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The Grim Challenge of Mental Health

By Dr. John Walker

More than 2.6 million Canadians -- one in ten adults -- are struggling with a common mental-health problem. Among young people aged 15 to 24, it's almost one in five. This compares to the five per cent of Canadians with diabetes, five per cent with heart disease, and six per cent with a thyroid condition.

In the last year, 4.7 per cent of Canadians experienced an anxiety disorder and 4.5 per cent faced major depression. Alcohol dependence afflicts 3.8 per cent of men and 1.3 per cent of women. Moderate-risk or problem gambling affects two per cent. For each of these problems, the rate is higher - often much higher - for younger Canadians before dropping off gradually with age. And, as we can all imagine, for each Canadian coping with a mental-health problem, several other family members often feel the impact.

The Canadian Community Health Survey of Mental Health and Wellbeing, released by Statistics Canada last week, found treatment rates for these problems were just as staggering as their prevalence.

In a survey of 37,000 Canadians from across the country, just 32 per cent of those identified as having one of these mental-health problems had seen or talked to one or more health professional about it in the previous year. Most of these contacted a family physician (26 per cent), while 12 per cent consulted a psychiatrist and eight per cent a psychologist. And, again, the rate of contact was even lower among young people.

But the survey does not include information on whether those making contact with the health-care system actually received effective treatment. Previous community surveys have found that many do not. While the survey did not include people living in First Nations communities, the unmet needs there are even higher, given the difficult social and health conditions they face.

These numbers represent a daunting challenge for our society. Mental-health problems are associated with increased health costs, reduced productivity in school, the workplace and the home, and missed life opportunities. Young people with anxiety problems, for example, have been found to make less progress in education and careers. Direct and indirect costs (lost productivity) of anxiety disorders in Canada have been estimated in the range of $100 billion.

How should Canada respond to this challenge? The temptation will be for mental-health providers and managers to ask for more of the same resources to provide more of the same services. Unfortunately, health planners discovered as far back as President John F. Kennedy's Commission on Mental Health in the 1960s that there has never been -- and can never be -- an economically viable system that can provide adequate treatments to all those with mental-health problems.

This means we cannot solve population health problems until we develop effective approaches to prevention. Examples from other areas of health abound. We do not really solve the problem of lung cancer until we reduce the rate of smoking in the population. We do not solve the problem of head injuries until we ensure that most drivers are wearing seatbelts and most cyclists don helmets. Treating individuals after the problem develops is very expensive and generally produces modest results at best. Cautious health-care providers may respond that we can't really do anything about prevention until we understand much more about the causes of anxiety and depression. They may also say that we should not spend even one dollar on prevention until we have done everything we can for everyone suffering from these problems.

But the reality is that we already know a great deal about the causes of anxiety and depression. Research over the last 25 years has clearly identified risk-factors: Starting life with a temperament prone to the development of anxiety and depression (often genetic factors); adverse experiences during childhood (a family that has difficulty due to conflict, abuse or poor parental coping); chronic life stresses (living in poverty or difficulty in relationships); and life stresses close to the onset of the mental-health problem.

Fortunately, each of these risk-factors responds to environmental change, including changes in the ability of the individual, family or community to cope with these problems. As with smoking and lung cancer, changing the risk-factors will change the outcome.

Convincing policymakers to devote more resources to prevention is not an easy matter. Prevention efforts often involve different personnel with different skills -- educators or community workers rather than traditional health-care providers. The latter often face heavy workloads and naturally put more energy into advocating for more of their style of services than for prevention. The public has an easier time understanding the need for resources to help a person suffering today, as compared to those required to prevent a problem that will happen some time in the future.

As well, prevention approaches often involve low-tech rather than high-tech solutions, so there is no commerical interest. In contrast, there is often strong commercial interest in marketing new pharmaceuticals and medical technologies, and these capture a large proportion of any new health-care dollars.

The good news is that some very promising prevention approaches are already gathering scientific support. The extent of the evidence for their effectiveness varies, but is often stronger than the evidence for treatment technologies that are widely implemented.

Current research supports the view that strengthening the ability of parents, schools and communities to support the development of healthy children and adolescents is the best

approach to preventing later mental-health problems. And there is no doubt that reducing child poverty is key.

It is already possible to identify young people (pre-school and kindergarten age) who exhibit risk-factors for later mental-health problems. Children demonstrating conflict and aggression are at risk for later problems with interpersonal conflict, legal problems and substance abuse. Those experiencing problems with anxiety are at increased risk for later problems with anxiety, depression and substance abuse.

Inexpensive classroom programs to assist these children have shown a positive impact on functioning many years later. Evaluations of anxiety programs in Australia, particularly, show longlasting results from very economical school-based interventions. In late adolescence and early adult years, there have also been promising developments with school-based programs to reduce problems with binge drinking. With adults, mental-health promotion is possible by reducing stress and increasing social support in the workplace and by reducing the impacts of poverty.

Still, there has been very little spent on research or programs of prevention in the mental-health field. The public-awareness campaigns that some people equate with prevention have some value, but they are not remotely adequate. We should be spending more research dollars to develop and evaluate prevention approaches and implement them as they are shown to be effective.

Beyond prevention, there is much that we should be doing to improve the treatment of mental-health problems in Canada. There has been a tremendous effort over the last 10 years to improve the recognition of mental-health problems and the provision of drug treatments in primary care. Much of this effort has been supported by the pharmaceutical industry. Individuals seeking help are often identified more quickly than in the past and offered medication treatment.

But psychosocial treatments, at least as effective as medication for problems such as anxiety and depression, are usually very difficult for primary-care providers and the public to arrange. These treatments are preferred by many consumers (particularly young people) and have the advantage in many cases of longer-lasting results, fewer side-effects, and lower medium- to long-term cost.

There is clear evidence that offering treatments closer to where people live (the school, in the case of young people, and the workplace and primary-care community settings for adults) will increase the uptake of services. Developing strategies to make these services more available has the potential to reduce the cost (per treated individual) and increase the acceptability of treatment for many mental-health problems. Our social services programs should be provided with more support to provide mental-health assistance to those most in need, and reach out to the most underserved groups.

As in all areas of health, developing strong public policy that supports health promotion will be the key to reducing the human suffering and economic losses associated with widespread mental-health problems.

Dr. John Walker is a Professor in the Department of Clinical Health Psychology at the University of Manitoba and Director of the Anxiety Disorders Program at St. Boniface General Hospital.