understanding of race or ethnicity through a number of factors related to race or ethnicity that can have an impact on access to mental health care. Based on data available from the CCHS 1.2 several variables have been analyzed to better understand how race affected access to care for respondents. The first

variable was country of birth. Previous research has found that those born outside of the United States do not access health care services as often as those born within the United States, unfortunately this data was not available for the Canadian context (Willie, et al., 1995). The second and third variables were immigrant status and length of time in Canada. As described in the literature, newer immigrants to Canada are healthier than Canadian residents, but unfortunately there is little data on access to care for those immigrants who are in need (Ali, 2002). The fourth factor was language. It is logical that if there are language barriers it will make accessing mental health care difficult and ineffective. Together these four factors reflect how race affects access to mental health care.

Education - In the majority of the literature education and income are referred to as socioeconomic status and are grouped together. One particular study that looked at specific disorders found that while education had an affect on access to mental health care, income did not (Steele, et al., 2007). For this reason, the education and income variables have been kept separate for the current study.

The level of education of the respondent was recorded in the survey at a variety of levels including: grade eight or lower, grade nine to ten, grade 11 to 13, secondary school graduate, some post-secondary school, trade certificate or diploma, a college certificate or diploma, a university certificate, a Bachelor's degree, and a post-graduate degree. For the purposes of the current research the education levels achieved were collapsed to reflect more concise levels of education, they include: less than secondary school, secondary

school graduate or some post secondary education, a trade certificate, a college diploma or a university certificate, a Bachelor's degree and post-graduate degree.

Income – The CCHS 1.2 included two income variables One was total household income from all sources. The CCHS 1.2 assigned survey respondents to either the lowest, lower middle, middle, upper middle or highest income adequacy group. The second was income adequacy. For the current study income adequacy will be used to describe how income affects access to mental health care because the total household income was recorded in the survey, but does not adequately reflect income status as it is dependent on other factors such as family size and location.

Subjective Need – If a respondent rates their mental health status as poor or fair they are considered to have a subjective need for mental health services. For the purposes of the current study, a respondent is considered to have subjective need for mental health services if they responded 'poor' or 'fair' to the question 'In general, would you say your mental health is (1) excellent, (2) very good, (3) good, (4) fair, or (5) poor?'.

Objective Need – If a respondent is flagged for a disorder after being given the World Mental Health – Composite International Diagnostic Interview Instrument (WMH-CIDI) specifically designed for this survey, they are considered to have an objective need for mental health services. Based on the survey and data file, a respondent is considered to have an objective need for mental health services if they were flagged for any of the

following disorders: depression, mania, panic disorder, social phobia, agoraphobia, alcohol abuse, illicit drug abuse, gambling problems and/or eating disorders.

Access – If the respondent was hospitalized or spoke to one or more of a variety of health care professionals about their mental health, then they are considered to have accessed mental health services. Based on the survey and data file, a respondent is considered to have accessed mental health services if they responded yes to one or more of the following questions: hospitalized for emotional, mental health, or addiction issues, saw a psychiatrist, saw a family doctor, saw an other medical doctor (such as a cardiologist, gynaecologist, urologist, and allergist), saw a psychologist, saw a nurse, saw a social worker/counsellor, saw a religious or spiritual advisor and/or saw another professional (such as, an acupuncturist, chiropractor, energy specialist, exercise/movement specialist, herbalist, homeopath, hypnotist, massage therapist, relaxation expert, and dietician).

Exploring Access

There are a variety of factors that contribute to the access of mental health services. The data from the CCHS 1.2 provides a chance to look at reasons that affect access to mental health services. This study will look in depth at whether services are accessed in the community or institutions, if individuals access professional services or turn to their peers for support, if individuals need to pay out of pocket for services and reports of inability to access services.

Location of services – Respondents accessed services from an institution if they saw a professional for mental health services at the hospital as an overnight patient, a health professional's office, a hospital emergency room, an outpatient clinic, or another type of clinic. Respondents accessed mental health care from the community if they saw a professional at home, spoke to them over the telephone, at a church or other religious place, or at work/school. Most respondents would not expect to see a mental health professional in their home, work or school, so there is some question about how useful this later definition is in assessing how often respondents accessed services in the community. Many clinics and health professional's offices are in the community.

Professional or peer support – The CCHS 1.2 assessed three different types of peer support. These were internet help groups, self help groups and telephone help lines.

Out of pocket payment – The CCHS 1.2 asked respondents if they were required to pay out of pocket for the mental health care services they accessed. The survey asked if they spent no money, some money but less than 5000 dollars, or more than 5000 dollars.

Barriers to Accessing Care Assessed by the CCHS 1.2 – The CCHS 1.2 first asked respondents whether they wanted to access mental health services and were unable to. Those that responded that they were unable to access services were asked further questions. The survey determined what services were inaccessible, including information about mental illness or treatment, information on the availability of services, access to medication, therapy or counselling, help with financial problems, housing problems,

personal relationships, employment and/or other problems. The survey also asked what the reasons were that prevented the respondents from accessing the care that they desired. These reasons were: they preferred to manage themselves, they thought nothing would help, they did not know how to access services, they were afraid to ask for help, they could not afford to pay for services, did not have the required transportation or child care, the professional was unavailable in the area, the professional was unavailable at the time, the waiting time was too long, the respondent did not get around to doing it, there were language problems the respondent had personal or family responsibilities and/ or other reasons.

Overall, the reasons listed above, as to why respondents did not access mental health services were organized into three main categories and evaluated by the CCHS 1.2. These categories were accessibility, acceptability and availability. Accessibility barriers relate to the individual's ability to get to the location that services are being offered. This can include factors such as transportation and proximity to the individual's home, but it can also include factors such as appropriate child care. Acceptability barriers would be any barrier that prevents an individual from accessing mental health care because they think it would not meet their needs. For example, if services were not offered in the appropriate language or were not culturally sensitive, preventing access for certain people, these would be considered acceptability behaviours. Availability barriers refer to the ability to access the appropriate care in a reasonable amount of time. These barriers would include the wait time to see the professional, as well as, the times during the day or week that professionals are available. These three barriers represent all the responses provided by

survey respondents to the question of why they were unable to access the mental health care that they wanted to access.

Accessing Mental Health Services from a Social Worker – Understanding who accesses mental health care from social workers and who could benefit from accessing mental health care from a social worker will help improve mental health services. The CCHS 1.2 asked respondents which professionals they sought mental health care from. By analysing the characteristics of respondents who indicated that they did speak to a social worker about their mental health concerns, services can be targeted to suit these individuals. In the same way, developing a sense of which respondents do not access mental health care from social workers, allows them to assess their services and ensure they are truly accessible to these individuals.

RESULTS

This study was designed to determine if the respondents of the Canadian Community Health Survey Cycle 1.2 – Mental Health and Well-being accessed mental health care based on need, or if there were other mitigating factors that affected who accessed care. The study is also interested in exploring access to care further by looking at where care is accessed (community or institution), if individuals seek professional help, peer support or both, if individuals are required to pay out of pocket, how long individuals use typically use services, if individuals are generally satisfied with their care, as well as what services individuals report they can not access and why. Data from the

survey also makes it possible to determine the characteristics of individuals who access mental health care from a social worker.

