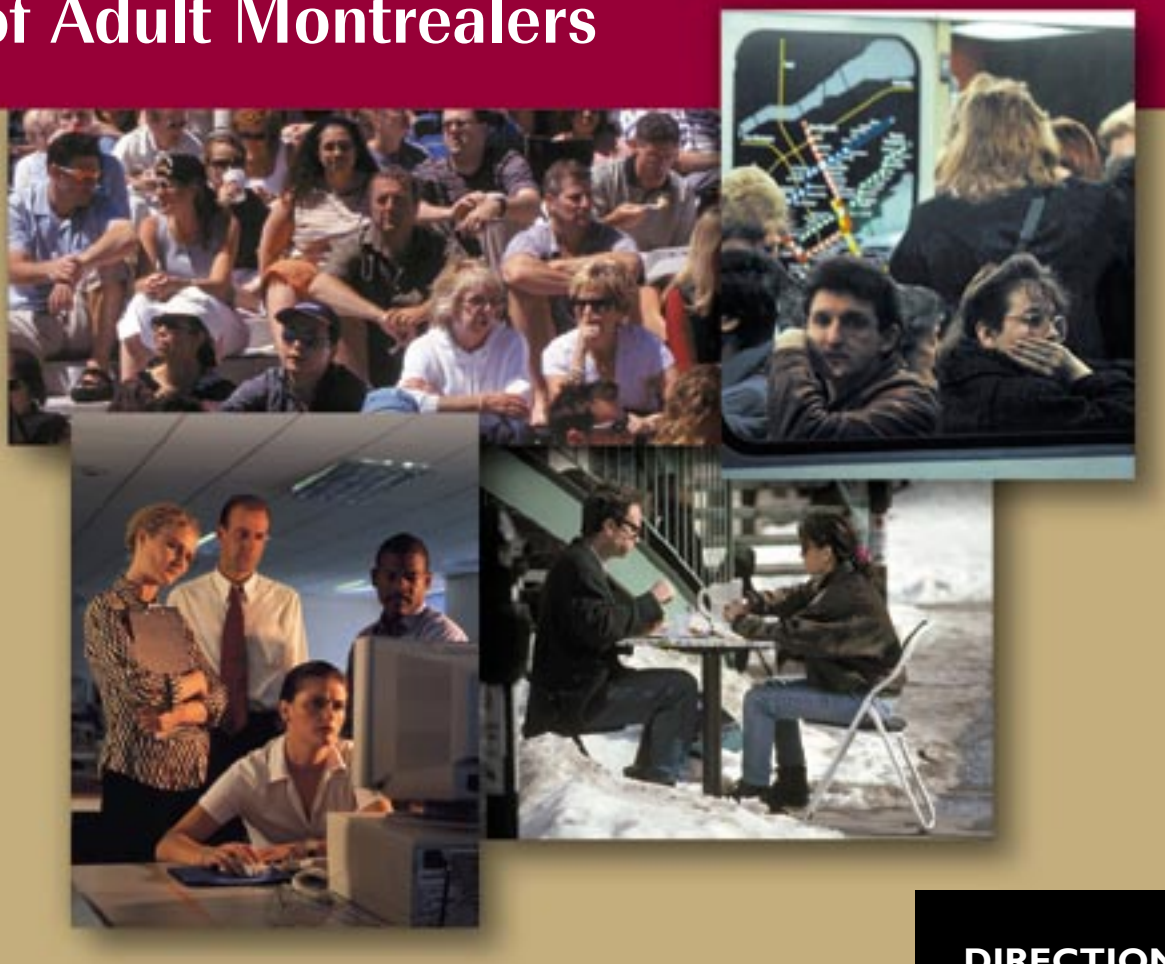
RÉGIE RÉGIONALE
DE LA SANTÉ ET DES
SERVICES SOCIAUX
DE MONTRÉAL-CENTRE

2001 Annual Report
on the Health of the Population

Keeping People Healthy:
A New Perspective on the Mental Health of Adult Montrealers



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DE LA SANTÉ
PUBLIQUE

Garder notre monde en santé

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on the Health of the Population

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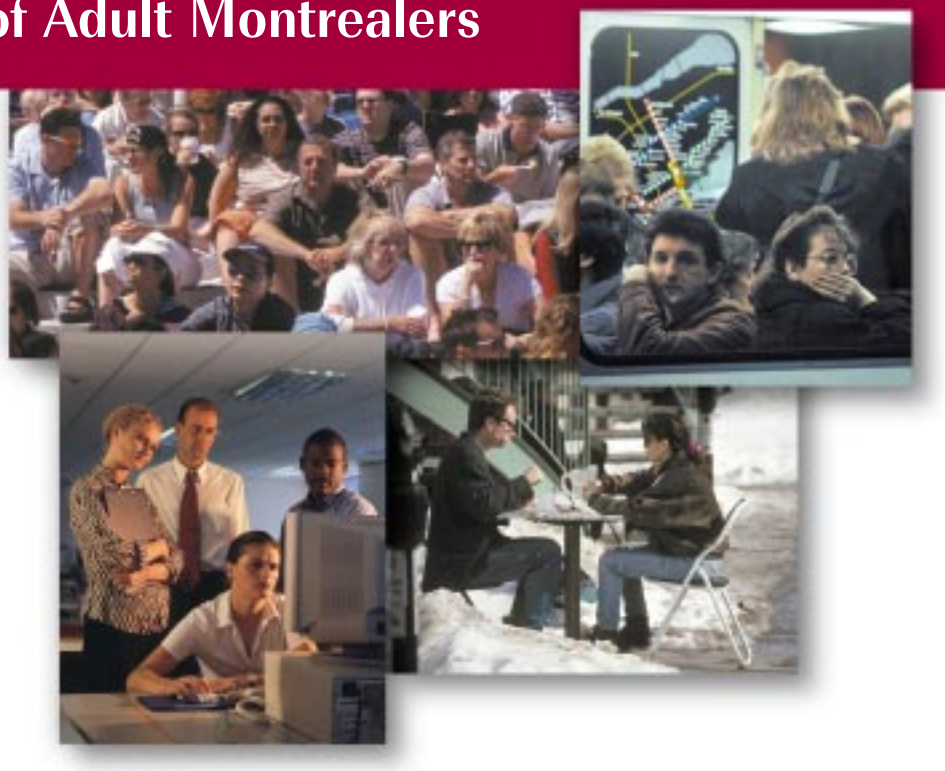

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Acknowledgements

Unlike our previous annual reports, this fourth edition is based largely on the work of one team, the mental health team attached to the Human and Social Ecology Unit. These professionals were the driving force of an important survey on the mental health of Montrealers which is the backbone of this annual report. I would like to take this opportunity to underline the quality of their work in regards to both the survey and the analysis. Special thanks go to the project team who gave two years of their time to this endeavour. Finally, we thank all who, either directly or indirectly, made it possible to bring this project to its successful conclusion.

Richard Lessard, M.D.
Director of Public Health

Foreword

Having examined successively in recent years social inequalities in health, the challenges facing an ageing population and the impact on health of the reorganization of the Montréal health care network, we are seeking in the 2001 annual report on public health to shed light on the mental health of adult Montrealers. If we have decided to entitle the report Keeping People Healthy, which was already our motto and, to some extent, our reason for existing as an organization, it is precisely to emphasize that the maintenance and enhancement of mental health is becoming an increasingly important issue in the community.

The problem of mental health has, for a long time, been considered essentially from a clinical standpoint. We are proposing to broach it in a public health perspective, as the World Health Organization has done, on a different scale, in its recently published report on mental health. We are interested not only in the prevalence of mental disorders but also in their determinants, with a view to proposing enhancements to the organization of services for individuals suffering from severe or transient disorders and to suggesting courses of action to maintain and enhance the mental health of the population overall.

Public health has, for a long time, gone beyond the scope of its traditional fields, i.e. infectious diseases and the environment. We are earmarking considerable resources for children and young people, for example. Several years ago, we decided to focus on the mental health of adults, a neglected area in the public health field, and set up a team interested in matching services and needs. It is the professionals from this team who conducted in 1999 an extensive survey of the mental health of Montrealers, the unpublished findings of which form the cornerstone of this report.

On the way, we felt it was important to broaden our reflection to include the opinions of community interveners such as managers, professionals and volunteers, in order to ascertain their reactions to the survey's findings and compare the findings with their knowledge of the milieu and practices. To this end, last September, we organized a round-table discussion with a number of the interveners to present to them our preliminary findings and encourage them to share with us their assessment of the situation. Their perceptions and comments considerably enriched our subsequent deliberations, especially from the standpoint of possible

courses of action. We would like to thank them sincerely for their contribution. Several excerpts from the round-table discussion are presented in special sections in the first two chapters of the annual report.

The annual reports of the Direction de la santé publique have a twofold function. The first function relates to the mandate of obtaining information on and monitoring the state of health of Montrealers. The report presents findings on the state of mental health of the population (Chapter 1) and data concerning mental health services (Chapter 2). Of course, these findings are incomplete and are far from reflecting the entire range of problems. However, they highlight a number of grey areas that warrant further examination and comment.

The second function is to analyse and discuss these data in order to share our conclusions with our partners and the public. Chapter 3 presents this analysis and proposes a number of recommendations.

Mental health is mobilizing budgets that reflect the burden of suffering that it imposes. Can we do better with the means at our disposal? Can we truly work together to keep people healthy?

Richard Lessard, M. D.
Director of Public Health

Round-table discussion of mental health interveners

September 17, 2001

Participants

Denis Aumais, volunteer with the Regroupement alternatif et communautaire des organismes en santé mentale (RACOR)

Rose-Marie Charest, clinical psychologist, President of the Ordre des psychologues du Québec

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Paul Lefort, general practitioner

André Luyet, psychiatrist, head of the psychiatry department, Hôpital Louis-Hypolite-Lafontaine, and President of the Assemblée des chefs de psychiatrie de l'Île de Montréal

Daniel Fecteau, Director General, CLSC Parc Extension

Moderator

Robert Perreault, psychiatrist, Direction de la santé publique

Summary

In its fourth annual report on public health, entitled *Keeping People Healthy: A New Perspective on the Mental Health of Adult Montrealers*, the Direction de la santé publique de Montréal-Centre (DSP) is focusing on the mental health of adult Montrealers. A number of sources confirm that mental health problems appear to be growing. WHO has noted, in particular, that five of the 10 most common causes of disability are related to mental disorders. In westernized societies, such disorders apparently rank second from the standpoint of the burden of the disease, just after cardiovascular diseases and ahead of various types of cancer. The European Community maintains that mental health problems have reached epidemic proportions.

Several years ago, the DSP established a team of mental health professionals who have sought, by and large, to match services and needs. In 1999, the team conducted an unprecedented regional survey on the mental health of Montrealers in conjunction with one of the measures in the "Accent on Access" plan adopted by the Régie régionale de Montréal-Centre. We have relied extensively on data from this survey to take stock of the mental health of Montrealers and recourse to services.

In particular, the survey reveals that 11% of Montrealers display one of the disorders measured during the previous year; one adult in five displays signs of psychological suffering; 18% of adults appear to require care; women do not necessarily seem to be more at risk than men; young adults are apparently more fragile than their elders; poor people suffer more extensively than others from mental disorders; and being in a relationship seems to provide protection.

From the standpoint of the use of services, the survey reveals that general practitioners are most frequently consulted; 50% of adult Montrealers grappling with mental disorders do not make use of any service; and relatively fewer young and elderly people use services. Among Montrealers who need care, only 20% appear to receive an appropriate response to their needs.

Given the occasionally surprising scope of the problems revealed by the survey, this report attempts to answer a number of questions. Is our health care system adequately serving the public with regard to availability, access, continuity and efficiency? Are our prevention and promotion programs and resources contributing sufficiently to reducing risk and enabling individuals to adopt habits that promote good mental health?

Generally speaking, the data presented reveal that Montrealers' needs are not matched with the services provided. Research suggests that transient disorders are the most frequent and that the individuals concerned or the professionals that they consult all too often overlook them. Such disorders are the main need that is not being satisfied. Moreover, the data

suggest that the management of severe, persistent disorders continues to be the principal mission of the mental health network. While the network does offer access to specialized services, it seems to have a harder time proposing solutions geared to genuine social reintegration. The authors' observations suggest that prevention continues to be the poor relation from the standpoint of services offered in the region.

When all is said and done, even if the Montréal health care network had been a precursor in the realm of the integration of services, problems persist. At present, while cooperation is growing, much remains to be done to harmonize the organization of services and better manage activities as regards each intervener's contribution and role, especially in terms of the integration of front-line services in the system.

Data concerning mental health in the workplace clearly indicate that the problem is growing and that it is not widely acknowledged by employees and employers or even the Commission de la santé et de la sécurité du travail. The authors deem this to be a research priority. However, beyond the health care network, the problem also demands genuine cooperation between employers, employees and researchers.

What can we do to maintain good mental health? The authors encourage us to rediscover the crucial, indeed therapeutic role, played by the confidant. Confiding in friends or relatives whom we esteem is an essential strategy for maintaining mental health. Another message that needs to be more widely disseminated is that consulting a professional can make a difference. To seek help to cope with psychological distress should be just as normal as consulting a physician concerning a physical symptom. We must also demystify mental illness and mental disorders by emphasizing the biological foundation of mental health. As interveners in the health care system, we must empower individuals with respect to their health, by such means as the simplification of information. Information on community resources should also be an integral part of the information disseminated.

This report emphasizes certain principles that could help guide the initiatives of various interveners, e.g. rely on protection factors, act early to reduce risk, minimize obstacles to access to services, integrate front-, second- and third-line services, inform and train, invest in the workplace, and establish the appropriate governance in the mental health care system.

Concretely, we must step up research, involve the public, improve support to caregivers, ensure that front-line professionals detect illness and intervene more rapidly, refocus specialized services on the second- and third-line sectors, better harmonize the initiatives of the community network, and ensure that managers learn to better manage complexity. The Direction de la santé publique believes that these are the key avenues that warrant consideration by those interveners in a position to enhance the mental health of Montrealers.

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Introduction

While most of us know about heart health and back health, mental health and mental illness are more obscure. They are complex issues that come to mind when we read about suicide statistics in the newspaper or meet a homeless person in the street who seems deeply disturbed.

Mental health figures more prominently in our lives than it appears to. Work colleagues suffering from burn-out, depressed relatives or friends, suicide attempts in the family: who among us has never directly or indirectly confronted mental health?

Public health focuses on the health of the entire population. It studies major health problems, helps to evaluate services and intervenes to protect the public from risks, prevent disease and promote health. Are mental health problems sufficiently widespread in society to warrant focusing on them from a public health standpoint?

According to the World Health Organization, five of the 10 leading causes of disability are related to mental disorders. Moreover, mental and behavioural disorders account for an estimated 12% of overall morbidity. In westernized societies, such disorders rank second with regard to the global burden of disease, i.e. 15.4 years lost through premature death or lived with a disability, and they rank just after cardiovascular disease (18.6 years lost) and ahead of all forms of cancer combined[1]. Among these mental disorders, mention should first be made of depression, followed by schizophrenia, bipolar disorders, and post-traumatic stress. Furthermore, these problems appear to becoming more widespread since, in countries with high incomes, neuropsychiatric diseases accounted in 1998 for 23% of years lived with a disability, compared with 15% in 1990[2]. An estimated 15% to 20% of adults now suffer from a mental health problem and at least one person in three will suffer from such a problem in his lifetime. In nearly one case out of seven, the mental disorder is accompanied by a second disorder, such as alcohol or drug dependence. This comorbidity is often associated with the chronicity of problems and more extensive use of services[3].