Demographics

As described by the methodology, the data for the current study comes from the CCHS 1.2. There were a total of 36,984 respondents across Canada. Of these respondents 16,773 (45.4 percent) were male and 20,211 (54.6 percent) were female. Respondents ranged in age from 15 years old to 80 years old or greater (survey data did not provide actual age of respondents, instead individuals were grouped into age ranges consisting of four years in each range with exception to the final age grouping of 80 years or older), with the majority of respondents in the 45 to 49 years old age range. There were 5673 (15.3 percent) of respondents aged 15 to 24, 12,813 (34.6 percent) aged 25 to 44 years, 10,762 (29.1 percent) aged 45 to 64 and 7736 (20.0 percent) aged 65 or older.

Based on the literature there are key characteristics that affect access to mental health care. Along with gender and age, these characteristics are race, education and income (definitions of how characteristics were operationalized based on available data, are listed in the methodology).

Race

The respondents of the survey were not asked outright about their race, however race or ethnicity can be somewhat reflected using a combination of four specific variables from the CCHS 1.2. The first variable was country of birth. The question asked respondents if they were born in Canada or not born in Canada. As with all questions in

the survey, respondents were given the option of not responding to the question. There were 30,962 (83.7 percent) respondents born in Canada and 5753 (15.6 percent) born outside of Canada. There were 269 (0.7 percent) respondents who chose not to respond to the question. The next variable was whether or not the individual had immigrated to Canada. Those who responded that they were born outside of Canada were asked what their immigrant status was. Not all respondents who were born outside of Canada identified as immigrants. It was found that 5598 (15.1 percent) of respondents were immigrants to Canada and 31,152 (84.2 percent) of respondents were not immigrants to Canada. There were 234 (0.6 percent) of respondents who chose not to respond to the question. The third variable was the length of time the respondent, who had immigrated to Canada, had been living in the country. It was found that of those who immigrated to Canada 1274 (22.8 percent of immigrants) had been living in Canada for zero to nine years and 4325 (77.3 percent of immigrants) had been living in Canada for ten years or more. There were 233 (0.04 percent of immigrants) who chose not to respond to the question. The last variable used to define race or ethnicity was language. Of the 36,984 respondents 26,594 (71.9 percent) spoke English and/or another language, 3270 (8.8 percent) spoke French and/or another language, 6541 (17.7 percent) spoke both English and French and 376 (1.0 percent) spoke neither English nor French. There were 203 (0.5 percent) of respondents who chose not to respond to the question.

Based on the number of respondents for each of the categories above it does not seem reasonable to continue to look at race as a characteristic affecting access to mental health care. It was expected from the outset of the study that there may not have been enough available data or properly defined variables in order to respond to all hypothesis

of the current study. This is the nature of conducting a secondary analysis of data. Due to the limited data and an unsatisfactory definition of race or ethnicity, due to the limitations of a secondary analysis of data race/ethnicity variables will not be used to analyze access to mental health care further. Recommendations for analyzing how race, including country of birth, immigrant status, length of time in Canada and language spoken will be included in the discussion section of this paper.

Education

Another characteristic that has been found to affect access to health care in the past is education. The CCHS 1.2 asked respondents what the highest level of education they had achieved was. Data was collected for the following categories: grade 8 or lower, grade 9 to 10, grade 11 to 13, secondary graduate, some post-secondary, trade certificate or diploma, college certificate or diploma, university certificate (less than a Bachelor's degree), a Bachelor's degree, university education greater than a Bachelor's degree. For the purposes of the current study the variables have been collapsed to better represent the varying levels of education. It was found that there were 10,592 (28.6 percent) did not graduate from high school, 9547 (25.8 percent) graduate from school or had some post-secondary education, 11,219 (30.3 percent) either had a trade certificate or diploma, a college certificate or diploma or a university certificate (less than a Bachelor's degree), 3658 (9.9 percent) had a Bachelor's degree and 1737 (4.7 percent) had educational achievements beyond a Bachelor's degree. Overall there were 231 (0.6 percent) respondents who chose not to respond to the question regarding level of education achieved.

Income

Income has also been found to affect an individual's access to health care. As described in the methodology, the current study is looking at income adequacy instead of total household income. Of the respondents to the survey 1599 (4.3 percent) were in the lowest adequacy category, 3355 (9.1 percent) were in the lower middle adequacy category, 8081 (21.8 percent) were in the middle adequacy category, 11782 (31.9 percent) were in the upper middle adequacy category and 8717 (23.6 percent) were in the highest income adequacy category. There were 3450 (9.3 percent) respondents who did not report their income.

Need

When assessing access to mental health care it is important to understand who needs mental health care. Understanding who needs care makes it possible to know whether or not the mental health care system is providing adequately for those in need. For the current study, need was considered for all respondents and broken down into the demographic variables listed above.

Within the CCHS 1.2 need was assessed two different ways. First subjective need was determined by asking respondents what they felt their mental health status was. Out of the 36,984 survey respondents 521 (1.4 percent) rated their own mental health as poor, 2448 (6.6 percent) rated their mental health as fair, 9967 (26.9 percent) rated their mental health as good, 14,422 (39.0 percent) rated their mental health as very good, and 9602 (26.0 percent) rated their mental health as excellent (Figure 1). Nine respondents chose not to respond to the question. As described in the methodology, a respondent was

deemed to have a subjective need for mental health care if they rated their mental health status as poor or fair. This means that 2969 (8.0 percent) of individuals had a subjective need for mental health care.

Figure 1: A respondent was deemed to have a subjective need for mental health care when they rated their mental health status as poor or fair. In total, 2969 respondents had a subjective need for mental health care.

Need was also looked at objectively. As described in the methodology section of this paper, a respondent was considered to have an objective need for mental health care when they were flagged for one or more disorders as per their responses to the survey questions. In total there were 3698 (10.0 percent) respondents with an objective need for mental health care. There were 1736 (4.7 percent) respondents flagged for depression,

333 (0.9 percent) flagged for mania, 463 (1.3 percent) flagged for panic disorder, 889 (2.4 percent) flagged for a social phobia, 132 (0.4 percent) flagged for agoraphobia, 607 (1.6 percent) flagged for alcohol abuse, 361 (1.0 percent) were flagged for illicit drug abuse, and 651 (1.8 percent) were flagged for eating disorders² (Figure 2).

Figure 2: Of the respondents who were flagged for mental illness by the WMH-CIDI, the majority were flagged for depression.

² Respondents could have been flagged for more than one disorder, thus the total number of respondents flagged per disorder will not equal the total number of respondents in need.

For the purposes of this study, objective need will be used to measure respondents need for mental health care. While subjective data can be used to predict certain behaviours, among other things, it is not always reliable (Bertrand & Mullainathan, 2001). By using the data on objective need it ensures that the measurement is consistent throughout all survey respondents. From this point forward, need for mental health care refers to objective need for mental health care.

The CCHS 1.2 asked respondents questions about their gambling behaviour. Over 27 000 respondents were flagged for excessive gambling behaviours. The majority of these individuals did not seek mental health care. It seems that the test used to flag individuals for excessive gambling behaviours may have resulted in a number of false positives, as the rate of problem gambling in Canada is far lower than what the CCHS 1.2 found. According to the Centre for Mental Health and Addictions, 3.2 percent of Canadian adults are affected by gambling problems (Centre for Mental Health and Addiction, 2009), whereas, the CCHS 1.2 has flagged over 75 percent of respondents as problem gamblers. For this reason, those flagged for excessive gambling behaviours are not included as having objective need for mental health care throughout this study.