These high figures warrant examination from a public health perspective. Given the scope of what is described in the European Community as an epidemic of mental disorders, in 1998 the Direction de la santé publique de Montréal-Centre set up a research team dedicated to mental health. Under its initial mandate, the team conducted the survey of the mental health of Montrealers, the findings of which form the cornerstone of this report and make it possible to respond to one of the measures adopted in the Régie régionale de Montréal-Centre's Accent on Access. The survey's findings allow us to draw a portrait of the mental health of Montrealers and the use they make of services. An analysis of these findings, combined with other information, will help clarify the challenges posed by the organization of services, the prevention of mental disorders and the promotion of mental health.

Until now, we have spoken of mental illness or mental disorders, on the one hand, and mental health, on the other. Following the example of a number of recognized experts, we believe that it is useful to make a distinction between the two expressions since they do not entirely describe the same situations and do not lead to the same type of intervention.

Mental health is the ability to make effective use of one's mental functions in order to engage in productive activities, maintain satisfying relationships with other people, adapt to change, and face adversity. It is essential for personal well-being, family and interpersonal relationships and the ability to participate in community life. It is the source of thought, communication, learning, emotional growth, self-esteem and resilience(a) and is virtually invisible to us as long as we do not have to contend with problems.

Mental health is equally tied to community and individual values and depends on numerous, interdependent factors such as economic, social, cultural, environmental and political conditions. It is, of course, hard to define, which complicates the implementation of mental health promotion programs. Mental health is, nonetheless, of fundamental

(a) Psychological robustness that enables some people to better contend than others with adversity and obstacles.

importance, which demands that we take the initiative to protect it and to create as many conditions as possible to foster its development.

Mental disorders or mental illness refer to disorders that can be diagnosed and that lead to an observable deterioration in cognitive ability, such as Alzheimer's disease, affective competence (e.g. depression), or behavioural capacity (e.g. attention disorder). In return, these changes engender numerous problems, such as distress, reduced social functioning, risk of death, suffering and loss of freedom. There are several ways of categorizing mental disorders and the most widely recognized method in North America is that of the American Psychiatric Association.[b] A distinction is usually made between severe mental disorders, which are generally chronic, and transient disorders, which can be of varying intensity but in respect of which the patient is more likely to regain a previous level of psychological and social functioning. Aside from the notion of mental disorder, other concepts such as **psychological distress** or **psychological suffering** are used.[c] While they are less specific than pathologies that can be diagnosed, they are nonetheless used to define genuine suffering.

The current state of knowledge allows us to confirm that most mental disorders result from complex causal chains in which biological vulnerability affects a number of environmental factors. The most effective treatments combine pharmacology, psychotherapy and environmental management. Such knowledge encourages us to no longer establish an ironclad distinction between physical and mental illness, an important step in changing attitudes. We also know that how the patient experiences the illness will depend largely on the degree of tolerance that society displays toward mental disorders. It also depends on the continuity of services offered to the patient.

We are broaching the question of mental health according to the conventional public health approach, which consists in recognizing who is well and who is sick, advocating intervention that ensures

(b) *Diagnostic and Statistical Manual*, Version 4 (DSM IV). This classification is used throughout the report.

(c) These concepts are used in population studies and are defined later.

that those who are well stay that way (the promotion of mental health), that those at risk obtain the necessary tools to control such risk (the prevention of psychological distress and mental illness, if possible), that those suffering from transient mental disorders quickly obtain the best treatment, and that those suffering from chronic mental disorders obtain the appropriate care.

Mental health is no longer reserved for major psychiatric hospitals. Most mentally ill people live in the community. Does our health care system adequately serve individuals suffering from mental disorders from the standpoint of availability, accessibility, continuity and efficiency? Does our prevention system offer sufficient staff, programs and resources to help reduce risks? Are we doing enough to promote the acquisition of abilities and skills to help individuals develop and maintain good mental health?

The public health approach poses such questions and attempts to answer them by means of scientific tools. It is the magnitude of the problems revealed by our survey of the mental health of Montrealers that triggered our decision to examine the question in our annual report. We have emphasized the development of knowledge specific to Montréal and the development of epidemiological monitoring tools. This report comprises data of various origins, drawn from surveys of different segments of Montréal's population or other sources, especially as regards the prevention of mental illness and the promotion of mental health.

Chapter 1 is devoted to the first ever assessment of the state of mental health of adult residents of Montréal-Centre and their needs. Chapter 2 analyses priority problems, which affords us an opportunity to examine the formal and informal assistance networks and the role played by prevention and promotion in the realm of mental health, not to mention the very topical issue of mental health in the workplace. Chapter 3 focuses on the initiatives that the Direction de la santé publique is advocating.

Background of the Mental Health Survey of Montrealers

To take stock of the mental health status of Montrealers, the population was divided into three sub-groups, i.e. the general population, individuals suffering from severe psychiatric disorders and individuals with particular needs. Indeed, needs differ significantly from one sub-group to another as do the ways of responding to such needs.

The first group comprises the vast majority of individuals living in private households, roughly three-quarters of whom are fairly psychologically balanced, individuals experiencing momentary psychological distress, and a smaller proportion of individuals suffering from more or less transient mental disorders. The population study is the best means of taking stock of the state of mental health of this group. Public information systems cannot provide information since, as we will see later, an important proportion of individuals in need have no contact with services.

As for individuals suffering from severe psychiatric disorders, the population study is not the best means of ascertaining their needs even though such individuals are living, increasingly, in the community. They are few in number, are less likely to have a telephone and are more inclined to refuse to take part in a survey. However, they often have contact with services, either because they are hospitalized, are receiving residential services or are receiving care on a fairly regular basis. Their care needs are, indeed, much greater. Information systems, such as the RAMQ information system, are much more useful, despite certain shortcomings. These individuals were not reached through our survey but, through other studies, and we will examine them and their needs in Chapter 2.

The population survey cannot reach another group of individuals who are very unwell, do not live in private households and appear not to use the health care system. For 20 years or so, in the wake of the reform of the mental health services network, the number of homeless people suffering from major psychiatric disorders has increased. Since these individuals are most numerous in the Montréal region, we will examine

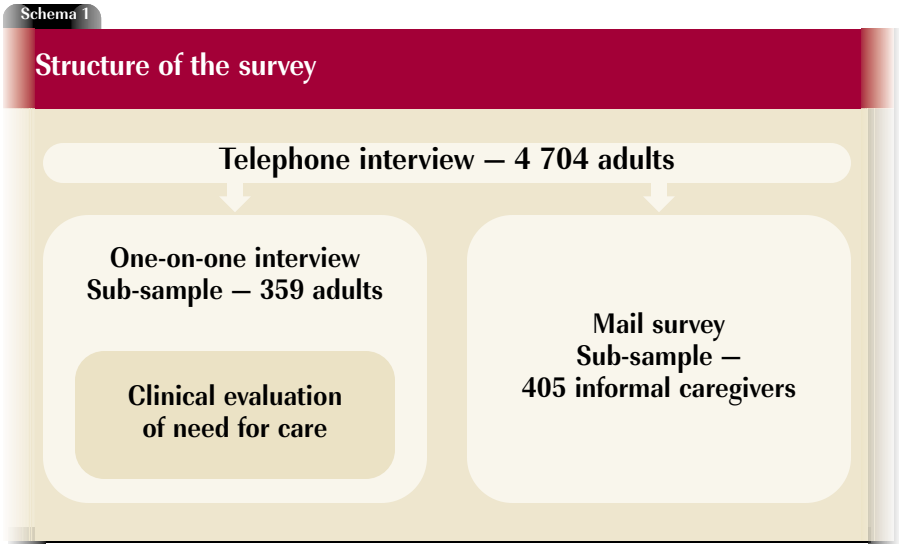
them in this report, especially as our researchers have conducted studies in this respect. In a population as diverse as that of Montréal, there are many other types of specific needs, e.g. those of immigrants. We are unable to present an exhaustive profile of each segment of the population but will briefly look at some of these needs.

Population survey method

In 1999, to ascertain the state of the mental health of adult Montrealers, belonging to the first group, the Direction de la santé publique conducted a three-part study:(d)

1) a telephone survey, above all to assess the state of mental health and recourse to services;
2) a more thorough one-on-one study with a sub-group of individuals with a view to highlighting mental health care needs and the appropriateness of the services received;
3) mail survey aimed at another sub-group of individuals who are caregivers for individuals in their immediate circle suffering from mental health problems.

Schema 1



(d) The research report of this survey presents complete details of the methodology.

Telephone interview

The first part of the survey, conducted among 4 704 randomly selected adults representing all Montrealers,[e] was intended, first and foremost, to evaluate the proportion of individuals suffering from mental disorders within the preceding 12 months[f] and in the course of their lifetimes.[g] The disorders measured are the most frequent ones[h] : depressive disorders, such as major depression; anxiety disorders, such as phobias, panic disorder and generalized anxiety disorder; and drug- or alcohol-related disorders. We also studied pathological gambling, which is deemed to be an emerging problem. Other indicators of psychological suffering were also assessed, i.e. certain disabilities, suicidal thoughts or attempted suicide and individual perception of state of mental health.

For the purpose of this survey, the notion of psychological suffering[i] encompasses:

- mental illness, if it was present during the past year;
- a rather negative perception of the individual's state of mental health in relation to other individuals of the same age;
- some inability to perform everyday tasks during the previous month, e.g. the individual had to stay in bed at least one day, was unable to engage in his usual activities or had to reduce them because of emotional or nervous problems or because of the consumption of alcohol or drugs;
- the presence of suicidal thoughts during the preceding 12 months.

(e) Montrealers are deemed to be the inhabitants of the Montréal-Centre region, i.e. all of Montréal Island.

(f) The 12 preceding months give a better idea of the magnitude of the problem in a recent period and are thus more useful with respect to the planning of services.

(g) The course of a lifetime gives a more accurate idea of accumulated problems than the preceding 12 months and the proportion of individuals affected in the past and whose disorder was considered cured within the 12 preceding months. While most individuals are deemed to be cured, some may remain fragile and require care to maintain their psychological equilibrium.

(h) Excluding most rare or serious disorders, such as psychoses.

(i) The concept of psychological suffering, as defined, was incorporated into the survey in light of the impossibility of measuring psychological distress during a telephone interview.

Respondents were also questioned on recourse to services and the consumption of prescription drugs. The survey made it possible to measure the respondents' knowledge of mental disorders and negative beliefs[j] concerning those suffering from such disorders. A series of questions made it possible to identify and briefly describe informal caregivers.

One-on-one interview

The second phase of the survey assessed care needs. Some of the respondents surveyed by telephone were invited to a second interview in order to examine more thoroughly the question of care needs. The survey focused, first and foremost, on individuals who had suffered recently from mental disorders, those who had suffered from such disorders in the past, those presenting only symptoms of mental health problems, and individuals who apparently displayed no sign of problems. Some 359 people agreed to participate in one-on-one interviews with psychologists lasting roughly 90 minutes. The mental disorders were measured once again, but this time, according to a broader range. Psychological distress,[k] [4] the presence of chronic diseases and physical impairments, stressful events that had occurred during the preceding year, the support network and social functioning were also examined. Precise information on the utilisation of services and medication intake was also collected and barriers and attitudes involving care were closely studied.

(j) A scale of measurement to pinpoint various myths associated with mental illness and conveyed by the public.

(k) Psychological distress is often described as a state of discomfort or malaise that does not necessarily reach significant clinical intensity. It is to overall mental health what fever, broadly speaking, is to infectious diseases, i.e. a measurable symptom, an obvious sign of a health problem but one which, by itself, cannot shed light on the cause and seriousness of the problem that it reveals. This notion has been used in the Santé Québec general health survey for over 10 years. The level of psychological distress is measured by means of the presence and frequency during the preceding week of symptoms of depression, anxiety, cognitive disabilities and irritability.

All of the data were analysed by a team of clinicians, i.e. a psychologist and a general practitioner who, by means of a structured evaluation grid, determined the individual's level of functioning, care needs, the type of treatment required, and the appropriateness of the services received.

Mail survey

The third phase of our survey focused on the caregivers of individuals grappling with mental health problems. We wanted to examine the assistance given to individuals suffering from all kinds of mental health problems, not just severe, chronic disorders. A caregiver was deemed to be anyone offering at least once every 15 days any kind of non-professional assistance to someone close to him suffering from emotional or nervous problems during the preceding month. In this way, we ascertained the number of people playing this role. In our survey, caregiving is regarded as a life experience, not just as a burden, a perspective that enables us to examine negative and positive facets of caregiving. Since caregiving can affect the physical and mental health of the caregiver, we studied the relationship between the caregiving context and the caregiver's mental health. We also collected information on requests by caregivers for consultations with various services, either in respect of their personal needs or to help them better fulfil their roles as caregivers.

1 Portrait of the Mental Health of Montrealers

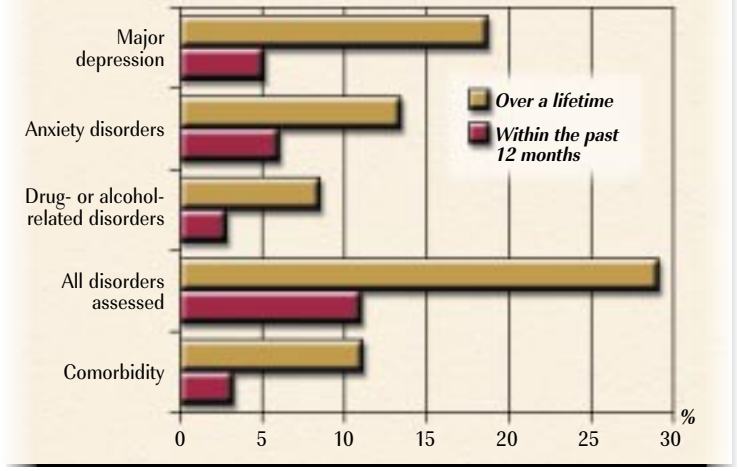
Through the survey of the mental health of Montrealers, we can more closely examine care needs, recourse to services, and the appropriateness of the services received. In this chapter, an emerging problem, pathological gambling, will also be examined along with two key themes, the mental health of the homeless and suicide, one of the most dramatic consequences of poor mental health.

State of mental health

The survey reveals that during the preceding year 11% of Montrealers appear to suffer from one of the disorders measured. Anxiety disorders are the most frequent (6%), followed closely by major depression (5%), and by disorders stemming from drug or alcohol use (3%). During their lifetimes, one of these disorders will affect 29% of the population and, in this instance, major depresssion is the most prevalent. Once again, it should be noted that the survey did not focus on severe and frequently protracted disorders, which affect approximately 2% of the population.