Since subjective need and objective need are measured differently, subjective need by the individual and objective need by the individual's scores on various tests for disorders, it was thought that it would be interesting to determine if the two variables were associated. There were 1255 respondents who both had a subjective need and objective need for mental health care. There were 1714 individuals who did not have an objective need for mental health care, but did have a subjective need. The majority of these individuals (1545) had reported their mental health status as fair, as opposed to

poor, of which only 169 respondents who were not in need of mental health care rated their own mental health status. By conducting a chi-square test of significance it was found that subjective and objective need are associated, $\chi^2(4, N=36960^3) = 4674.076$, $p < 0.001$.

Need and Characteristics

The characteristics of those in need of mental health care are important to consider in order to understand if the same people in need of mental health care are accessing mental health care. As mentioned, from this point forward, need for mental health care refers to an objective need for mental health care. The percentages in brackets following the total number of respondents for each characteristic are based on the total number of respondents who were in need of mental health care. There were 1476 (39.9 percent) male respondents in need of mental health care and 2222 (60.1 percent) females in need of mental health care.

In order to determine if gender was significantly associated with need for mental health care a chi-square test was conducted. The gender of the respondent was significantly associated with the likelihood that they would need mental health care, $\chi^2(1, N=36984) = 49.04$, $p < 0.001$.

As indicated in the demographics section, age was collapsed to better reflect life stages. There were 957 (25.9 percent) respondents aged 15 to 24 in need of mental health care, 1579 (42.7 percent) of respondents aged 25 to 44 were in need of mental health

³ There were 24 individuals who did rate their mental health status.

care, 933 (25.2 percent) of respondents aged 45 to 64 years were in need of mental health care and 229 (6.2 percent) of respondents aged 65 years or older were in need of mental health care.

To assess whether age was significantly associated with need for mental health care a chi-square test was conducted. The age of the respondent was significantly associated with need for mental health care, $\chi^2(3, N=36984) = 821.535, p<0.001$.

There were 1063 (28.7 percent) of respondents who did not graduate from high school that were in need of mental health care. Of those who either graduate from high school or had some post-secondary education 1094 (29.6 percent) were in need of mental health care. Of those who earned a trade certificate or diploma, a college certificate or diploma or a university certificate (less than a Bachelor's degree) 1106 (29.9 percent) had a need for mental health care. Of those with a Bachelor's degree, 292 (7.9 percent) were in need of mental health care. There were 123 (3.3 percent) respondents who had achieved a level of education greater than a Bachelor's degree who were in need of mental health care.

In order to determine if there was an association between educational level achieved and need for mental health care a chi-square test was conducted. The educational level of respondents was significantly associated with need for mental health care, $\chi^2(5, N=36984) = 56.303, p<0.001$.

As previously described, income adequacy was used for the purposes of the current study. There were 335 (9.1 percent) respondents in the lowest income adequacy group in need of mental health care, 452 (12.2 percent) in the lower middle income adequacy group in need of mental health care, 808 (21.8 percent) in the middle income

adequacy group in need of mental health care, 1114 (30.1 percent) in the upper middle income adequacy group in need of mental health care and 658 (17.8 percent) in the highest income adequacy group in need of mental health care. In total 331 (9.0 percent) of respondents did not report their income.

To determine if income was significantly associated with need for mental health care a chi-square test was conducted. It was found that the income (defined as income adequacy level) of the respondent was significantly associated with need for mental health care, $\chi^2(5, N=36984) = 320.758, p < 0.001$.

Need and Access

The CCHS 1.2 asked respondents which, if any, professionals they spoke to or sought mental health care from. The survey asked respondents if they had discussed their mental health with a psychiatrist, family doctor, other medical doctor (such as cardiologist, gynaecologist, urologist, and allergist), psychologist, social worker, religious advisor, or other professionals (such as acupuncturist, chiropractor, energy specialist, exercise/movement specialist, herbalist, homeopath, hypnotist, massage therapist, relaxation expert, and dietician). The survey also asked if the respondent had ever been hospitalized overnight for reasons related to mental health, alcohol or drugs. Keep in mind that respondents could have seen more than one professional and also could have been hospitalized overnight.

Of the 3698 respondents in need of mental health care 144 (3.9 percent) were hospitalized overnight during their lifetime for reasons related to mental health, alcohol or drug use, 1124 (30.4 percent) people spoke to a psychiatrist, 1721 (46.5 percent) spoke

to a family doctor, 195 (5.3 percent) respondents spoke to another medical doctor, 855 (23.1 percent) spoke to a psychologist, 326 (8.8 percent) spoke to a nurse, 1013 spoke to a social worker (27.4 percent), 357 (9.7 percent) spoke to a religious advisor and 147 (4.0 percent) spoke to other professionals (Figure 3).

Figure 3: The majority of respondents sought mental health care with their family doctor. Few were hospitalized; saw other medical doctors or other professionals. Almost 37 percent of respondents did not access any mental health care.

Out of the 3698 respondents who had an objective need for mental health care 2344 (63.4 percent) spoke to one or more professionals or were hospitalized overnight for reasons related to mental health, alcohol or drug use about their mental health. This means that 1354 (36.6 percent) of respondents in need of mental health care were unable to access care.

A chi-square test was conducted in order to determine if there was a significant association between need for mental health care and access to mental health care. It was found that the two variables are significantly associated, $\chi^2(1, N=36984) = 3238.545$, $p < 0.001$.

Access and Characteristics

The characteristics of those in need but who did not access mental health care indicate if there are certain characteristics that are consistently associated with a lack of access to mental health care. Of the 1476 (39.9 percent) male respondents in need, 658 (44.6 percent) did not access mental health care. There were 696 (31.3 percent) females who did not access mental health care out of the 2222 (60.1 percent) in need of that care.

In order to determine if gender is significantly associated with access to mental health care a chi-square test of significance was conducted. It was found that the gender of the respondent was significantly associated with access to mental health care, as defined by the current study, $\chi^2(1, N=36984) = 5.97$, $p < 0.05$.

There was an inconsistency found in the literature with regards to the type of mental health care accessed by males and females. The current study found that in general males and females access the same types of care with one major exception. Females (20.1 percent) were far more likely to discuss their mental health status with their general practitioner than males (11.4 percent) were. A chi-square test indicated that gender was significantly associated with accessing mental health care from a general practitioner, $\chi^2(1, N=36846) = 509.917$, $p < 0.001$.

The general practitioner does appear to be the gateway to other mental health care. This study found that of the 5953 respondents who saw their general practitioner for mental health care 2404 spoke to a psychiatrist, 465 also talked to another medical doctor, 458 were hospitalized for mental health issues or drug or alcohol abuse, 1720 also spoke to a psychologist, 650 talked to a nurse, 1854 saw a social worker, 857 spoke with a religious advisor and 263 saw another professional about their concerns. Interestingly though, men who were seen by a general practitioner were more likely than women to see all other types of mental health care professionals, with the exception of social workers.

There were 487 (51.2 percent) respondents aged 15 to 24 years who were in need of mental health care but unable to access it. Of the age group 25 to 44 years old, 499 (31.6 percent) were in need, but unable to access mental health care. In the age group 45 years to 64 years old, 262 (28.1 percent) were unable to access mental health care when in need. Of those aged 65 years or older, 106 (46.9 percent) were unable to access mental health care when in need of it.

A chi-square test was conducted to determine if age was significantly associated with access to mental health care a chi-square test of significance was conducted. It was found that the age of the respondent was significantly associated with access to mental health care, $\chi^2(3, N=36984) = 552.887, p<0.001$.

There were 429 (40.4 percent) of respondents who had not graduated from high school who were in need of mental health care but unable to access it. Of those who either graduated from high school or had some post-secondary education there were 433 (39.5 percent) respondents who were in need but unable to access mental health care. Of those who earned a trade certificate or diploma, a college certificate or diploma or a

university certificate (less than a Bachelor's) 363 (32.8 percent) were in need of mental health care but unable to access it. There were 87 (29.8 percent) of respondents with a Bachelor's degree who did not access mental health care when they were in need of it. There were 31 (25.2 percent) respondents who did not access mental health care when they were in need of it who had achieved a level of education greater than a Bachelor's degree.

In order to determine if level of education achieved was significantly associated with access to mental health care a chi-square test was conducted. It was found that the level of education of the respondent was significantly associated with access to mental health care, $\chi^2(5, N=36984) = 66.200, p<0.001$.

There were 66 (19.7 percent) in the lowest income adequacy group who were in need of mental health care but unable to access care. Of those in the lower middle income adequacy group 129 (28.5 percent) were in need of care but unable to access it. In the middle income adequacy group 295 (36.5 percent) and in the upper middle 432 (40.6 percent) and 280 (42.2 percent) in the highest income adequacy group were unable to access mental health care even though they were in need of mental health care.

In order to calculate if income adequacy was significantly associated with access to mental health care a chi-square test was conducted. It was found that the income adequacy level of the respondent was significantly associated with access to mental health care, $\chi^2(5, N=36984) = 11.719, p<0.05$.

Exploring Access

Location of Services

Mental health services are offered in different locations. Overtime services have shifted from the institution to the community. As discussed in the literature review, there has been a lot of momentum toward community services in the last few years. Based on the available data from the CCHS 1.2 it was possible to see if respondents were accessing care in institutional settings or in community based settings. The survey asked respondents if they had accessed care in a hospital overnight, as health professional's office, a hospital emergency room, an outpatient clinic, or another type of clinic, home, on the telephone, at church or other religious place or at work or school. For the purposes of this study institutional settings included a hospital overnight, as health professional's office, a hospital emergency room, an outpatient clinic, or another type of clinic and community settings included at home, on the telephone, at church or other religious place or at work or school.

Overall, not dependent on need for mental health care, 9233 (24.9 percent) respondents accessed mental health care. Of these 9233 respondents only 4094 (11.1 percent) responded to the questions in the survey about where they accessed the mental health care. Of the 4094 respondents who accessed some type of mental health care 3773 (92.2 percent) accessed mental health care services in institutional settings and 833 (20.3 percent) accessed services in the community. There were 512 (12.5 percent) respondents who accessed services in both institutional and community settings. This means that 61.5 percent of those who accessed services in the community also accessed services in institutional settings.

Respondents of the survey accessed mental health care most often in health professionals' offices (3434), then other clinics, such as day surgery or cancer clinics (807), outpatient clinics (323), on the telephone (314), and work or school (302), at home (269), at a church (228), as a hospital outpatient (191) and in a hospital emergency room (89).

Peer Support

The CCHS 1.2 asked the respondents if they sought peer support from internet groups, self-help groups or telephone help lines. Out of all 36984 survey respondents 277 (0.7 percent) used internet support groups, 1985 (5.4 percent) used self-help groups, and 766 (2.1 percent) used telephone help lines. In total peer support was accessed 3028 times. There were 2573 respondents who accessed peer support for their mental health issues, of which 521 respondents accessed more than one type of peer support.

Respondents also accessed professional support. In total, 9233 respondents accessed professional support and many accessed more than one type of professional support. Overall professional support was accessed 19,213 times. There were 2055 respondents who accessed both peer support and professional support. This means that there were 518 respondents who accessed only peer support for their mental health issues.

Payment

Despite having universal health care in Canada there are certain types of health care or certain professionals who are not covered by provincial insurance. Out of the 9233 (24.9 percent) of respondents who accessed mental health care, 7050 (76.0 percent)

spent no money on mental health services. There were 2857 (30.94 percent) respondents who spent some money, but less than 5000 dollars. There were only 43 (0.5 percent) of respondents who spent more than 5000 dollars. There were 430 (1.2 percent) respondents who did not provide a response to this question (Figure 4).

Figure 4: The majority of survey respondents were not required to pay out of their own pocket for mental health services.

The CCHS 1.2 asked respondents who accessed other professionals (acupuncturist, chiropractor, energy specialist, exercise/movement specialist, herbalist, homeopath, hypnotist, massage therapist, relaxation expert, dietician or other), social workers, nurses, psychologists, if insurance covered at least part of their services. Seventy-one respondents did not have insurance to cover mental health services with

other professionals, 338 respondents did not have insurance to cover access to a social worker, 70 respondents did not have insurance to cover the costs associated with seeing a nurse and 201 respondents did not have insurance to cover the costs of accessing a psychologist.

Barriers to Accessing Care Assessed by the CCHS 1.2

The CCHS 1.2 asked respondents if they wanted to access mental health services but did not do so. Of the 36,984 respondents 1798 (4.9 percent) reported that they wanted to access care but did not.

There were a variety of different types of mental health services that individuals wanted to access, but did not. These types of care were: information about mental illness or treatment (353, 19.7 percent of those who wanted but did not access care), information on the availability of services (257, 14.4 percent), access to medication (182, 10.2 percent), therapy or counselling (932, 52.1 percent), financial problems (181, 10.1 percent), housing problems (72, 4.0 percent), personal relationships (333, 18.6 percent), employment status (141, 7.9 percent), and/or other (199, 11.1 percent).

The survey also asked respondents to report their reason(s) for not accessing mental health care. These reasons were: they preferred to manage themselves (567, 31.7 percent), they thought nothing would help (196, 11.0 percent), they did not know how to access services (317, 17.7 percent), they were afraid to ask for help (297, 16.6 percent), they could not afford to pay for services (207, 11.6 percent), did not have the required transportation or child care (102, 5.7 percent), the professional was unavailable in the area (129, 7.2 percent), the professional was unavailable at the time (146, 8.2 percent),

the waiting time was too long (142, 7.9 percent), the respondent did not get around to doing it (333, 18.6 percent), there were language problems (10, 0.6 percent), the respondent had personal or family responsibilities (79, 4.4 percent), and/ or other reasons (193, 10.8 percent).

The CCHS 1.2 organized the different reasons for not accessing mental health care to reflect three specific barriers to accessing care. Accessibility barriers prevented 257 (14.4 percent of those who wanted but could not get) respondents from accessing care. There were 1326 (74.1 percent) respondents prevented from accessing mental health care due to acceptability barriers. Lastly, there were 345 (19.3 percent) respondents prevented from accessing mental health care because of availability barriers.

Access to Social Workers

As part of exploring access to mental health care it is important to understand who does and does not access mental health care from social workers. Overall 3070 respondents spoke to a social worker about their mental health status. Social workers were accessed for mental health care in all provinces. In total there were 1854 survey respondents in need of mental health care who accessed mental health services from social workers. This means that 2216 survey respondents accessed mental health care from a social worker even though they were not technically in need of mental health care according to the diagnostic tests included in the CCHS 1.2.

Survey respondents in each age group accessed social work services for mental health purposes. Those who are 25 to 44 years old (1490, 48.5 percent) accessed services from a social worker most often, followed by those in the 45 to 64 year old age range

(923, 30 percent) and those who were 15 to 24 years old (502, 16.4 percent). Those least likely to access mental health care were 65 years or older (146, 4.8 percent).

Males and females both access mental health care from social workers. Females (2027, 66 percent) were more likely to access mental health care from social workers than males (1043, 34 percent) were. This difference was significant, $\chi^2(1, N=3070) = 175.151$, $p < 0.001$.