Chart 1

Prevalence of mental disorders over a lifetime or during a 12-month period



An individual may suffer from more than one of these disorders, e.g. major depression, anxiety disorders and disorders related to alcohol and drug use, a condition known as comorbidity. Over a lifetime or during a year, comorbidity affects roughly one-third of individuals suffering from mental disorders.

Psychological suffering affects one adult in five

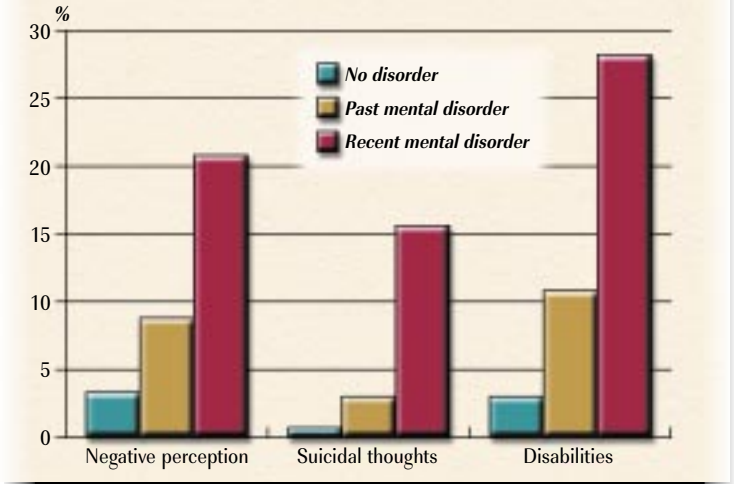
Our survey reveals that nearly 19% of Montrealers display signs of psychological suffering. Few of them display the four symptoms as defined on page 17 (0.6%). Most of them display only one symptom (13%), and 5%, two or three.

Among Montrealers who suffered from a mental disorder within the past 12 months, 28% said they suffered disabilities during the preceding month, 16% entertained suicidal thoughts within the previous year, and 21% deemed their state of mental health to be rather poor. Among the respondents who suffered from a mental disorder in the past, the presence of these other signs is less prevalent but still relatively high. It would appear that many of them remain in a fragile state. However, it is encouraging to note that 75% of respondents who suffered

from an established mental disorder in the past no longer display any sign of suffering. A small proportion of Montrealers perceive their mental health as poor, said they had entertained suicidal thoughts or suffered disabilities without our detecting a recent or past mental disorder. In light of this information, we must not conclude that these forms of suffering are negligible.

Chart 2

Prevalence of signs of psychological suffering according to absence of mental disorders within the past 12 months or sometime in the past



18% of Montrealers need care

According to our clinicians' evaluation, 18% of adults need care. It should be noted in passing that the presence of a mental disorder or suffering does not necessarily call for recourse to health care services. However, the needs detected by the clinicians are clearly associated with various symptoms of psychological suffering.

Mental health problems, i.e. mental disorders, psychological suffering and need for care, are not distributed randomly in the population of Montréal.

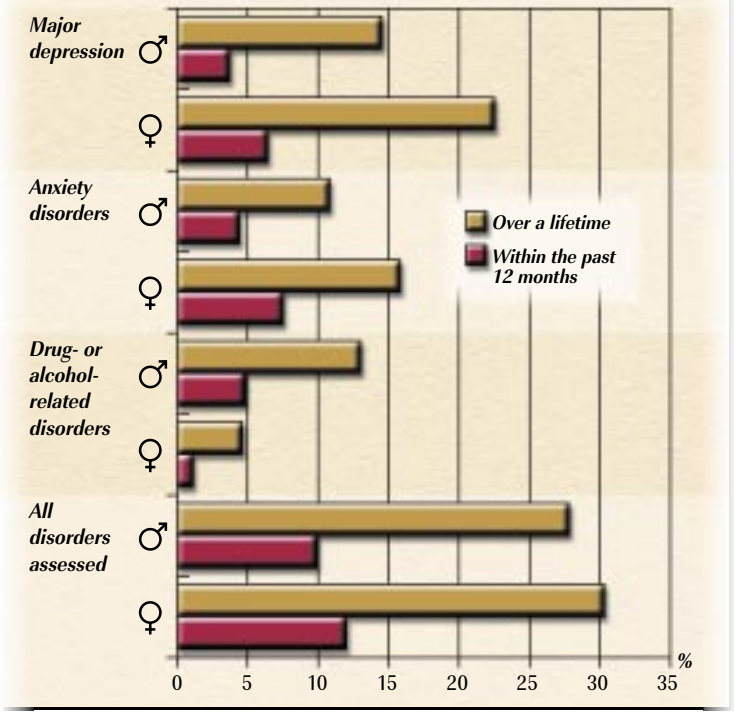
Are women more at risk than men?

More women than men suffer from major depression and anxiety disorders while more men suffer from alcohol- and drug-related disorders. When all disorders are considered, while prevalence tends to be higher among women over the preceding 12 months, it is similar among men and women over the course of a lifetime. Women are also more often affected by psychological suffering. Furthermore, clinicians believe that more women than men need care, although we must not conclude that women are generally more subject to illness than men.

To properly understand the situation, we must look beyond the survey's framework. It should be noted, for example, that mortality rates through suicide are higher among men even though attempted suicides in the course of a lifetime are more numerous among women. Among long-term patients in major psychiatric hospitals, there are roughly six men for every four women, while in short-term-care hospitals, the breakdown is more or less equal. Among the homeless and in prisons, where men make up the majority, there are high proportions of individuals suffering from serious mental disorders. International studies confirm that schizophrenia and other psychoses are more frequent among men. While men are perhaps as frequently affected by mental disorders as women, fewer men are found in the private homes in which we conducted our survey.

Chart 3

Prevalence of mental disorders, by sex



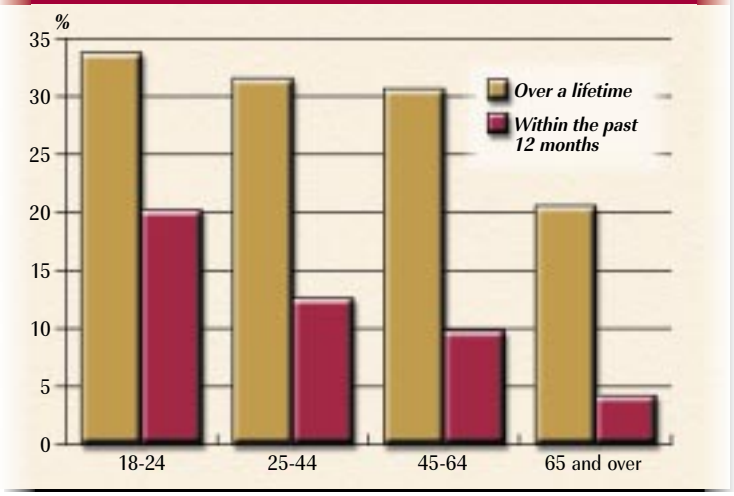
Mortality due to suicide

The problem of suicide is a major public health concern and a reduction in the mortality rate through suicide is one of our province-wide priorities[5]. In relation to other big Canadian cities, Montréal's rank in 1996 was similar to that of Edmonton and Calgary but was markedly above Toronto[6]. The same year, in relation to other regions of Québec, Montréal-Centre had the lowest suicide rate but ranked first due to the size of its population. Mortality through suicide was roughly three times higher among men than among women in 1994-1998, above all in the 20-24 age group and in the 35-54 age group.

Young adults are more fragile

Chart 4

Prevalence of mental disorders, by age (all of the disorders assessed)



An inverse relationship has been observed between age and the prevalence of mental disorders. As age increases, the number of individuals suffering from mental disorders declines, regardless of the type of disorder or the reference period. The same is true of psychological suffering. These tendencies are also noted elsewhere in the world. It may seem surprising that prevalence in the course of a lifetime is not higher among the elderly, given the extensive period of time in which such disorders can develop. Various explanatory hypotheses[7] have been put forward and, in particular:

- selective memory: as we age, the more we forget the distant past, which affects our ability to recall facts;
- major depression and drug- and alcohol-related disorders are closely associated with suicide and the individuals affected are no longer there;
- some types of mental disorders appear to be growing more prevalent in the upcoming generations.

The second hypothesis is a reminder of the importance of responding promptly when an individual displays signs of a mental disorder and the third one encourages us to review the impact of our lifestyles on mental health.

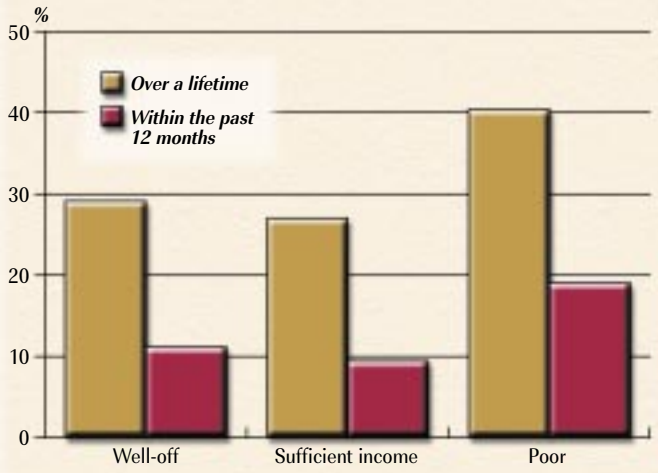
Poverty, both cause and consequence

There is a clear link between poverty and mental disorders. Regardless of the type of disorder and the reference period, individuals who perceive themselves as being poor suffer from markedly more mental disorders than those who believe they have sufficient income or are well-off. The same applies to psychological suffering and need for care.

It has also been noted that more limited education is linked to high prevalence of alcohol- and drug-related disorders, comorbidity, psychological suffering and need for care. Most epidemiological studies conducted here and elsewhere draw similar conclusions. However, it should be noted that these factors can be both the cause and the consequence of mental health problems.

Chart 5

Prevalence of mental disorders, according to perception of financial situation



The homeless

Since the early 1980s, we have been hearing more and more about mental disorders among the homeless. The reform of psychiatric care has been called into question, especially deinstitutionalization combined with inadequate community programs aimed at the chronically ill in order to offset the loss of beds. Unfavourable economic conditions have also been cited, e.g. unemployment, the reduction in social assistance programs and the decrease in the number of low-cost housing units.

According to a study conducted in 1998[8], the network of services for the homeless in Montréal deals with 28 000 individuals per year, 13 000 of whom have no fixed address. A subsequent survey[9] revealed a very high frequency of mental disorders, i.e. 43% of disorders such as schizophrenia, major depression, bipolar disorder and pathological gambling. Figures are equally high in respect of drug- and alcohol-related disorders: 46% of the homeless display one disorder and 17%, both. Personality disorders are also very frequent. Overall, 7 out of 10 individuals suffer from at least one of the three types of disorders measured and, as is to be expected, comorbidity is very high.

The homeless are much harder to treat, in particular because of difficult childhoods, the combination of disorders and their social alienation. Given that the disorders very often begin prior to the first period of homelessness (this is true of 75% of homeless people hospitalized in psychiatry[10]), adequate post-hospital follow-up would perhaps prevent the mentally ill from becoming homeless.

Relationships provide protection

Couples with children appear to have the best living situation. Single parents and separated and divorced individuals are more likely to display a high prevalence of mental disorders, experience psychological suffering and need care. These living situations are just as likely to be a cause as a consequence of mental disorders. We know that such disorders can wreck havoc to a relationship, just as the problems experienced by a couple represent stressful events that can unleash or aggravate this type of disorder. Be that as it may, such individuals warrant our attention from the standpoint of the planning of services.

Cultural diversity

Individuals born in Canada are at greater risk of suffering, or having suffered, from a mental disorder than those born outside the country. More native-born than foreign-born Canadians require care. Four hypotheses appear to explain these discrepancies. The survey does not enable us to evaluate disorders linked to trauma experienced by immigrants exposed to acts of war and organized violence such as torture and disappearance nor, perhaps, does it make it possible to understand cultural differences in the expression of psychological suffering. Persons who decide to immigrate are often in a better state of physical and mental health, this is a natural selection in the country of origin. Selection criteria governing immigrants also ensure that individuals with the most resources are admitted, thus creating a selection effect upon entry into Canada. All of these factors warrant caution with respect to the interpretation of the findings. Care offered to immigrants poses special problems, among others to make a diagnosis despite cultural and linguistic barriers. Given the considerable cultural diversity of the Montréal-Centre region, access to and the availability of adapted services must remain an objective to be achieved.

Use of services

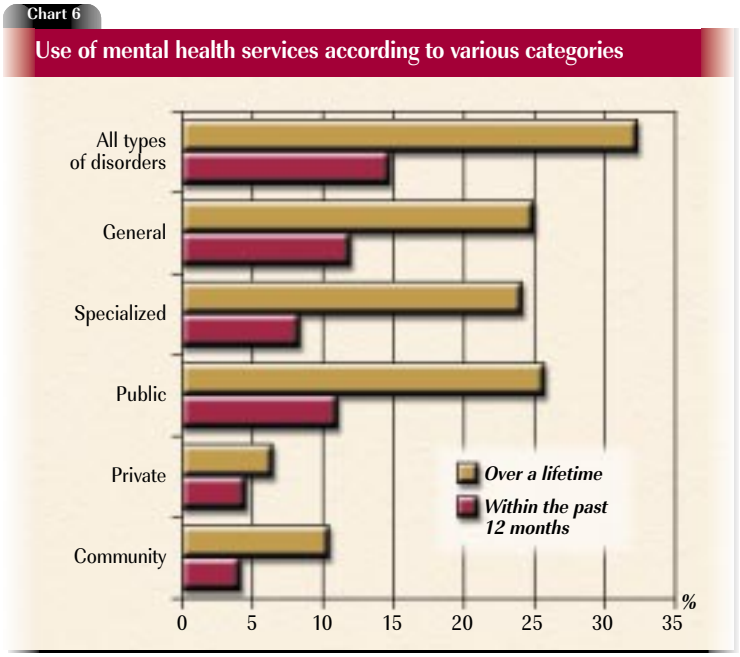
What use do Montrealers make of mental health services? Just over three Montrealers in 10 have relied on such services during their lifetime, of whom roughly half have done so over the past 12 months. Such services are defined very broadly and cover everything from hospitalization in psychiatric care to a visit to a member of the clergy.

General practitioners, the most consulted health professional

GPs are the most widely consulted health professionals with respect to mental health (7% of respondents over the preceding 12 months), followed by psychologists (5%), psychiatrists (2.7%), other medical specialists, social workers and alternative medicine specialists. Respondents also consulted other types of professionals, but to a lesser extent. According to a study conducted in the east end of Montréal,[11] greater numbers of patients consult GPs, but psychologists are consulted most often by a given person in a year, i.e. 4.5 visits in the case of GPs, 21.1 visits in the case of the psychologists, and 4.5 visits in the case of psychiatrists.

Chart 6

Use of mental health services according to various categories



Very few Montrealers (0.6%) indicated that they had been hospitalized in the 12 preceding months and 1.1% of respondents said that they had gone to an emergency department. Thus, hospitalization in the psychiatric ward is a fairly rare occurrence for most people living at home.