The likelihood of accessing a social worker for mental health care differs by level of education achieved. Those most likely to see a social worker earned a trade certificate, college diploma or university certificate (1030, 33.6 percent) followed by those who were secondary graduates or attended some post-secondary education (820, 26.7 percent) and those who did not graduate from high school (658, 21.4 percent). Those least likely to access a social worker achieved a Bachelor's degree (362, 11.8 percent) or a post-graduate degree (181, 5.9 percent).

Income also predicts the likelihood a respondent would access mental health care from a social worker. Those in the upper middle (934, 30.4 percent) income category were most likely to access mental health care from a social worker. Those in the highest (675, 22.0 percent) income category were next most likely to access mental health care from a social worker, followed by those in the middle (613, 20.2 percent) income category. Those least likely to access mental health care from a social worker were in the lowest (264, 8.6 percent) income category, followed by those in the lower middle (366, 11.9 percent) income category.

As described above, there are a variety of locations that mental health care can be accessed. Since social workers work in a variety of different locations survey respondents

accessed care from social workers in all locations that were assessed by the CCHS 1.2. Mental health services were most likely to be accessed in a health professionals office (447) followed by other clinics (135), in schools (135), on the telephone (92), in the home (91), outpatient clinics (52), while hospitalized (25), in church (16) and lastly, the emergency room (8)⁴.

The results of these analyses provide evidence that there are barriers to accessing mental health care in Canada. In turn, these results need to be factored in to the mental health care system and any attempts to make changes to it. By incorporating these differences, it will be possible to make improvements in access to care for all.

DISCUSSION

The intention of this research was to develop an understanding of access to mental health care in Canada. By analysing characteristics of individuals who were unable to access mental health care, it was possible to determine structural barriers to mental health care. Understanding structural barriers allows mental health professionals and policy makers, to improve their services. Data from the Canadian Community Health Survey Cycle 1.2 – Mental Health and Wellbeing was used to analyze the current situation. In addition, the data from the CCHS made it possible to explore a variety of factors affecting access to mental health.

Much of the literature about access to mental health care reviewed for this study was from the United States. While these studies provide valuable background, it is

⁴ Individuals may have accessed care from social workers in more than one location.

important to understand how factors affect access to mental health care in the Canadian context. Comparing the literature from the United States with the findings of this research, it appears that access to mental health care in Canada is generally good. Those most in need of care are able to access care, as are the majority of others who require it. This being said, there are certain areas that could be improved.

Need and Access

Results indicated that need for mental health care predicted access to mental health care; however, there were still a considerable number of respondents in need of mental health care who did not access it. One of the most remarkable findings in this study was that over one third of individuals who were assessed as in need of mental health care did not access mental health care. It is evident based on this statistic that there are barriers preventing individuals from accessing the mental health care that they need. The results indicated that all characteristics assessed, age, gender, education and income, were significantly associated with a lack of access to mental health care.

Gender

Results indicated that gender was significantly associated with access to mental health care. This means that the gender of the individual predicts whether they are more likely to access mental health care than others. Results of the study found that women were more in need of mental health care than men, which is consistent with the literature (Addis & Mahalik, 2003; Ang, Lim & Tan, 2004; Morgan, Ness & Robinson, 2003; Vogel & Wester, 2003). Women were also more likely to access care than men, which is

also consistent with the literature (Figure 5) (Addis & Mahalik, 2003; Ang, Lim & Tan, 2004; Morgan, Ness & Robinson, 2003; Vogel & Wester, 2003).

Figure 5: Males were less likely than females to access mental health care when in need of it.

One inconsistency that was found in the literature was that women accessed specialty mental health care, such as care from a psychologist or psychiatrist, more often than men (Mackenzie et al., 2006). Other researchers actually found that men accessed specialty mental health care more than women (Wang, Lane, Olfson, Pincus, Wells & Kessler, 2005). If individuals have differential access to types of mental health care there may be inconsistencies in the adequacy of care they receive. The current study found that, of those who access mental health care, men and women access the same types of mental health care with one major exception. This means that men and women access specialty

care at similar rates. However, the one major exception was that women accessed care from general practitioners at a far greater rate than men did. While general practitioners are trained to assess mental health status they are not considered to be adequately equipped to treat on-going mental health issues. Women that only receive mental health care from a general practitioner may not be getting adequate mental health care to deal with their mental health issues, depending on the severity or type of their mental health difficulties.

In the Canadian health care system general practitioners are the gateway to other mental health practitioners. For example, they often provide referrals to more specialized levels of mental health care such as a psychologist or psychiatrist. This study found that individuals who saw their general practitioner about their mental health status were also likely to see another professional as well. Interestingly though, men who were seen by a general practitioner were far more likely than women to see all other types of mental health care professionals, with the exception of social workers. Past research suggests that men are more likely to be referred to more specialized mental health professionals than women, because they are perceived as more dangerous (Willie, et al., 1995). More research is required to determine if these differences in the care that men and women receive are equally adequate or if the differences mean that individuals of one gender receive better mental health care than individuals of the other gender.

Age

Like gender, age was significantly associated with mental health care. Those most in need of mental health care were in the age range of 25 to 44 years old. Individuals in

this age group accessed care more frequently than others, with exception to those aged 45 to 64. Those most likely to not access mental health care were 15 to 24 years old and 65 years or older, which is consistent with the literature (Figure 6) (Swartz et. al., 1998; Mackenzie, et al., 2006). Further research to determine why these age groups do not access mental health care when needed is important and will make it possible to address the issues preventing their access to care. Breaking down the barriers to accessing care will help individuals with mental health issues get the treatment that they need.

Figure 6: Respondents age 15 to 24 (51.2 percent) were most likely to not receive the mental health care that they needed, followed by those 65 years or older (46.9 percent).

As the case study of Ashley Smith (New Brunswick Ombudsman and Child and Youth Advocate, 2008) indicated, mental illness in youth is often overlooked. The

finding that 15 to 24 year olds are least likely to access mental health care is consistent with the current literature on the subject (Kataoka, et al., 2002). It has been found that adolescents will forego mental health care for a variety of reasons, including waiting lists for care, lack of parental consent, transportation issues, an inability to pay for services and a lack of knowledge about where or how to access services (Samargia, et al., 2006). Often times, mental health issues in youth are overlooked as typical teenage behaviour. When problems are not adequately understood care will not be sought.

As mentioned, those 65 years and older, also access mental health care less often than others, which is consistent with the literature. There are likely a variety of reasons why seniors are less likely to access care. One often mentioned in the literature is stigma. Mental illness has just recently begun to come out of the shadows, as the Kirby report (2006) made evident. Many seniors are used to being silent or shameful about mental illness. This factor is highly likely to affect willingness to access mental health care. Addressing stigma is an important aspect in increasing access to mental health care for seniors, as well as others.

It is important to educate general practitioners and others who work with youth to recognize the signs and symptoms of mental illness. By recognizing that this age group does not get the care that they need it makes it possible to allow those who work with youth to realize that more attention needs to be paid to teenagers so that their access to mental health care will improve.

Education

While all four variables (gender, age, education and income) were significantly associated with access to mental health care, education was most strongly associated with a lack of access to mental health care. The results of this study found that when looking at the level of education and access to mental health care were similar to what was found in a study by Steele and colleagues (2007). The lower the level of education, the more likely the individual was to need mental health care and the least likely they were to access it (Figure 7).

Education level predicts both need for and access to mental health mental health care. There are clearly barriers to accessing mental health care when those most in need of care are not accessing it. Past research has hypothesized that those with less formal education do not access mental health care because they are unaware of their options (Steele, et al., 2007). It has also been hypothesized that mental health professionals are less likely to see more specialized care as useful for those with less education. Regardless of why those with less education are less likely to access mental health care, it is important to work towards improving access, to improve the lives of these individuals.

Figure 7: There is a clear gradient when it comes to education and access to mental health care. The lower the level of education achieved, the more likely the respondent was to need mental health care and the less likely they were to access that care.

Income

Income was also significantly associated with access to mental health care. The results indicated that those most in need of mental health care are in the upper middle income category. Like with education and access to mental health care there was a gradient, however, it was not as predicted. The higher the income adequacy, the less likely the respondent was to access mental health care (Figure 8). Past research from other countries, mainly the United States, found that those in lower income groups were most likely to be in need of mental health care and least likely to be able to access it (Swartz, et al., 1998). The results from the current study indicate that this is not the case,

at least in Canada. These differences may be due to the Canadian health care system, where all individuals have basic coverage for health care and there is a better developed welfare system, than other countries such as the United States.

Figure 8: It appears from this figure that need for mental health care and lack of access to care peaks at the upper middle income category. However, as income adequacy increases, likelihood of accessing mental health care decreases when lack of access is assessed as a percentage of need. From lowest to highest the percentages of respondents who lack access to mental health care but are in need are 19.7 percent, 28.5 percent, 36.5 percent, 38.8 percent and 42.6 percent.

Often times, the stigma that comes along with mental illness or need for mental health care can affect a person's willingness to access mental health care. This is often

more so the case for those in the middle upper and highest income categories (Corrigan et al., 2004). Stigma can affect access to mental health care and individual wellbeing. By gaining a better understanding of why people in the upper middle income category are least likely to access mental health care when needed, be it stigma or for other reasons, a system can be developed to provide more accessible care for these individuals.

Exploring Access

The intention of this research was to develop an understanding of access to mental health care in Canada. Knowing who accesses care is important, but there are many other facets of access to mental health care that are also valuable. There were several different areas that were analyzed to determine some of the details of access to mental health care in Canada. First, the location of services was explored. Next the type of support, whether it was peer support or professional support that was examined. Access to care based on ability to pay was also analyzed. Details about why respondents were unable to access services when they wanted, them were determined. Lastly, access to social workers was explored in depth. By looking at these different factors it was possible to develop a more thorough understanding of access to mental health care in Canada.

Location of services

For the current study location of services was broken down into institutional settings and community settings. For the purposes of this study, institutional settings were all those offered in hospitals, doctor's offices and clinics. Community settings were in the home, at work, at school or at church. Unfortunately the operational definitions of

institution and community settings were limited to what the CCHS 1.2 had to offer. Ideally, there would have been clear and more concise definitions of these locations based on proximity to the individual and type of services accessible at each location. However, having limited data is a repercussion of conducting a secondary analysis of data. Future research incorporating these factors would be useful to fully understand where services are accessed.

Based on what was available in the CCHS 1.2 respondents accessed care in institutional settings much more often than they accessed care in community settings, although, this finding is possibly over-inflated due to the difficulties in defining institutional and community settings. Despite over-inflation, these findings are likely representative of actual trends. When individuals did access care in their community they were 61.5 percent likely to also access care in an institutional setting. Over the years mental health care has been shifting from the institution to the community, yet it appears that this transformation is not yet complete. Fewer services are offered in institutional settings now because funding in institutions has decreased in favour of services being offered in community settings. This is problematic because the funding has not shifted to community settings, resulting in a lack of services for individuals in need. Much research has been done on the importance of having mental health care available at the community level but funding and support need to be there for individual's in order to see the benefit. When services in the community are accessible and appropriate it is likely that there will be a shift in the location that services are accessed from. Until this shift occurs it is an indication that the proper services are not available in the community.

Peer support

As with many challenging times in life, peer support is an essential component of well-being. The CCHS 1.2 asked respondents about their use of peer support mechanisms such as internet groups, self-help groups or telephone help lines. In total, 2573 respondents accessed one of these types of peer support. The vast majority of respondents who accessed peer support also accessed professional support. Most people seem to use both types of support which is ideal, as they are both valuable for different reasons. Of the different types of peer support self-help groups appear to be the most popular.

There is limited research on the impact of self-help groups. Research looking at the outcomes of peer support would provide evidence for or against peer support groups. It would also serve to highlight who may benefit and in what ways. The limited research on peer support available focused on health outcomes. It would be interesting to conduct a survey of user satisfaction with peer support for mental health issues to fully understand how they affect wellbeing.

As mentioned, many respondents sought both professional and peer support. The CCHS 1.2 looked at a variety of different types of professionals who provide mental health support, including: psychiatrist, general practitioner, other medical doctors (such as a cardiologist, gynaecologist, urologist, and/or allergist), psychologists, nurses, social workers, religious advisors and other professionals (such as, an acupuncturist, chiropractor, energy specialist, exercise/movement specialist, herbalist, homeopath, hypnotist, massage therapist, relaxation expert, and/or dietician).

The majority of respondents spoke to their general practitioner for mental health support. Many also spoke with psychiatrists, psychologists and social workers. A large

number spoke with a variety of professionals about their mental health status. It is possible that individuals speak about their mental health issues with professionals that they are comfortable with or have an on-going professional relationship with, but often times these professionals are not trained to adequately assess or provide appropriate treatment for mental illness. It is encouraging that most people speak to mental health professionals such as a psychiatrist, psychologist or social worker; however the current study found that almost a fifth of respondents did not know how to access mental health care. Educating the public is an important factor in helping individuals to understand how to access mental health care professionals.

While many individuals were unaware of how to access mental health care, there could also be another issue. The variety of professionals that respondents sought mental health care from speaks to the availability of mental health professionals and services. It is possible that there is a lack of available services, preventing individuals from accessing the mental health care that they desire. Further research regarding access to specific professionals is important in order to determine what services are lacking in order to increase availability.

Payment

In Canada, basic health care services are free for all residents. Each province has a health care insurance program that provides access to basic services, including certain mental health professionals. Not all mental health services are covered by insurance which results in some services requiring individuals to pay out of their own pockets, or

use other health insurance programs to cover costs. It is important to know if ability to pay for services has an affect on access to services.

Only 43 respondents were required to pay more than 5000 dollars for mental health services. However, 2857 respondents of the CCHS 1.2 had to pay some money but less than 5000 dollars. This does not seem to have had a major impact on access to mental health care, but nonetheless it did have an impact. When respondents were asked why they did not access mental health services when they wanted to 11.6 percent were unable to access services because they were unable to afford them. While this percentage may seem low compared to other countries where many more citizens are unable to access care due to the inability to afford them, this is still a considerable number of people who need and want services, but are unable to access them because of financial constraints. This needs to be taken into consideration in the future when making changes to the mental health care system. Developing a system that would close the gap in services for these individuals is important to improving their mental health and well-being and aligning mental health care with other health services, which are offered free of charge. Mental health is equally as important as physical health.

Barriers to Accessing Mental Health Care as Assessed by the CCHS 1.2

The CCHS 1.2 asked respondents a variety of questions regarding their desire for and ability to access mental health care. By looking at the responses to these questions it is possible to understand more about self-confessed inability to access mental health care. The survey asked respondents if they wanted to access mental health care and were

unable to, what type of care they were unable to access and the reasons why they were unable, or did not access the mental health care that they desired.