When Montrealers consult a health professional, they rely more often on general services(l) than specialized services.(m) Moreover, they tend to

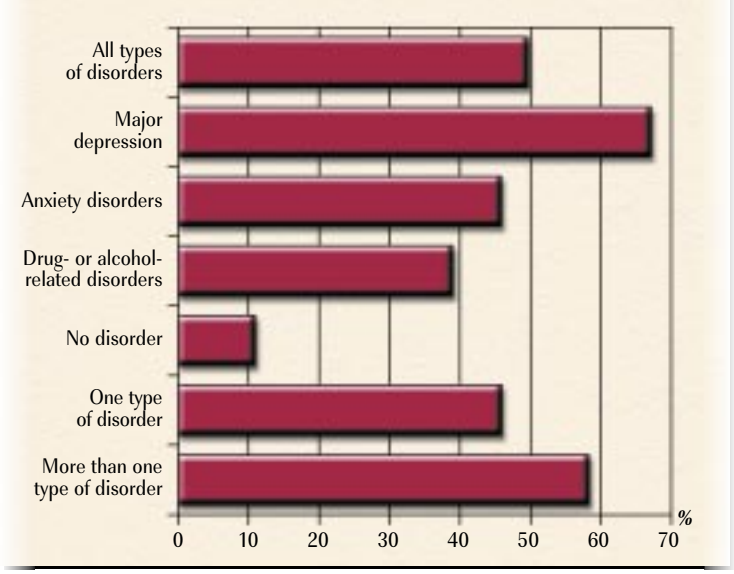
(l) Physicians (except psychiatrists), social workers, nurses and occupational therapists, CLSCs, alternative medicine, and members of the clergy.

(m) Psychiatrists, psychologists, hospitalization, visits to emergency admitting and psychiatric outpatient clinics, community agencies, self-help groups, crisis centres, drug addiction treatment centres, and so on.

rely more extensively on public services[n] than private[o] or community services.[p] It is, nonetheless, astonishing that, in a free health care system such as ours, approximately one-third of the respondents make use of services provided by professionals whom they must pay, above all psychologists in private practice.

Chart 7

Use of services according to the presence of mental disorders (within the past 12 months)



What about individuals suffering from a mental disorder? Roughly 50% of Montrealers who were coping during the past year with this type of disorder and 56% of those coping with psychological suffering did not rely on any service. While such conditions do not always demand care, over half of the individuals who need care are not seeking out services to answer their needs, according to our clinicians' assessment. People suffering from major depression and those suffering from more than one disorder are more inclined to use services. The individuals who, according to our clinicians need care, are more likely to rely on specialized care when they make use of services.

Who consults physicians?

As might be suspected, the individuals most likely to consult a health professional are those displaying the most signs of psychological suffering. Given similar psychological suffering, young people (in the 18-24 age group), the elderly (65 and over), as well as individuals living with a spouse and men are less inclined to use services. Certain factors facilitate the use of specific services. Better-educated people resort

(n) All types of physicians, psychologists or psychotherapists in public establishments, social workers, nurses, occupational therapists, CLSC services, and hopital in-resident and outpatient services.

(o) Psychologists and psychotherapists in private practice, alternative medicine.

(p) Self-help groups, community agencies, telephone help-lines, members of the clergy, crisis centres and addiction treatment centres.

more extensively to specialized services, especially private services. Those individuals who harbour more negative beliefs about the mentally ill are less inclined to resort to services.

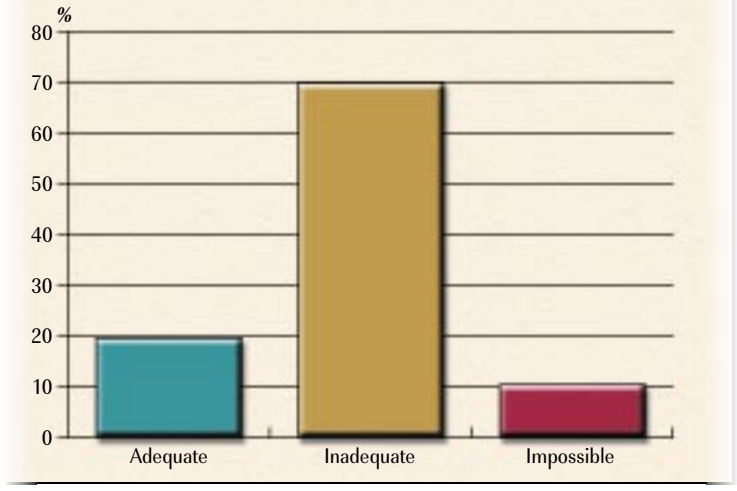
The place where patients usually consult a health professional with respect to health problems is also more or less suited to expressing their needs. For example, a patient who is in the habit of consulting a physician in the latter's office or at a CLSC will probably more readily talk about his symptoms than in an emergency department or a walk-in clinic. According to our analyses, men, young people and less well educated individuals are more likely to consult in this way, precisely the groups that tend not to use services when they experience psychological suffering. It is important to have a family physician, with whom it appears easier to establish a relationship.

Appropriateness of services

Among the 18% of Montrealers who, according to our clinicians, need care, only 20% are receiving an adequate response, 70% do not appear to receive the services they require, and the needs of 10% appear to be impossible to satisfy. Those who are not receiving the services they require are experiencing considerable distress and need adapted care. Individuals suffering from anxiety disorders are especially likely not to receive the services they need. As for needs that are impossible to satisfy, they often relate to individuals who refuse all treatment, e.g. psychotherapy, medication, and so on, or in respect of whom all attempts to provide the desired care have proven unsuccessful. This category includes more men than women and individuals with limited education.

Chart 8

Response to need for care



In light of our survey, the population can be broken down into four groups from the standpoint of the planning of services. Members of the first group, which includes the vast majority of Montrealers, have no need for care or recourse to services. It would be advisable to engage in promotional initiatives in order to maintain this state of balance.

According to our teams of clinicians, the members of the second group use services, although they do not need care. Do they make excessive use of services? The data do not suggest as much. This group is probably not homogeneous in that it appears to include individuals suffering from mental disorders that have been more or less cured (six months or one year earlier they would have been assessed as being in need of care) and individuals whose milder psychological suffering has led them to a path of personal growth. The latter may benefit from preventive measures. To the extent that excessive use is not made of services, this group could be combined with the first group from the standpoint of planning services.

Schema 2

Need for care and use of services in the four groups

		Need for care: Yes	Need for care: No
Use of services	Yes	Group 4 9 %	Group 2 7 %
	No	Group 3 9 %	**Group 1 75 %**

The third group is made up of individuals who are deemed in clinical terms to require care but who have not made use of services during the previous year, equivalent to roughly 9% of the population and almost half of the individuals requiring care. It should be noted that these individuals display fewer signs of psychological suffering than those who resort to services (group 4). However, it is disturbing that so many people deemed by clinicians to need care have no contact with the health care system in the broadest sense. It is young people in the 18-24 age group, single parents and individuals who do not claim to have any disabilities or who perceive their state of mental health as adequate who are the least inclined to consult a health professional. As for their clinical profile, it has been noted that this group of

non-users is made up, above all, of individuals suffering from only one mental disorder (in relation to those with more than one disorder), individuals who have suffered in the past from a mental disorder (rather than at present), and individuals suffering from an alcohol- or drug-related disorder. Planning services aimed at this group must focus, first and foremost, on encouraging recourse to services.

" People are seeking help and all they usually get is drugs"

Ghislain Goulet

The last group, which accounts for 9% of the population, is made up of individuals who have been clinically assessed as requiring care and who make use of services. Is their situation better? Not to the extent that we would like. Our clinicians believe that roughly one-third of the members of this group receive adequate care, that 61% do not receive the necessary services and that a small proportion (6%) appear to have needs that are impossible to satisfy. Who are these individuals who, while they do make use of services, do not receive the care they require? As might be expected, their state of mental health appears to deteriorate more than that of patients receiving the necessary care. They display a high degree of psychological distress and perceived their state of mental health as poor. From a clinical standpoint, the problem is assessed as important and comorbidity is frequent. Moreover, when an anxiety disorder or a drug- or alcohol-related disorder is present, the risk that the individual does not receive the appropriate services is greater. The individuals receiving adequate care appear to be those suffering from an isolated case of depression. Level of education also plays a role since the individuals who are not receiving the necessary care are often the least educated.

"The key to the problem of secondary prevention is to offer properly structured support to the GPs..."

Paul Lefort

The inadequacy of the care received seems to stem from irregular services or an interruption in contact with services: 80% of individuals receiving the necessary services said that they had used services during the preceding month, as against only 46% of those who were not receiving adequate services. Planning in respect of this group consists in enhancing detection, referral and treatment.

Pathological gambling

Gambling and betting are very popular among Montrealers, including government-sponsored gambling, betting between friends or illegal gambling. Everyone is familiar with gambling and betting and most people engage in them. Over three-quarters of the population participate or have participated in such activities. Most individuals regard gambling and betting as a form of entertainment or harmless fun and nothing more. While this is most often the case, for a small proportion of the population, gambling is a pathology that affects them and those close to them. In Montréal, roughly 1% of the population is considered to be pathological gamblers, and 2% to be at risk, i.e. approximately 28 000 adults. The situation is even more worrisome among minors. Recent studies reveal that a majority of young people start betting in fourth grade on sporting events or participate in card games, a form of legally accessible gambling, since legislation prohibits minors from participating in government-sponsored gambling. Adults tend to participate in government-sponsored lotteries and to play slot machines and video lottery terminals. A recent study reveals that not all gambling has the same pathological risk. For example, the risk is much higher in the case of slot machines and video lottery terminals.

Community issues

In light of our survey, we have observed, over a 12-month period, that 19% of Montrealers display signs of psychological suffering, including 11% suffering from major depression, an anxiety disorder or a drug- or alcohol-related disorder. According to our clinicians' assessment, a similar proportion of individuals (18%) need care. Mental health problems are not rare in the population and other studies in Canada, the United States, Australia and England have similar findings.

Our study is the first one conducted in Montréal and to get an idea of the change in mental health over time, we must refer to Santé Québec, which, on several occasions, has measured the psychological distress level. Following a significant increase in 1992, the rate appears to have fallen

in 1998 to a level equivalent to what it was in 1987. While, overall, a recrudescence of mental health problems does not seem to have occurred, we have nonetheless observed emerging problems, such as pathological gambling. However, certain problems such as depression and alcohol- and drug-related problems have been increasing for the past 40 or 50 years, a situation that not only affects the planning of adapted services but also underscores the relevance of preventive measures.

Whether the individuals surveyed suffer from a mental disorder, psychological suffering or need care, barely half of them consult health professionals. This is worrisome insofar as such individuals often delay consulting. Their state of mental health can deteriorate, thus making treatment lengthier and more complex. In order for the health care system to help an individual who is suffering, the individual must request assistance in one way or another. However, the individual may be reluctant to do so, for fear of being thought crazy, labelled as mentally ill and rejected by those close to him. In addition, the individual may not be aware that his symptoms reveal a mental health problem or think that the problem will go away of its own accord. Under the circumstances, family and friends can encourage the person to consult a health professional, provided that they recognize the signs of the illness. For this reason, public awareness campaigns are essential.

"There is no leeway for empowerment. It is something important to consider in our practices and our methods of working, if we are to complete deinstitutionalization, among other things. This means integrating these individuals into the community so that they become full-fledged citizens."

Ghislain Goulet

Young adults warrant special attention in respect of measures aimed at encouraging people to seek help. They make up the sub-group in which the highest incidence of mental health morbidity has been noted and which is the least inclined to make use of services. Anxiety disorders are the most frequent among young people. It is regrettable that they do not consult health professionals more extensively since there are effective, relatively short treatments for such disorders. Untreated, anxiety disorders risk degenerating into other disorders, such as major depression or alcohol- or drug-related disorders, or even suicidal behaviour, with the result that intervention becomes much more complex, which explains the importance of intervening early on.

To enhance recourse to services, the health care system also has a role to play. Most people consult a GP, which means the latter plays a key role in detection and access to the appropriate treatment. Many patients consult a GP for various reasons, without always clearly mentioning their mental health problem. It is incumbent upon the physician to be vigilant and to recognize the signs of mental disorders. Some GPs have trouble recognizing the disorders or may be reluctant to do so. For this reason, training and better organized services could overcome these shortcomings.

"Mental health gets short shrift in family medicine"
Paul Lefort

It should also be noted that an analysis of the appropriateness of services reveals that 60% of individuals using services due to a mental health problem do not receive an appropriate response to their needs. When their state of health has badly deteriorated, they are less inclined to resort to specialized services. They have likely asked a GP or another front-line caregiver for assistance. The problem lies, by and large, in the willingness and ability to recognize the disorder and to refer the patient to the appropriate treatment. Accessibility in this instance could well be economic in nature, bearing in mind the link between poverty and psychological suffering, especially as psychotherapy is very often the approach adopted and such treatment usually engenders expenses.

As we have seen, some individuals are more affected than others by mental health problems, a factor that we must bear in mind when targeting various measures. For example, we must clearly allocate more resources to preventive and curative measures among the under-privileged. Moreover, we must offer support measures to help individuals overcome trying events such as separation or divorce.

Round-table discussion with mental health professionals

September 17, 2001

A two-tiered system?

- *One person in three in private consultation is a lot less than I expected. What strikes me is that we have a two-tiered system in mental health. People with money have access to numerous services while those who don't have money have much more limited access. We can only deplore this situation, above all since we know that there is a clear link between mental health and socio-economic conditions. You have to be in good shape and informed to find the appropriate care.* ***Rose-Marie Charest***

- *The findings concerning the level of satisfaction with response to needs and the difficulty of gaining access to services don't surprise me. Nearly 99% of our members live on income security. They experience serious problems in terms of access to different services and diversified services.* ***Ghislain Goulet***

- *Twenty-five years ago, patients were referred to the CLSCs, which are now referring them to private practitioners. What happens to the two-thirds of patients who cannot pay?* ***Rose-Marie Charest***

- *Access to services poses a problem. At the CLSC, we have a mental health team but we do not have a psychologist to ensure long-term follow-up among patients with serious transient disorders. We are trying to refer them to therapists who charge lower rates than their colleagues do. Over time, some CLSCs have succeeded in developing such services, although many do not offer them. If they do offer the services, it is through the mental health team and access is limited.* ***Daniel Fecteau***

Exclusion

- *Homelessness is an extremely complex problem that we must avoid examining in a simplistic manner. We must respect the rights of homeless people who are sick and who categorically refuse to seek care. Often, those in the homeless person's circle are so worried that they force the individual to consult although the latter sees no reason to do so.*

  In the case of the homeless, matching the needy person and service providers is even more complex. ***André Luyet***

- *We are focusing on the homeless and other clienteles but we are overlooking people who have never had contact with the network and who do not wish to do so. They refuse to consult physicians and to be treated but they are willing to talk to friends or other people. Other people have had contact with the network, been disgusted by it, withdrawn from it and want to have nothing to do with it. Still other individuals have as little contact as possible with the system. They take medication to feel well and otherwise rely on community organizations. We must also deal with these people.* ***Denis Aumais***

Empowerment

- *People are seeking help and all they usually get is drugs. They must get out of the loop to find what they are looking for. They often say that they are not just a mental health problem and would like to live their lives. Their entire life revolves around mental-health follow-up and they are not treated as persons but as problems. They are in a ghetto and are having trouble getting out of it and regaining some freedom, which can be found, for example, in the community network.* ***Ghislain Goulet***

- *We are working with users to bring their viewpoints to the attention of decision-makers and those who deliver services in the network. As a group, these people are willing to speak and we must listen to them. Individually, it's exactly the same thing. There is no leeway for empowerment. It is something important to consider in our practices and our methods of working, if we are to complete deinstitutionalization, among other things. This means integrating these individuals into the community so that they become full-fledged citizens.* ***Chislain Goulet***

- *The legislation says that anyone can refuse treatment and thus has the right to abruptly stop taking drugs and experience extreme withdrawal. But if the person does so, he receives no support. When someone wants to take charge of his life, we are not prepared to support him. We tell him that he can't, that he's not informed, that he's mentally ill.* ***Denis Aumais***

Cultural diversity

- *If we fail to take into account cultural diversity, if health care professionals are not prepared to differentiate between an interview with someone of Chinese origin and a native-born Quebecer, people will hit the roof. The US Surgeon General recently emphasized that the crucial problem in mental health at present is that members of the cultural communities do not consult health professionals. Only extremely serious cases of decompensation and psychosis emerge from these communities. We must take a closer look at the problem.* ***Rose-Marie Charest***

- *There is prejudice against psychiatric illnesses in the cultural communities.* ***Jacques Hendlisz***

- *Intervention involving recent immigrants, especially refugees, is overly ghettoized in our network. We leave this type of intervention and clientele to a few establishments that are coping with this problem. However, within a few years, all Montrealers will have to deal with it. We should rely on those establishments and professionals with expertise in the field in order to prepare the upcoming generation of health professionals.*

  The question of post-traumatic shock is another specific problem that we are facing. We have numerous refugees in our sector. People do not necessarily consult us for that reason but we ultimately realize that their malaise stems from post-traumatic shock. Our mental health physician sees and treats many of them. The number of refugees and recent immigrants is growing on Montréal Island. How should we intervene? How can we detect problems? There is much to be done in this respect. ***Daniel Fecteau***

GPs, the gateway to the system

- *The key to the problem of secondary prevention is to offer properly structured support to the GPs who deal with mental health. They would be more interested in doing so if they had this support, i.e. access to a psychiatrist who can be consulted during the day when problems arise.*

  Mental health gets short shrift in family medicine. The population affected unquestionably has a problem obtaining care. However, there is no mention that 85% of mental health problems are dealt with in private practice, where mental health is deemed to be very hard to manage. There are no analyses or X-rays. All we have to guide us is our clinical sense, supported by the DMS-IV, which has 900 pages. Not everyone is motivated enough to get through it. ***Paul Lefort***

Funding

- *Residential facilities are a major problem in the mental health field. We want fewer institutional facilities and more support in the community. However, there are no residential facilities available. We have known for years that this is the number one problem in the central and western portion of Montréal and the same is true almost everywhere else in Montréal.*

  We cannot discuss community organizations without raising the problem of funding. In the wake of the shift to ambulatory care, activities have increased. Community organizations are incapable of fully assuming their role. Funding problems have compelled a number of them to reduce access and services, even when needs and services are properly matched. On top of this, they have trouble keeping staff, which the public network actively recruits. We are asking community organizations to do what we cannot do but without providing adequate funding, which must be stabilized and increased. Such organizations have not developed for years, which is especially true of crisis centres, some of which have even had to eliminate beds. ***Daniel Fecteau***

- *Most of our patients are now treated in the community while measurement units have not been adjusted to reflect this situation and we are penalized as a result. It appears that our measurement units are dropping and our costs are increasing. The funding of foster families and leasing costs account for nearly 10% of our budget. The belief that most of the budget has stayed in the psychiatric hospitals despite deinstitutionalization is erroneous.* ***Jacques Hendlisz***

2 Focus on Determinants of Health

CHAPTER 2 EXAMINES the organization of the health care system in light of new needs. To this end, an analysis is undertaken of the organization of the health care system, which is largely devoted to individuals coping with severe disorders. A historic overview is presented and problems related to informal caregivers, on whom little attention has focused until now, are explored. Then, two questions that warrant further examination are discussed, i.e. prevention and promotion in the realm of mental health and mental health in the workplace.

The organization of mental health services

Historic overview

In Québec as in the West overall, patients suffering from mental health problems were for a long time committed to mental institutions operated by religious communities. Hospitals, which often accommodated several thousand patients, acted essentially as caretakers and offered little in the way of structured care.(q)

The individuals admitted to such institutions were usually deprived of their rights. Until 1972, confinement during closed treatment and the duration of such treatment were entirely at the discretion of the medical superintendent (equivalent to the director of professional services today), without the possibility of appeal. The same discretionary power was exercised in the case of individuals suffering from mental health problems who had committed an offence under the *Criminal Code*. In 1974, the entrance to what was then called the Hôpital Saint-Jean-de-Dieu was still guarded by armed police officers, who could also be summoned to the bedside of overly agitated patients.

However, various factors meant that the situation changed very quickly, starting, of course, with the introduction in 1956 of antipsychotic drugs. This was followed, in Québec, by the implementation of the first specialty programs in psychiatry in 1958, a medical specialization that experienced such lightning growth that it soon ranked second in terms of staffing. Other factors included the influence of community psychiatry, as practised in France, and the American experience in Community Mental Health Clinics.

Above all, it was the book *Les fous crient au secours* by Jean-Charles Pagé who, after a stay in Saint-Jean-de-Dieu, denounced living conditions in these hospitals. His observations, repeated by the medical establishment and the unions, raised a groundswell of public indignation

(q) Some of the information presented here is drawn from the souvenir booklet *20 ans de Santé mentale au Québec — Regards critiques des acteurs et des collaborateurs*, Montréal, 1996.

and led to the establishment of a task force whose report, published in 1962, launched the sweeping deinstitutionalization movement that prevailed for several years. The report also led to the development of community psychiatry, the establishment of departments of psychiatry in general hospitals, called upon other professions such as social workers, psychologists and occupational therapists, and broadened the services offered (foster families, group homes, and so on). People no longer spoke of mental illness but of mental health.

"In Québec, we have undertaken deinstitutionalization and our reform while maintaining the same inadequate concepts concerning patient treatment. We have not changed our philosophy or our mentality."

Jacques Hendlisz

From then on, the mental health sector was the focal point of experiments that other health sectors often adopted. Indeed, deinstitutionalization marked the first and most important shift to ambulatory care. Mention should be made, among other things, of: the introduction in the early 1970s of the first alternative community resources; some degree of regionalization starting in 1977 with the administrative commissions of the regional health and social services boards; the establishment of the Comité de la santé mentale du Québec (CSMQ), an advisory body in the ministère de la Santé et des Services sociaux; the emergence of patients' rights groups and associations of family and friends; the first regional service organization plans, and so on.

However, it is, above all, in its 1989 mental health policy that Québec innovated, all the more so since the policy's elaboration in conjunction with the deliberations of the CSMQ was largely entrusted to experts outside the ministère des Affaires sociales. This undertaking systematically relied on representatives of users, their families and friends, interveners, community leaders and decision-makers. The policy even preceded the more comprehensive health and social services policy introduced three years later and included several of its key policy directions, i.e. the primacy of the individual, recognition of the role of community ressources in planning and providing services, partnership, regionalization and service delivery in the living environment. Several facets of the mental health policy were adopted in France and Latin America and by WHO, for example.

While the policy was generally well received, its implementation was more laborious than anticipated and a number of major components of the original project were never put into effect. It should be noted that, in the meantime, the imperative of putting public finances in order arose and the transitional funds needed to achieve a genuine reorganization were, for all intents and purposes, non-existent. This factor was compounded by the unwillingness of certain institutions and constraints in work organization. All of these factors led the regional board to note in 1995 that the targets set in the 1990 regional service organization plan were far from being achieved.[12]

"Does the money devoted to severe, chronic disorders truly generate well-being among the patients concerned?"

Ghislain Goulet

In the wake of the review of the mental health policy in 1995-1996[13], the government proposed a number of guidelines, which, following consultation throughout Québec, led in 1998 to an action plan to reorganize mental health services. Even more so than in the policy, officials insisted on the response to individuals coping with serious mental health problems. Virtually no mention was made of transient disorders and promotion and prevention. It is this action plan that now determines priorities with respect to development and the reorganization of services and practices.

In 1999, the Minister of Health set up a support group to ensure the action plan's application. Following a province-wide tour, a progress report[14] was discussed at the Forum sur la santé mentale in September 2000, which assembled the main partners and was chaired by the Minister. A number of priority targets were set, to be implemented by 2002.[15]

Although the organization of mental health services in Montréal differs from other regions, if only because of organization by sectors and the presence of university hospitals, the implementation of the action plan is coming up against similar problems, while, as we will see later, other problems are specific to Montréal.

Range of services(r)

Since the late 1960s, mental health services in the public health network in the Montréal-Centre region have been divided into sectors. In other words, "each establishment is responsible for offering specialized short-term services to residents in its sector wishing to obtain services."[16] A restrictive interpretation of this measure, which appears to prevail in some places, means that the services are accessible only to residents of the sector, while the *Act respecting health services and social services* stipulates that users are free to choose where they obtain services.

"The problem of access to services is not limited to the fact that CLSCs do not have psychologists. It is more a question of poverty and access to services in the private sector."

Daniel Fecteau

Child psychiatry services (for young people under 18 years of age) and adult psychiatric services are divided differently into sectors, not to mention the territorial divisions pertaining to the CLSCs (some of which are governed by two sectors of psychiatry), the Centres Jeunesse or the school boards, with which intervention must sometimes be coordinated. Other anomalies have been observed with regard to access or continuity, for example, English-speaking users living in sectors where services are offered in French, or French-speaking users living in sectors where services are offered in English. Front-line physicians do not operate by sector and thus are called upon to contact a number of second-line services. Some users are treated in one hospital for their physical health problems and obtain psychiatric care in another facility.

A sectoral organization has advantages, the main one being broader knowledge among interveners of the living environment and existing resources. Moreover, it confirms explicit responsibility for a defined population. Reflection is under way at the regional level among the key stakeholders, who are expected to agree shortly on possible solutions.

(r) Some of the data are drawn from the *Tableau de bord évolutif en santé mentale pour la Région de Montréal-Centre*, prepared in May 1999 by D. Brassard *et al.* and the *Tableau de bord central de la Régie régionale de Montréal-Centre*, published in January 2001.

The front-line mental health network in Montréal comprises:

- nearly 2 000 general practitioners working in 450 physician's offices or clinics;
- 29 CLSCs offering psychosocial services within their territories, although the treatment of mental health problems varies from one establishment to the next since some of the facilities do not have designated teams; 26 CLSCs offer mental health integration-rehabilitation services, and five of them provide ambulatory psycho-geriatric services; 140 full-time-equivalent health professionals deliver these services;[17]
- 13 hospitals offering emergency psychiatric services, for a total of roughly 45 stretchers;
- six crisis intervention centres offering temporary shelter for roughly 50 people;
- 2 240 psychologists, members of the Ordre des psychologues du Québec,[18] of whom 1 260 work in the health and social services network;
- an unspecified number of psychotherapists, who are not members of the Ordre des psychologues, and practitioners of alternative medicine.

The second- and third-line network encompasses:

- hospitals with psychiatric care units, i.e. six for young people, 12 for adults and three for the elderly, located in 10 general and specialized care hospitals and in four psychiatric care hospitals; over 500 psychiatrists and child psychiatrists work in the hospitals, along with 3 850 professionals or full-time-equivalent paramedics.[19] The number of beds in psychiatry dropped markedly, from 659 to 479 between 1995-1996 and 1997-1998 in general and specialized care hospitals and from 2 357 to 2 050 in psychiatric care hospitals. Cutbacks have been higher in adult care units.
- psychiatric outpatient services for young people or adults (or both) in 14 hospitals, as a number of outpatient clinics have been decentralized;

- 10 day hospitals and nine day centres operated by hospitals;
- three psychiatric care hospitals offering mental health social reintegration and rehabilitation services;
- one hospital offering home nursing care in the realm of mental health;
- six designated hospitals that also take charge of the entire residential care network in the community; in 2001, roughly 3 840 residential places were available, almost as many as in 1995, to which must be added some 250 places in group homes.

Mention must be made of the dynamic presence of nearly 80 community organizations subsidized by the regional board offering front- and second-line services, e.g. prevention and promotion, patients' rights, crisis intervention, residential services, daily life skills training, work habits training, community accompaniment, community mutual aid, specialized treatment, multiple problems, support for families. Moreover, 13 community organizations offer residential places in the community to individuals suffering from serious disorders. In 1997-1998, the regional board earmarked $3.4 million for this residential services, although we do not know the exact number of places offered to the public. Some 20 other community agencies that are not subsidized by the regional board are also working in the realm of mental health.

"We cannot discuss community organizations without raising the problem of funding…

Daniel Fecteau

From a budgetary standpoint, the public health and social services network allocated, all told, over $380 million in 1997-1998 to mental health services in the region, a 3.2% drop in relation to fiscal 1994-1995 and less than the 5.7% overall reduction in the regional network's budget. It should be noted that, during the same period, $23.3 million was reallocated to outpatient and community-based services.

Issues and challenges of service reorganization

As is readily apparent, the funding available to satisfy mental health needs in Montréal-Centre is substantial, at least when compared with most other regions of Québec. However, we must not be deceived by the argument to the effect that the region also serves clienteles from outside its official territory. Under 10% of users of services do not

live in the territory, a proportion that is markedly smaller than is the case with respect to physical health, for example, although one-quarter of patients receiving long-term hospital care come from outside the territory. However, it is true that specific needs exist in an urban environment such as ours and that we must take into account historic and context-sensitive factors, if only teaching and research hospitals.

While the funds allocated are considerable, are they adequately satisfying the public's needs? We will attempt to answer this question by focusing on three groups, i.e. individuals suffering from severe mental disorders, transient disorders or specific problems.

Individuals suffering from severe mental disorders

As we have seen, individuals suffering from severe mental health disorders have been the focus of a major part of the reorganization of services. Although they are relatively few in number, i.e. roughly 2% of the population, they are vulnerable, at high risk of being marginalized, and require several types of assistance. They often live in extreme poverty and must confront deep-seated prejudice.

We must also take into account a new situation that prevails among such individuals who, less and less, have been deinstitutionalized or never lived in an institution and thus require other types of services and a new approach.[20] For example, an effort is now made to place greater emphasis on the individual's abilities rather than his disease or symptoms. Empowerment,(s) the general principle guiding the action plan, despite the concept's rather nebulous side, reflects the same vision: an attempt is made to broaden the individual's control over his environment and to ensure that patients can take control of their lives.