While the survey takes into consideration many different types of mental health care, including a variety of health professionals and religious advisors, some individuals may not be interested in discussing their mental health status with health professionals, they may wish to deal with their issues privately or with support from family members and/or friends. The choice to deal with mental health issues without professional support is a valid choice; however it is important that individuals are informed about all of their options before making a choice. Educating the public about their options is essential in helping individuals to make the most informed choice possible when deciding how to approach mental health issues.

There were 1798 (4.9 percent) of respondents who wanted mental health care but were unable to access it were asked about the type of mental health care that they wanted and were unable to access and why they did not access the care. The majority (52.1 percent) of respondents, who wanted mental health care but were unable to access it, were interested in accessing therapy or counselling. Individuals were also interested in information about mental illness and treatment (19.7 percent), information about mental health services (14.4 percent) and/or help with personal relationships (18.6 percent). Understanding the type of care that individuals want but are unable to access is important in working towards making these services more accessible for all. Developing better ways of sharing information about the types of services available and who provides care, would be a good way to start addressing the lack of availability of these services.

There were many reasons that respondents listed as reasons why they were unable to access the mental health care that they desired. Most individuals chose to manage themselves (31.7 percent) as opposed to accessing professional mental health care. Other common reasons were that the individuals did not get around to it (18.6 percent), they did not know how to (17.7 percent), and they were afraid to ask for help (16.6 percent). Again these reasons seem to come down to a lack of knowledge or information with respect to mental illness in general as well as the treatment of mental illness. Education is an important factor in helping individuals understand what can be done to help improve their mental health status and where they should go for mental health care.

It was interesting to find that almost one fifth of respondents did not know how to access mental health care. This reflects another limitation of using survey data. It is not possible to look at the findings in depth. Respondents are not able to provide insight into their responses. A qualitative study using interviews to gather data would allow for respondents to expand on their responses and in this case delve into details with respect to why they did not know how to access mental health care. While the survey data does not allow for definitive answers, it is possible to hypothesize as to why respondents did not know how to access mental health care. For example, the primary health care system focuses on physical health, as opposed to mental health. If people are unaware that they can see someone other than a general practitioner when they are experiencing mental health issues, they may not know where else to go. Again, this speaks to the need for more education on mental health. Education campaigns focused on helping individuals learn about the available mental health resources would be beneficial.

Overall the reasons individuals who wanted mental health care were unable to access care, were broken down into three main aspects. These were accessibility, acceptability and availability. The majority of respondents were unable to access desired mental health care due to acceptability barriers. This means that respondents most often do not access care because they think it will not meet their needs. If appropriate services were available individuals may put forth more of an effort to access them and individuals would make the effort to get around to it or trust professionals to help them manage their illness as opposed to managing it by themselves.

Access to Social Workers

As part of exploring access to mental health care it is important to understand the role social workers play in mental health care. Knowing who does and does not access mental health care from social workers will allow them to be prepared for those that seek their services and be able to reach out to those that do not seek their services, but may benefit from them. Social work services were accessed by 27.4 percent (1013) of respondents who were in need of mental health care. This indicates that social workers provide a valuable service for Canadians in need of mental health care as they are accessed third most often when respondents required mental health care, preceded only by general practitioners and psychiatrists. In total 3070 respondents accessed mental health care from a social worker, which means others, who were not determined to be in need of mental health care, also used social work services. It is important to understand who uses social work services in order to provide the best, most appropriate services.

This also provides an understanding of who does not access social work services but may benefit from them, in order to improve services for these groups of individuals.

Social workers are most likely to see those in the 25 to 44 year old age group, females, those who have earned a trade certificate, college diploma or university certificate and/ or are in the upper middle income category. Since these are the individuals that social workers see most often, it is important that they are prepared to address the mental health needs of these individuals. Seniors, males, those who earned a post-graduate degree and those in the lowest and lower middle income categories were least likely to access mental health care from a social worker. With exception to those who have earned a post-graduate degree, those in the other categories are highly likely to need mental health care. Social workers can take this information and reach out to these individuals.

Implications for Social Work Practice and Policy

Social workers were the third most accessed professional for mental health care. It is important to be aware of the large proportion of individuals who rely on social workers for mental health care in order to make the services provided the best that they can be. While people with certain characteristics need mental health care more than others, it is not necessarily beneficial to only target these groups. Policy and practice should be inclusive of anyone who wants or needs mental health care. Understanding who is currently underserved by social workers and the mental health care system in general makes it possible to develop initiatives to increase accessibility to services for these individuals, while maintaining services for others. In particular, those currently

underserved by social workers are seniors, males, those who earned a post-graduate degree and those in the lowest and lower middle income categories.

As structural social workers, knowing the barriers to accessing mental health care makes it possible to begin breaking them down. This study found that males, youth and seniors, people who achieved lower levels of education and those in higher income adequacy categories, were underserved by the mental health system overall as they were least likely to access care when needed. Further research to determine what the barriers are for each of these groups is necessary to begin addressing them. Just by being aware of those who do not typically receive the care they need, social workers can attempt to improve their access and then work with them to help them feel and be more empowered in their situation. By doing this, the barriers to accessing mental health care will begin to breakdown.

In working to break down the barriers identified in this study, education would be useful. By informing health professionals, including social workers and the general public about a variety of issues would be useful. Knowing how to identify if someone is in need or would benefit from care is extremely important, as is being able to direct these individuals to the appropriate mental health professionals. In particular for social workers, education on mental health and mental illness is crucial, as it is inextricably linked with many facets of their work. Improving knowledge about who would benefit from care and how to access it would improve overall access to mental health care.

An article by Uri Aviram (2002) pointed out that social workers in the mental health field rarely challenge the dominance of the psychiatric professions. In doing this, social workers have limited their ability to help those with mental illness. Mental health

care continues to be based on physical health care models, which limits who receives care, as well as the type of care they receive. When individuals are only treated for biological issues, the contextual causes of their illness are ignored. Here is where social workers play an increasingly important role. More and more, social workers are part of interdisciplinary care teams that help individuals deal with all aspects of both physical and mental illness. Social workers need to continue to integrate themselves into care teams in order to ensure that the whole person is treated. By challenging the dominance of psychiatric professions, treatment will be more adequate for all (Aviram, 2002).

As mentioned, the Mental Health Commission of Canada is currently working on a national mental health strategy (MHCC, 2009), which makes now, the ideal time to start addressing some of the barriers that have been identified in this study. One of the aspects mentioned in this study, stigma, is a focus of the Strategy. As the results of this study indicated stigma may be impacting access to care, it is great that the Strategy is working to make a difference and improve access. The other findings of this study can also contribute to the National Mental Health Strategy.

The results of this study indicate that males, youth and seniors, people who achieved lower levels of education and those in higher income adequacy categories are less likely to access mental health care when needed. In developing the National Mental Health Strategy, it is important to take into consideration that based on these findings, there are structural barriers preventing equal access to mental health care. Further research to better understand the nature of these barriers is needed in order to be able to ensure that they are addressed in the National Mental Health Strategy. In the meantime, it

is important that the Strategy acknowledge that access to mental health care is currently not equal for all and identify a plan to work towards equal access.

CONCLUSION

Much of the previous research on access to mental health care looks solely at populations who have been treated for mental health issues and focuses on their satisfaction with the care as well as their health outcomes. While it is important to understand the value of treatment, it is also important to look at who accesses treatment in general. By understanding why certain people do not access mental health services is important in making improvements in the care of underserved populations.