This is true of housing, for example. Patients are less and less interested in residential facilities, which often resemble a form of hospitalization, and instead are seeking supervised accommodation or community support. One-third of single people on low-cost housing waiting lists at the Office municipal d'habitation de Montréal (OMH) have declared

(s) Empowerment is the feeling of having control over the environment.

a previous history of psychiatric care.[21] However, until recently, hospitals have set up extensive residential facilities. The regional board recently established a partnership with the OMH, the Fédération des OSBL d'habitation de Montréal, community organizations and the CLSCs in order to offer community support services to residents of low-cost housing suffering from often serious mental health problems. The Direction de la santé publique is assessing a number of these promising initiatives.

Another section is being implemented more slowly, i.e. integration into the labour market or other productive activities. These two types of needs imply an intersectoral approach at the local, regional and provincial levels although, for the time being, this remains wishful thinking.

There are various models of community-based follow-up. For the most severely affected patients, there is widespread acceptance of the Program for Assertive Community Treatment (PACT), focusing on intensive follow-up by community-based teams.[22] This type of program reduces the number and length of hospital stays, increases the satisfaction of users and their loved ones and, when overall costs are considered, seems to be more efficient than the existing model.

Follow-up relies on an interdisciplinary approach in order to provide all clinical and rehabilitation services in the living environment in addition to helping individuals satisfy their basic material needs, e.g. housing, food and clothing, always from the standpoint of empowerment. To avoid crises, the team must be able to respond at all times to distress, with a view to ensuring the continuity of services, a key notion for several decades in the realm of mental health. At present, there is no intensive follow-up service in the region that meets all of the criteria of PACT, including services that are available 24 hours a day, seven days a week. The number of people who could benefit from such services is estimated at nearly 2 000.

One essential condition for the operation of such a program is an integrated network of institutional and community services, which

should facilitate the organization of the Québec system overall, where health services and social services are integrated. A study now under way in the Direction de la santé publique is aimed at measuring the degree of integration of services in three sectors and assessing its impact on individuals suffering from acute disorders. Preliminary findings reveal striking discrepancies from one sector to another that affect the satisfaction of needs and the users' quality of life. It appears that the type of network best able to ensure that patients are properly maintained in the community is:

- diversified with respect to resources and thus able to satisfy a variety of needs, e.g. housing, community follow-up, reintegration service, crisis centre, day centre, and so on;
- fairly small, i.e. it has a limited number of resources which are in constant touch with other caregivers in the sector;
- decentralized, i.e. its inter-organizational links do not depend on a central facility. The ministerial action plan proposed designating an entity in each territory to coordinate services and able to react at all times, although this measure came up against a twofold problem in that it hinders the free choice of users and threatens the management autonomy of organizations.

Day hospitals are another type of service whose key role is widely acknowledged. It should be noted that in Montréal-Centre such hospitals are found in each sub-region and are often attached to hospitals.

The CLSCs are playing a growing role in treating patients suffering from acute disorders. Between 1997-1998 and 1999-2000, the number of users they served increased by 62%, from 1 922 to 3 316. However, the services provided vary from one establishment to the next.

For over 25 years, the community network has also played an essential role in respect of patients suffering from severe disorders by an ongoing questioning and renewal of practices. The range of services and approaches that it proposes is valuable although full advantage is not always taken of it because of problems in coordinating the community and public networks.

In a more preventive perspective, early intervention among young psychotics is becoming increasingly widespread.[23] When a young patient is referred at the onset of symptoms of the disease, a better prognosis and less deterioration in the quality of his life are observed.[24] This approach demands that staff in youth clinics, the schools and the Centres Jeunesse, among others, be made aware of symptomatic and compensatory behaviour such as abusive drug and alcohol consumption, and be able to pinpoint the appropriate referral procedures. The division between child psychiatry and adult psychiatry hampers the continuity of care.

Individuals suffering from transient disorders

As we noted in Chapter 1, many people are likely to suffer at some time in their lifetimes from so-called transient disorders, which can worsen if the appropriate treatment is not provided in a timely manner. Since ministerial policies centre on the services to be offered individuals suffering from severe disorders, we have perhaps neglected transient disorders, which are nonetheless clearly more frequent and which we are only just beginning to understand from the standpoint of disability and the loss of quality of life, not to mention their economic consequences.[25]

Family physicians are the professional in whom most Montrealers confide to discuss mental health problems. However, in practice, patients display some reluctance and it is sometimes in light of a physical symptom that patients can be encouraged to speak of their psychological problems. Family physicians, especially the youngest members of the profession, are deemed to have received training that enables them to detect and adequately care for such patients, up to a point.[26]

Furthermore, the regional board organizes specific training programs, in particular to enhance the detection of anxiety disorders or depression. In Sweden,[27] such a program has substantially reduced the cost of treating depression due to early detection and treatment and thus reduced recourse to hospital psychiatric care. A reduction in the suicide rate has also been noted.

However, some reluctance has been observed among family physicians to treat patients suffering from mental health problems, mainly because of the time needed to investigate this type of problem: several interviews are often necessary before the physician can make a reliable diagnosis. At the same time, mention must be made of the lack of financial incentive in taking charge of such patients under the fee-for-service system.

Other factors also come into play. Referral is the biggest problem. If the patient is in a critical state, he can be sent to a psychiatric emergency department. To the contrary, in the case of a minor problem such as mild or reactive depression, physicians can take charge of the patient. The question arises in respect of all of the cases that lie between these two extremes. If need be, a patient with sufficient financial resources can be referred to a private therapist, although the number of sessions to which insured parties are entitled is limited.

Limited access to second-line mental health services in Montréal is worrisome: it takes several months to get an appointment in psychiatry. The notion of shared care, which is beginning to emerge in certain sub-regions in Montréal, offers a solution that must be encouraged. It emphasizes exchanges of expertise and collaboration between family

physicians and second-line services, as proposed by the recent report of the Commission d'étude sur les services de santé et les services sociaux.[28]

In concrete terms, this means regular one-on-one exchanges with the family physician, while ensuring access to consultation and support services regarding medication, the therapeutic approach chosen or the selection of the relevant resources. Such a program established in Ontario has shown that the contribution of specialized staff has helped support the physician's role, that it enhances the continuity of care and increases access to specialized services. It would be useful to ascertain whether the organization of second-line services in specialized mental health clinics, structured according to diagnosis or the therapeutic approach, as observed in certain departments of psychiatry, promotes the implementation of such a model.[29]

"… we must support those suffering from transient problems before they become severe, long-term ones"
Denis Aumais

The absence of a central information clearinghouse covering all of the services and organizations in the field of mental health is another shortcoming that is hampering the work of front-line professionals and would also benefit patients if they had access to it.[30]

The CLSCs have recorded an increase in the number of users suffering from transient disorders, although to a lesser extent than in the case of patients suffering from acute disorders, i.e. from 23 852 in 1997-1998 to 27 033 in 1999-2000. The regional board's *tableau de bord* (chart of indicators) published in January 2001 nonetheless noted that "the increase in the volume of users served does not assume that patients are receiving an adequate response to their needs. The resources planned to provide basic mental health services are slow in being allocated."[31]

As is true of individuals suffering from severe disorders, community organizations also have a role to play. In particular, self-help groups, often overseen by individuals who are experiencing or have experienced such disorders, are an important resource for patients.

In one specific case, i.e. anxiety disorders among young people, diagnosis and treatment often leave a lot to be desired although it would

be fairly simple to improve the situation by means of information and training sessions.[32] There exits a broad range of interventions with proven effectiveness that front- or second-line health care professionals and support and self-help groups can offer. Early intervention is all the more relevant given that a high rate of comorbidity is often associated with anxiety disorders, which, in most instances, are the first disorder to appear. Such disorders often occur toward the end of adolescence and in the early twenties and young people are the ideal target for intervention.

It is in light of this information that the Régie régionale de Montréal-Centre launched an awareness campaign focusing on anxiety disorders among young people in the 14-25 age group. Since it is clear that there is a risk of increasing demand for assistance without the network being able to respond adequately to such demand, the first step will be to heighten awareness among and train front-line interveners such as physicians and psychosocial interveners with respect to detection, referral and the treatment of anxiety disorders in young people. Furthermore, an organizational assessment in each of the sub-regions will make it possible to optimize the existing organization from the standpoint of availability, accessibility and continuity.

Specific clienteles

Aside from the problems of access mentioned earlier, not all individuals requiring care are receiving the assistance they need, whether they are suffering from severe or transient disorders. Sometimes this is because they are unamenable to obtaining services but often because the network is incapable of providing an appropriate response.

For example, some homosexuals have difficulty dealing with the consequences of their orientation, e.g. being at odds with their families, social isolation. HIV-AIDS patients often require strong psychological support in order to contend with their condition, not to mention the organic complications that occur among those who develop the disease, especially during its advanced stages.[33]

Moreover, individuals suffering from multiple problems find it harder to take advantage of services and are also more vulnerable to gaps in service delivery. This includes, above all, individuals suffering from personality disorders, alcohol-related problems, drug addiction or mental handicaps, in addition to mental health problems. Interveners are reluctant to provide such individuals with sustained care and few specialized services are available. However, a number of encouraging experiments are being carried out, such as community liaison services that certain hospitals offer to unstable patients, a large proportion of whom use alcohol and drugs and who are often homeless.

"We must respect the rights of homeless people who are sick and who categorically refuse to seek care."
André Luyet

As we noted earlier, a high proportion of homeless people experience mental health problems. Many of them have frequently made use of mental health services during their lifetimes, although the rate of use in the recent past has declined markedly.[34] The grudging reception that they receive from certain health professionals in the network partly explains why they shun the services. In addition, they are often released prematurely from emergency services or psychiatric care units and are not referred to community facilities likely to help them. We have noted a considerable need for training and information among health care professionals. Perhaps we should also contemplate centralizing specialized staff in order to consolidate the expertise available.

One innovative initiative warrants mention: the team from the CLSC des Faubourgs has made this clientele a priority and they are trying to reach them in their living environment. They are also testing new approaches. Another type of service should be encouraged, i.e. residential services accompanied by support services, such as group and individual therapy, reintegration into the labour force, and the availability

of a case manager who helps the individual satisfy his needs. Experience in the United States has demonstrated the merit of this approach, i.e. a favourable impact from the standpoint of symptomatology and quality of life and a reduction in the use of emergency and hospital services.[35]

Another specific case is individuals suffering from a mental health problem who commit a misdemeanour. Progress has been made in this respect, through the services of Urgence psychosociale, for example, which are not, unfortunately, offered by all CLSCs, and community resources such as Diogène, which help released prisoners reintegrate into the community, not to mention, of course, the services offered by the Institut Pinel. In addition, bill 39,(t) which came into force three years ago, authorizes the police to bring a person against his will to a psychiatric emergency department or a CLSC. This measure is hardly trifling given that the Montréal Police Department receives roughly 3 000 calls each year concerning people coping with a mental health problem.[36]

The growing immigrant population in Montréal also poses specific challenges. Broadly speaking, immigrants face various kinds of stress that can trigger an array of mental disorders. Stress can occur at different times, e.g. upon arrival in the host country, through the shock of integrating into a new social, cultural and institutional environment, but also prior to departure from the home country, especially among those who have witnessed violence, as is often the case with refugees. Migration makes the individual more vulnerable, especially because it confirms a break with society and family and is accompanied by uncertainty and instability. A recent study conducted by the Direction

(t) *Act respecting the protection of persons whose mental state presents a danger to themselves or to others.*

de la santé publique among immigrant women reveals that most emotional problems are linked to isolation and separation from the family that migration engenders.[37]

Communication, too, sometimes poses a problem. Ignorance of the language causes insecurity that can become a big source of anxiety and a significant obstacle during a psychiatric evaluation. Finally, practitioners occasionally observe behaviour that is considered normal in some cultures but that may be deemed pathological in another culture.

"The US Surgeon General recently emphasized that the crucial problem in mental health at present is that members of the cultural communities do not consult health professionals."

Rose-Marie Charest

The informal care network

Advances in psychopharmacology and the reorganization of the health care network mean that growing numbers of individuals suffering from mental disorders are being treated outside of institutions. Under the circumstances, family and friends have an essential role to play not only in providing assistance and basic care but also in ensuring that the dependent person receives care and other necessary services.

The family is the main source of support for many people suffering from mental disorders and it also provides them with a living environment. However, the situation of caregivers is fragile and the assistance they give the dependent person can adversely affect their own physical and mental health. Some studies have revealed a higher degree of psychological stress among caregivers. As the MSSS has emphasized,[38] "families and friends very often give so much of themselves that they exhaust themselves for want of sufficient support."

There is a consensus concerning the importance of the contribution made by caregivers. The Comité pour la Révision du cadre de référence sur les services à domicile[39] acknowledges the contribution made by family living with a disabled person and confirms the need to support them by taking into account the specific needs stemming from their commitment.

Profile of informal caregivers and care receivers

According to the data obtained by means of the postal section of our survey, one person in three (35%) has in his immediate circle a person suffering from mental health problems. Of this number, half are caregivers according to the study's criteria, i.e. 17% of the total population. Their average age is 42 and women are slightly more numerous than men in assuming this role (55% and 45%, respectively). There is a higher proportion of caregivers among young people between 18 and 24 years of age, among labour force participants or students, separated or divorced individuals or members of single-parent families, and among native-born Canadians. It should be noted that one-third of the people recognized as caregivers claim to be the main caregiver. A close link has been noted between psychological suffering and caregiving insofar as, in relation to the general population, caregivers are more likely to suffer from mental health problems.

"Caregivers are truly suffering and we must say so"
André Luyet

According to the data collected, the care receiver is more often than not a woman (54%), between 25 and 44 years of age (50%), for an average age of 39. In addition, the care receiver is most often a friend of the caregiver (36%) or a close family member such as a brother, sister, father or mother (19%), or a member of the extended family (16%), a child (10%) or spouse (6%). Neighbours and colleagues account for 13% of dependent persons. The disorders from which care receivers suffer are, above all, depression (38%) but also drug addiction (22%) and psychotic or anxiety disorders (over 10% each). Among 43% of the care receivers, the mental health problems do not cause any disability.(u) One care receiver out of five displays at least three of these problems. The problem has been apparent for less than one year in the case of very few care receivers (5%).

"… helping someone without the means to do so causes suffering."
Rose-Marie Charest

Assistance provided by caregivers

While the extent of the assistance provided by caregivers to loved ones coping with mental health problems is widely acknowledged, it is hard to accurately assess the situation since it cannot be accounted for in the same way as care delivered in institutions.

(u) Disability means difficulty in caring for oneself, working, studying or engaging in recreational activities and difficulty experienced in relationships with family members or friends.

Contrary to many studies, the activities inventoried in our study are not confined to practical assistance such as personal care, domestic tasks and so on, but cover a broad range of activities.

Table 1

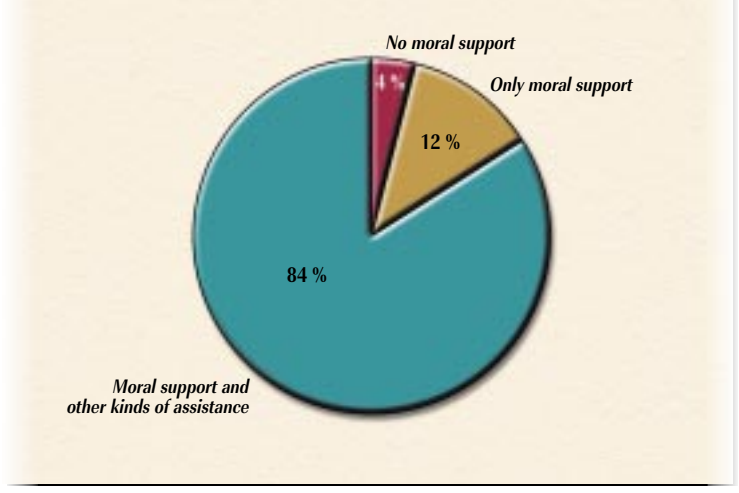
Proportion of caregivers who provided each type of assistance during the 4 weeks prior to the survey (n=405)

	%
A. Tasks associated with assistance to and care for the dependent person	
Moral or psychological support	97
Medical care	68
Support related to daily living activities	48
Supervision	36
Physical care	30
B. Tasks associated with negociations between the dependent person, the community and public services	
Mobilizing health and social service resources	60
Negociations to ensure social integration	35

We note that, while virtually all caregivers offer moral or psychological support, only 12% of them limit themselves to this type of assistance. Supervision is a pivotal role played by caregivers since many care receivers cannot be left unattended. While it is hard to measure the time devoted to this activity, this facet of the caregiver's role is a major source of concern. As researchers have noted,[40] "supervision goes far beyond simply being present and entails active supervision, often similar to that involving young children. Such supervision can even be synonymous with a constant presence, especially during crises."

Chart 9

Proportion of caregivers who offer moral support



Caregivers devote a considerable amount of time to acting as a mediator between the dependent person, the community and public services. Indeed, many caregivers devote themselves to such activities, which

demand of them a considerable effort since the care receivers have frequent contact with institutions and community facilities and may have difficult relations with various members of the community such as neighbours, landlords, employers, and so on.

The analysis of the number of assistance activities among the seven types evaluated reveals the magnitude of this task: only 12% of caregivers provide only one kind of assistance, while over half (55%) provide four or more. To offer such support to a family member likely demands a regular presence and follow-up and even when the caregiver does not live with the care receiver, it does not mean that the task in any way diminishes. A comparison of the number of tasks accomplished depending on whether or not the caregiver lives with the care receiver reveals no significant difference, although the role of principal caregiver does appreciably affect the extent of the assistance provided. The latter is also closely tied to the nature and severity of the care receiver's problem. Caregivers perform more tasks when dealing with drug addiction or psychotic and manic-depressive disorders than when dealing with anxiety disorders or depression. The number of assistance activities increases markedly with the number of the care receiver's disabilities and when the care receiver is receiving services, especially complex ones.

Experience of caregiving

To regularly provide a relative or a friend with support affects the caregiver and we wanted to find out about the caregiver's experience.

Analyses conducted to ascertain factors related to a negative experience of caregiving reveal several issues, mainly the seriousness of the care receiver's problem and the number of disabilities and the duration of his disorder. It should be noted that the type of disorder is not a decisive factor but that a more negative experience stems from the care receiver's inability to engage in his usual activities. The other factors relate to the caregiver's commitment, i.e. the number of tasks performed and whether the caregiver is the main caregiver or a relative or a member of the immediate family. The experience is deemed to be more negative

when the caregiver is a woman, possibly because women make a more emotional commitment to caregiving while men adopt a more rational, action-centred approach. Similarly, the fragile state of the caregiver's mental health, reflected in suicidal thoughts and the consumption of medication for reasons of mental health, is also linked to a more negative experience.

Many caregivers also enjoy positive personal experiences. A link has been observed between the caregiver's commitment and the positive nature of the experience. Thus, the commitment is decisive in respect of both the positive and negative aspects of the experience. A strong correlation has been noted between the two dimensions of experience, which indicates that it is not one-dimensional, i.e. either negative or positive. To the contrary, it can be simultaneously burdensome and satisfying.

Services used by caregivers and their service needs

With a view to assessing the appropriateness of services, we examined the services received by caregivers in conjunction with their support role. Some 22% of caregivers resorted to services during the preceding 12 months; 11% consulted a social worker, 10%, a physician and 7%, self-help groups. Among these caregivers, roughly two-thirds resorted to two or more services. Moreover, 36% indicated that the professional consulted was, most often, a social worker, and for 12%, a self-help group. These services were received most often through a community organization (18%) or in a CLSC (17%). The majority of caregivers (83%) did not pay for such services, which, in over half of the cases (61%) satisfied their needs.

Analyses used to pinpoint determinants in respect of the use of services reveal a link between the number of disabilities from which the care receiver suffers and recourse by the caregiver to services. Of all the variables that describe the care receiver's problem, only this one is significant. Indeed, it is more decisive than the type of problem. The type of relationship with the care receiver and the caregiver's commitment to the relationship are also associated with recourse to services. When the caregiver is a relative of the care receiver or lives

with the latter, the caregiver relies more heavily on services. It is astonishing to note that the number of tasks is not a decisive factor from the standpoint of the use of services. Caregivers who have already used services in respect of their own mental health problems make more extensive use of services to support them in their role. It may be thought that they are more familiar with the health and social services network and are less reluctant to consult health professionals.

As for the services that caregivers would like to receive, it should be noted that just over half of them (57%) would like to obtain services that they are not now receiving. When asked which service or professional they deem to be the most important among the requested services, 26% indicated the psychologist, 19%, the social worker, and 13%, self-help groups. These findings suggest that the caregivers' needs focus more on moral or psychological support than practical help or respite. For nearly one-third of the caregivers, the main reason for which they do not receive these services is that they do not know whom to approach. Other caregivers mentioned the expense (30%) and problems of access (15%).

Mental health promotion and prevention

Mental health and mental disorders have their own dynamic but coexist. From the standpoint of population health, we must rely on complementary approaches that make it possible to reduce the impact of mental disorders through prevention and optimize the state of psychological well-being through health promotion.

Scientific research has made it possible to pinpoint two key targets for health promotion and prevention: empowerment, or the feeling of having control over the environment; and resilience, the psychological robustness that enables some people more than others to overcome adversity and those inevitable obstacles that life throws in one's path. It should be noted that attitudes conducive to mental health can be acquired. At the individual level, several types of psychotherapy rely on this logic, while from a collective standpoint,

it is health-promotion approaches that adopt social and political mobilization strategies in addition to individual learning perspectives.

Researchers have focused on individuals who succeed in overcoming difficult situations and who possess a natural resistance, called resilience. They have observed that some individuals can get through difficult experiences such as painful living conditions, pathological families, divorce, death, illness or torture without disruption. The research highlights certain states of mind that resilient individuals appear to share. For example, such individuals:

- focus on the immediate situation rather than the overall situation, e.g. make comfortable someone who is dying instead of thinking about death;
- find ways to cast difficult situations in a positive light;
- adopt a clearly positive approach, which assumes that the problems are temporary rather than permanent - "I've had a rotten day," instead of "Things always go wrong";
- tend to be more specific in their analyses - "I've got a bad habit," instead of "I'm worthless";
- give themselves credit when things go right and ascribe things that go wrong to external factors - "I'm a good golfer but my golf club is lousy".

Interaction between the individual and his living environment and, above all, the power that the individual exercises, define what is called empowerment. Numerous studies have emphasized the close link between the absence of empowerment and increased mortality.[41] Empowerment is a multifaceted concept whereby individuals assume control over or master their lives in their social and political environment.

Through participation in democratic and social life and their determination to bring about social change at all levels of society, individuals develop the feeling that they exercise some control over their lives and can hope to achieve personal and community goals.

WHO's latest annual report mentions the "epidemic" of mental disorders and its economic, social and political impact and calls for broader efforts to promote mental health and prevent mental disorders. The costs of these programs are minimal when compared with the savings they can engender, especially in the workplace, where the consequences of a mental disorder are immediately quantifiable: aside from the cost of using health services, this morbidity is accompanied by a precipitous drop in productivity for businesses and society, and engenders substantial economic losses.

As is true of several other health problems, especially heart health, health services provide only part of the solution. The crisis in health care funding and problems experienced by deinstitutionalization programs are hampering the ability to provide adequate care by means of clinical approaches. Measures centred on risk factors, through prevention, and protection factors, through the promotion of mental health, are, more than ever, the key to the comprehensive management of mental health issues.

Before we advocate investing more heavily in this field, let us first examine the objectives of promotion and prevention programs and the nature of their impact as revealed in research.

Impact of mental health promotion

A recent analysis of the impact of mental health promotion[42] reveals that it affects health, social, economic and political factors. It would be useful to examine the variables that may be affected.

The effect of health promotion on health pertains, in particular, to quality of life, satisfaction, feelings of competence, self-esteem, feelings of empowerment, and participation in the creation of favourable living environments. This results in a reduction in aggressiveness, behavioural problems, learning disorders, abuse and neglect. It has been shown that individuals suffering from psychiatric disorders enjoy improved healthy functioning, disorder-free periods and a reduction in certain symptoms and that they are less likely to experience depression, somatization, anxiety and relapses.

Mental health promotion also affects social factors, such as improved interpersonal relationships, the ability to empathize and offer support, more extensive social participation, tolerance and a feeling of social responsibility, and a feeling of control over one's life and environment.

Measurable economic effects have also been noted, e.g. reductions in the duration of hospitalization, recourse to legal services, insurance expenses, and the inability to work.

Political effects are not negligible since the improvement in mental health also affects public order issues such as aggression, violence, delinquency, dropping out or work organization.

Impact of the prevention of mental disorders

Prevention focuses on a reduction in risk factors that would lead to the development or exacerbation of pathologies and is usually predicated on the assumption that the causes of a problem, or at least the factors affecting it, are well known. While we better understand the functioning of the brain, we still do not fully understand mental disorders. However, advances in research in the realms of genetics and molecular biology hold out the promise that more precise preventive measures will be achievable in the near future.

Causal chains in respect of mental disorders are complex. Despite our limited knowledge, it is possible to reduce the impact of mental disorders by targeting, before they appear, all of the biological, psychosocial or physical factors known to play a causal role. Prevention tackles both risk factors and pathogenic conditions.[43] For example, recent discoveries show that, despite the presence of genetic factors associated with schizophrenia, it is possible by changing the environment to reduce the intensity of its symptoms.[44] Aside from biological factors, events such as a couple's breaking up, the death of a loved one, economic difficulties, racism, poor physical health and disabilities are all risk factors in respect of which preventive measures can be adopted.

Thus, self-help and social support programs, stress management programs in the workplace, assistance programs for the bereaved, and training programs concerning the detection of depression are all initiatives that focus directly on risk factors related to the causal chain of numerous mental disorders.

"Promotion and prevention efforts (public campaigns) appear very white, middle class to me. We must develop new strategies"

Daniel Fecteau

Promotion and prevention programs

Most mental health prevention and promotion programs are aimed at young people at different phases in their development, i.e. the perinatal, pre-school and school stages. Through a number of government and NGO initiatives, the promotion of mental health among children is expanding. Some examples are *Naître égaux, grandir en santé*,[45] *Grandir, le magazine des parents*[46] or the *1,2,3 Go initiative*.[47] Other political initiatives (*Un Québec fou de ses enfants*) have also helped to develop this sector.

In comparison, the adult clientele gets short shrift as regards prevention in mental health. While the initiatives are imaginative, they are too few in number, e.g. the regional program *La prévention, ça commence dans ma cour*, introduced in our region in 1995.

Preventive or promotional measures developed for adults tend to focus on pivotal events such as falling in love, the birth of a child, entry into the labour market, retirement, and so on. For example, some programs seek to minimize the impact on mental health of risk factors such as divorce, pregnancy without support, stress in the workplace, the loss

of a job, chronic poverty, discrimination, and so on. At the same time, they strive to bolster resilience by enabling individuals to solve their problems, fostering the development of support networks and ensuring a range of medical and social services accessible to everyone.[48] A typical program that is frequently cited is the San Francisco Depression Prevention Research Project, a secondary prevention program aimed at reducing depression among front-line patients from cultural communities and low-income households.[49] After only one year, the program had achieved a significant reduction in depression rates and had had a positive impact.

In our region, the key prevention-promotion programs aimed at adults focus, above all, on preventing the adverse effects of stress and bolstering their ability to adapt to certain critical periods in life.[50]

Specific measures have been adopted to enhance women's ability to adapt to stress and foster their optimum development, autonomy and empowerment. Moreover, other programs seek to help the unemployed maintain psychological balance. A number of programs have also been designed for couples to enable them to adapt to stressful situations, such as the birth of a child, the loss of a job, separation or divorce, and so on. Some programs offer informal caregivers support in the form of emergency respite.[51]

Unfortunately, such initiatives have usually been limited in scope, of short duration and too few of them have been evaluated. While the efficacy of prevention-promotion has been demonstrated scientifically, when we observe what has been done in Québec and Canada, we see that the programs are largely underfunded and that the mechanisms aimed at ensuring their systematic application are deficient.

Social inequality, a key issue in promotion

Low income is not the only indicator of poverty, which must be regarded as a multifaceted situation encompassing an array of material and social hardships.[52] Social inequality stems, among other things, from limited education, inadequate working conditions, economic inactivity and exclusion from the decision-making process.[53]

Several challenges arise with regard to the impact of inequality on the mental health of adults. Conditions that often go hand in hand with poverty, such as the harshness of everyday life, social prejudices, cumbersome social and administrative rules and the loss of power, significantly affect mental health.[54] Indeed, many epidemiological studies confirm that poverty is an aggravating factor that can disturb mental health.[55] Among young adults, in particular, problems in entering the labour market and high unemployment are stress factors that can appreciably affect their mental health. The same applies to many immigrants, who, at least during the first years of their integration, must contend with hitherto unknown economic insecurity.[56]

While the importance of individual risk factors in respect of mental health has been established, it is thought that attention must focus on broader determinants by relying on the ecological model of poverty.[57] This model has the advantage of taking into account environmental risks, which, from the standpoint of poverty, can lead to mental health problems. Mention should be made, for example, of the disintegration of the family, the breakdown of neighbourhoods, social isolation, stigmatization, and the lack of access to health and social services. Individual mental health is undermined by stressful living conditions, limited or entirely lacking social support, and an inability to face problems.

Observers believe that various factors linked to social disinsertion are even more decisive with regard to an individual's mental health than poverty is.[58] In order to avoid stigmatization, we should attack poverty rather than the poor. Society must endeavour to give everyone access to an egalitarian environment so that everyone benefits from healthier socioeconomic conditions. Once this principle is adopted, it becomes easier for the individual to establish healthy interpersonal relationships, to feel part of the community and to benefit from social recognition.

Aside from economic inequality, inequality related to education, gender, physical and mental handicaps, living environments and

ethnocultural affinity must be eliminated, as such inequality acts as an environmental and structural obstacle to good mental health.[59]

The workplace and mental health

Despite sweeping upheavals, work in western societies still plays a decisive role in defining personal and collective identities. However, the nature and organization of work and working conditions have changed in recent decades. Changes in the nature of work reflect growth in the services sector and the development of new technologies that have engendered new physical and cognitive constraints stemming, in particular, from computerization and automation. While work is now less physically demanding than it used to be, it is more demanding psychologically and emotionally.[60]

"The response to the problem is not exclusive to health. Living conditions are a contributing factor. We must set the example if we are to successfully encourage others to act so that our health and education systems adapt to thousands of individual needs."