This study also adds to the literature by understanding access to mental health care from the Canadian perspective. Much of the literature is from other countries or specific regions in Canada. If not from a specific region, the Canadian studies were looking at a very specific population. This study looks at access to mental health care in Canada for those with a variety of mental health disorders and in terms of accessing a variety of types of mental health care. Overall, access to mental health care in Canada is generally good, as those most in need are typically able to access the mental health care that they require. However, despite access being decent overall, there are still certain people who are less likely to access care than others. Addressing these barriers will improve the system overall.

A big picture view of the state of access to mental health care in Canada is useful as overall trends in access to care are important in making big changes that benefit many people. The findings of this study, as discussed above, contribute to the literature by

identifying structural barriers to mental health care. By identifying the barriers, the mental health community can begin to work towards breaking them down in order to provide access to mental health care for all who need and desire it.

Limitations of the study

While this study provides very valuable research on access to mental health care in Canada it is not without limitations. As mentioned, there are inherent limitations with conducting a secondary analysis of data. The purpose behind the original data collection was that it be used to analyze the health care system and health status of Canadians, which makes the data suitable for the purposes of the current study. However, the data are still not ideal at times as there are specific questions that could have yielded more precise data if this study had not been based on a secondary analysis of data. For example, more explicit data on the location that services were accessed would have been useful. This being said, the study still provides a useful base from which to work. Preliminary trends suggest where further research would be valuable.

In the same sense, operational definitions for terms used in the study were limited to what the survey data provided. For example, objective need was defined by diagnostic surveys. There are bound to be people that were in need of mental health care, but were not flagged by the diagnostic tools, and vice versa. For example, assessment of problem gambling flagged 75 percent of respondents, while the Centre for Mental Health and Addiction reports that only 3.2 percent of adult Canadians are problem gamblers (CMHA, 2009). In this case, it appears that the diagnostic tool resulted in an extreme over representation of certain disorder, resulting in the data having to be removed from

analyses, so as not to drastically skew the results. While it would have been ideal to have had respondents assessed by professionals to avoid diagnostic errors, this is not realistic when conducting such a large, national survey. Diagnostic tools such as the one used in the CCHS 1.2, are created specifically for this purpose and are used in other large surveys, to acquire the most accurate data possible. Being limited by the quality of the information available in the survey is a downfall of using survey data. However, the data still provide a general sense of access to mental health care in Canada and provide indicators of what types of future research would be valuable.

There were also large gaps in information in the survey that would have enhanced the discussion of access to mental health care considerably. For example, an important part of understanding access to mental health services in Canada is understanding access to mental health care on reserve and in rural and remote areas. These populations were not surveyed and thus there is no available data for the current study. Past research suggests that there are challenges accessing any type of health care in rural and remote areas, thus it is expected that access to mental health care is also limited in these regions. Future research should include individuals in rural and remote locations in order to gain full understanding of access to mental health services in Canada.

In the same way, not including Aboriginals who reside on reserves, leaves out valuable data that would provide a better understanding of access to mental health care for Aboriginals. Leaving out such a large portion of Canada's population makes it difficult to get a national picture of access to mental health care. Being Aboriginal was determined to be a social determinant of health in itself, making information about access to care for Aboriginals important to improving access to mental health care in Canada.

Since only those with a home address and telephone number were able to be surveyed, those who are homeless or living in shelters were not included. Individuals who were institutionalized, in prisons or hospitals, at the time were also left out of the survey results. Leaving out these people paints a better picture than actually exists. Those who are homeless have been found to have a very high prevalence of mental illness and substance abuse and are not likely to access care (Hwang, 2001). Those who were inpatients at a hospital during the time of the survey may have had mental health issues and may or may not have been receiving care for them, depending on their reasons for being in the hospital. Individuals who were incarcerated also have a higher prevalence of mental illness than the general population, and mental health care in prisons is known to be lacking (Lamb & Weinberger, 1998). Overall, those left out of the survey data could have had a drastic effect on the results. In order to really determine what access to mental health care is like in Canada, it is necessary to incorporate the populations that were missing from the CCHS 1.2 into the results.

Another gap in the survey data was with respect to information on respondent's race. Past versions of the survey asked respondents outright which race they identified with, however Cycle 1.2 did not ask this question, which leaves users of the survey data to combine various questions to better understand race. Looking at various factors related to race is not necessarily problematic, especially in Canada, where race itself may not be the factor affecting access to mental health care. Assessing language spoken, length of time in Canada after immigration, and the individual's country of birth, would provide a better picture of factors affecting access to mental health care. The current study

attempted to use data related to these factors, however, the data available was lacking and not representative of Canadians.

With information about race missing it makes it difficult, if not impossible, to fully understand how race affects access to mental health care. Based on literature from the United States, race has a significant impact on access to mental health care, as well as the type of care received. By leaving out this data the survey keeps issues of race and access to mental health care or mental health status hidden.

Another limitation of secondary analysis of data is the sampling methods. It was found that only 1.02 percent of all respondents spoke neither English nor French. This speaks to the sample of respondents as this number is not a true representation of the Canadian population. Research from other countries has indicated that language can be a barrier to accessing mental health care. By under representing the population of those who speak neither English nor French the sample surveyed limits the available data and prevents an understanding of how language affects need for and access to mental health care.

Along with gaps in the information collected, another limitation of the study is how the data was recorded. The majority of the data was at the nominal level which significantly inhibits the types of statistical analyses that are possible. The questions asked in the current study utilized nominal data which made it impossible to analyze the interactions between factors. The factors used to understand access to mental health care, age, gender, education level and income level, are factors that interact with each other in ways that are impractical to ignore. If interaction effects were measurable there is a possibility that stronger effects would have been found. Being able to discuss how

different characteristics interact to affect access to mental health care would have added to the discussion. While it is valuable to understand the trends with individual characteristics, these characteristics are not mutually exclusive. Future research should consider collecting data at a level higher than nominal, in order to be able to analyze the interactions that could affect access to mental health care.

Another, more general limitation of this study was that quantitative data limits the richness of the data. Many findings of this study require further research to fully understand. For example, almost one fifth of respondents who wanted to access mental health care but were unable to indicated that they did not know how to access mental health care. Quantitative studies make it difficult to look at specific topics in depth. Qualitative studies would be beneficial to explore some of the findings of this study in further detail, to gain a better understanding of why these trends occur.

In general, the limitations do not affect the quality of data or discussion of the current research. However, the limitations do prevent a complete discussion of access to mental health care in Canada from being had. Based on the trends and findings presented here, future research would be valuable to address these limitations and move forward.

Future Research

Throughout the discussion of results there are a variety of recommendations of future research. These recommendations essentially stem from the need to take the findings of this study and work towards improving access to mental health care for currently underserved populations in Canada. All factors were significantly associated with access to mental health care, meaning that certain individuals are more likely to access mental health care than others. This finding indicates that there are structural

barriers to accessing mental health care in Canada. Collecting data in a different format would allow for analysis of interaction effects that are important to a complete understanding of access to mental health care. As well, qualitative studies would increase the richness of the data by allowing for specific topics to be explored in depth.

The results of this study indicate existing trends in accessing to mental health care. Understanding who access mental health care and who does not is the first step in improving access to mental health care for all. Future research should focus on ways of improving access to mental health care for those who are in need of mental health care but do not access it, in particular, males, youth and seniors, people who achieved lower levels of education and those in higher income adequacy categories. The results of this study are the first step in improving access to mental health care for the more than one third of respondents of the CCHS 1.2 that were in need of mental health care and unable to access it and for all other Canadians who need and want mental health care but are unable to access it.

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