Ghislain Goulet

Changes in work organization are reflected, above all, in an intensification that has imposed itself through new management methods under which more stringent control is exercised over individual and collective productivity and the quest for streamlining staff.[61] American and European surveys have revealed a striking increase in time constraints over the past 20 years. No such data are available in Québec, although a recent survey among Québec workers benefiting from a group insurance plan reveals that over half of workers claim to experience considerable stress in the workplace.[62] As for working conditions, changes have centred, above all, on job insecurity as illustrated by increased recourse to subcontracting or private employment agencies. Insecurity and escalating pressure have been associated with more frequent violence and intimidation in the workplace.[63]

Impact on mental health

In conjunction with these upheavals, short- and long-term inability to work because of psychiatric disorders is rising.[64] It should be noted that, between 1990 and 1997, the number of claims accepted by the CSST concerning employment injuries related to stress, burn-out or other psychological factors almost doubled, from 530 to 994, accompanied

by an annual increase in costs from $1.5 million to $5.1 million, while the total number of claims that the CSST accepted fell from 207 127 to 119 914 a year, i.e. by nearly half, during the same period.[65]

Table 2

Compensated occupational diseases (1) related to stress, psychological burn-out or other psychological factors (2)

	1990	1991	1992	1993	1994	1995	1996	1997
Anxiety, stress...	87	109	158	129	274	408	461	421
Professional burn-out	15	15	15	22	52	24	15	12
Nervous shock	428	539	482	579	610	475	525	561
Total	530	663	655	730	936	907	1 001	994
Amounts disbursed to income replacement indemnity	1,5M	2,5M	2,6M	3,2M	4,6M	4,4M	5,1M	5,1M
All claims	207 127	180 275	148 128	136 361	138 124	132 556	122 212	119 914

Source : C.S.S.T., D.S.G.I., Service de la statistique (99-01-18)

(1) Claims paid by the C.S.S.T. and covered by the income replacement indemnity.

(2) Data based on information calculated as of 31 December of the year following the claim.

Subsequent claims stemming from mental disorders accepted by the CSST levelled off somewhat, especially because of the legal obligation imposed on workers to have recognized mental illness as an employment injury.

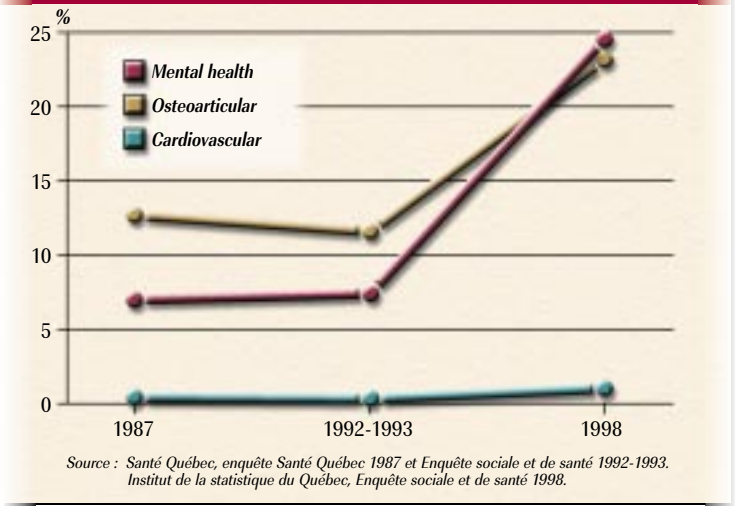
Given the limitations imposed by the legal framework, applications for compensation in respect of mental disorders are more extensively handled under company wage loss plans. An analysis of the causes of long-term leave compensated in Québec by private wage loss insurance reveals that between 30% and 50% of such leave is attributable to mental health problems, compared with only 18% in 1990.[66]

The findings of three general surveys of the health and well-being of Quebecers conducted between 1987 and 1998 clearly show that the inability to work because of mental health problems almost doubled, from 7% to 13%, that women are affected more than men, and that the average number of days of disablement per person attributable

to these problems more than tripled between 1992 and 1998, from 7.4 to 24.6 per 100 persons, an increase of more than 200%.[67]

Chart 10

Change in the average annual number of disability days



Source : Santé Québec, enquête Santé Québec 1987 et Enquête sociale et de santé 1992-1993. Institut de la statistique du Québec, Enquête sociale et de santé 1998.

When this increase is applied to the entire labour force, mental health problems accounted for nearly 600 000 lost workdays in Québec in 1998. Under the circumstances, we can better understand the findings of a survey conducted by Watson Wyatt in the spring of 2000, which reveals that most Canadian private and public organizations believe that the biggest problem in the future will be the increase in compensation claims related to psychological problems.[68] This concern arises, above all, because the direct costs engendered by absenteeism in the workplace and disability, equivalent in 1997 to 5.6% of the total payroll, now stand at 7.1%. When indirect costs are added, such as the replacement of absent workers and the attendant drop in productivity, the total stands at 17%.

An analysis of the factors underlying this new epidemic reveals that personal factors are mentioned in only 10% of cases, that one-third of cases are related solely to problems encountered in the workplace, and that work is blamed in roughly 90% of cases.[69]

Research indicates close links between certain facets of work organization and mental health problems. Intense psychological pressure and limited decision-making autonomy have been linked to depression, psychological distress, burn-out and greater reliance on psychoactive drugs.[70, 71, 72, 73, 74, 75] In these studies, decision-making autonomy in the workplace is twofold, i.e. the ability to make use of one's skills and develop new ones, and the possibility of deciding how to do one's work and participate in decision-making in this respect. Psychological pressure refers to the amount of work, intellectual demands and time constraints.

Other facets of work organization have been linked to mental health problems, e.g. limited social support, a lack of recognition, and a feeling of injustice. Generally speaking, social support encompasses all of the utilitarian social interactions that occur in the workplace among colleagues and supervisors.[76] More specifically, two types of social support are found in the workplace, i.e. socio-emotional support and instrumental support. Socio-emotional support refers to the degree of social and emotional integration and trust between colleagues and supervisors, i.e. the team spirit and cohesion prevailing in the work group. Instrumental support refers to the extent of the assistance that other people provide in carrying out tasks. A lack of recognition and a feeling of injustice in respect of colleagues and supervisors refers to an imbalance between the individual's efforts and certain legitimate expectations from the standpoint of remuneration, esteem, respect, status and promotion,[77] which recent studies focusing on Montréal Island emphasize.[78]

Table 3

Limited decision-making autonomy in the workplace, by sex and age, employed population 15 years and over, Montréal 1992-1993 and 1998

	1992-1993	1998
Men	46 %	50 %
Women	56 %	62 %
Both sexes		
15-24 years	68 %	68 %
25-44 years	52 %	55 %
45 years and over	44 %	51 %
Total	**51 %**	**55 %**

Source: Santé Québec, Enquête sociale et de santé 1992-1993. *Institut de la statistique du Québec,* Enquête sociale et de santé 1998.

An analysis of the findings of the 1998 Santé Québec survey of the state of mental health of workers in the Montréal area reveals that a higher proportion of individuals who experience high psychological pressure in the workplace are likely to be subject to intimidation than those experiencing low psychological pressure (22% and 14%, respectively). Individuals who say that they have been intimidated are also more numerous, proportionally, in displaying a high level of psychological distress than those who have never experienced intimidation (34% and 17%, respectively). A study devoted to CLSC-CHSLD staff in Montréal produced similar findings.[79] A link has also been observed between intimidation in the workplace and periods of acute nervousness or irritability. Roughly 12% of workers who have been intimidated perceive their mental health as average or poor, compared with 6% of workers who have never been intimidated.

Preventive intervention

Most preventive measures whose efficacy has been proven focus on a reduction in the effect of stress, not its causes,[80] which is all the more paradoxical since organizational factors play a bigger role than individual factors in burn-out.[81]

Recent studies pinpoint different types of intervention in respect of which success factors have been noted, such as support from senior management, participation by all employees, and a combination of measures aimed at the organization and the individual.[82, 83, 84] Measures geared to individuals, including awareness and stress management techniques, are often carried out in conjunction with an employee assistance program (EAP). Approaches centred on work organization are aimed at reducing the importance of pathogenic factors and are often implemented with an entirely different objective in mind, such as the enhancement of productivity. For example, longitudinal tracking of Finnish municipal workers between 1990 and 1997, a period that witnessed staff cutbacks and major reorganization, reveals that certain factors have a decisive effect on the reduction of sick leave, i.e. increase opportunities for workers to use their skills, make decisions on work organization or exercise control over uncertainty in the workplace, and receive considerable or improved support from the supervisor.

Among initiatives centred at once on work organization and the individual and that combine support from management and the mobilization of staff, mention should be made of the measures adopted by the CLSC de Charlevoix to combat burn-out.[85] Within one year, the action

plan reduced to levels in preceding years the number of days of sick leave for psychological reasons, which had almost tripled between March 1999 and April 2000 along with a fivefold increase in wage loss insurance. Aside from an integrated approach aimed at eliminating at the source pathogenic situations, officials accorded a great deal of attention to re-entry into the labour force by workers suffering from mental health problems, by means of a series of measures, e.g. a return to work plan, including worker reception and the reorganization of work loads and job descriptions.

A public health perspective

It is from a public health perspective that we must tackle constraints in the workplace psychosocial environment since there are effective strategies for reducing stress-related diseases in the workplace, which are among the most frequent, costly and disabling health problems. Moreover, the success of initiatives aimed at reducing health problems linked to stress in the workplace can hardly be dissociated from a more comprehensive public health policy, which should seek to establish monitoring systems in workplaces at risk and propose legal and financial means that encourage businesses to apply preventive strategies with a view to counteracting this pandemic that has struck the western world. The Tokyo Declaration (1998) states that we must establish national and regional monitoring programmes in order to ascertain the extent of stress-related health problems in the workplace and to evaluate the effect of remedial programs. Aside from public initiatives, there is every reason to call upon businesses, which, as corporate citizens, have a key role to play. Solutions already exist, e.g. participative management, whereby employees play an active role in seeking the most appropriate solutions.

Round-table discussion with mental health professionals

September 17, 2001

Front-line and second-line services

- *We must make front-line services more functional with more efficient support from specialists and psychiatrists.* ***Paul Lefort***
- *We must make front-line services, provided by GPs, more functional. If general practitioners are the only gateway to mental health services for patients, they will have less and less time to devote to physical health.* ***Rose-Marie Charest***
- *Physicians are not alone in providing front-line services. The CLSCs also play an important role, although mental health teams are very uneven from one CLSC to another. Services must be better distributed, with a minimum level of service everywhere.* ***André Luyet***
- *CLSCs should serve as the entry point, but in the mental health field you have to look to find CLSCs that play this role.* ***Denis Aumais***
- *More extensive specialized staff in mental health should be provided on family medicine teams and in the CLSCs. When a psychologist has met and evaluated a patient and submits an evaluation report to a psychiatrist, the latter can do something in 15 minutes. If we helped second-line professionals by better preparing patients who have contact with them, we could bolster the psychiatrists' efficiency. The problem is that this works only for those individuals who can afford a psychologist.* ***Rose-Marie Charest***
- *The problem of access to services is not limited to the fact that CLSCs do not have psychologists. It is more a question of poverty and access to services in the private sector.* ***Daniel Fecteau***
- *In order to move off-site, we at the Douglas Hospital tried to offer all second-line services outside the hospital. We opened sectoral clinics as close to the CLSCs as possible. CLSCs and GPs were supposed to refer patients to us and we were to offer psychiatric consultations before sending the stabilized patients back to the CLSCs or the GPs. When they were unable to ensure follow-up, we were supposed to refer patients to our outpatient programs for hospitalization depending on their state of health.*

  That was the plan. In fact, from the outset, the GPs and CLSCs in our sector tended to refer all cases to us because we are a psychiatric hospital. Moreover, they sometimes have difficulty taking back their patients. The more knowledgeable front-line service providers are, the more services they can offer.

  Patients end up in emergency. We treat them in our sectoral clinics but when we are ready to turn them over the CLSCs or GPs, they aren't there. ***Jacques Hendlisz***
- *While we have decided to concentrate on second-line services in psychiatry, we must also provide front- and third-line services. GPs who accept new cases are rare. Walk-in clinics seem to be in vogue but they do not favour genuine management and evaluation of patients and the establishment of a relationship with them. Furthermore, they do not allow health professionals to take the time necessary to become familiar with what are often fairly complex problems. Following evaluation, we would like to send many patients back to front-line services that are not, or are no longer, there and thus cannot take over from us.*

While there is talk at present of front-line services, there is nothing more open than an emergency waiting room in a hospital. That is where patients go when they do not know to whom they should turn for the treatment of transient disorders. It is hardly surprising that patients obtain a more or less satisfactory response. They get an evaluation and a referral.

We deal with partners and it is partnerships that we must develop, broaden and formalize more extensively. ***André Luyet***

- *I'm rather afraid that, as a society, we're dumping on the community sector all the responsibilities for which we have no resources, without giving it the necessary support. You physicians say that you need the support of specialists to more efficiently provide front-line services. Imagine how people in the community sector would benefit from it. Professionals could have a multiplier effect on services if they are put in a position where they can supervise, give advice and offer support to caregivers who are supposed to be informal caregivers.* ***Rose-Marie Charest***
- *We cannot discuss community organizations without raising the problem of funding...* ***Daniel Fecteau***

Severe disorders and transient disorders

- *The MSSS seems to be focusing its priorities, initiatives and funding on patients suffering from severe, chronic disorders. Does this mean that their needs are satisfied? Does the money devoted to severe, chronic disorders truly generate well-being among the patients concerned?* ***Ghislain Goulet***
- *It is true that we are investing too much in severe, chronic disorders. Acute transient disorders that are improperly diagnosed or that are not treated can nonetheless cause irreparable harm and mobilize extensive resources. Where are the savings? What about quality of life?* ***Daniel Fecteau***
- *The MSSS talks a lot about severe, chronic disorders and perhaps much less about transient disorders. We should be careful to avoid creating an imbalance by wanting to remedy a problem that has perhaps been underestimated. Both problems are genuine and warrant our full attention.* ***André Luyet***

The role played by the hospitals

- *In Québec, a report prepared by the Groupe d'évaluation des nouvelles technologies recommended, in light of the problems we are encountering in organizing services, that hospitals be responsible for intensive follow-up, although it is not politically correct for them to do so. Active Community Therapy (ACT) programs, which have existed in the United States for 25 years and rely on utterly remarkable documentation, have scarcely made inroads in Québec, where barely four or five teams have been established, as against 60 in Ontario.* ***Jacques Hendlisz***
- *It strikes me that there is little justification for claiming that hospitals must carry out intensive follow-up in the community or are we saying that departments of psychiatry with sufficient and varied resources should ensure such follow-up? This is not a strong argument and I would not dare defend it.* ***Daniel Fecteau***
- *The expression "entry point" is frightening. If we have an entry point, we don't have an exit point. And when there is one, it has a giant rubber band attached to it. We know when we enter the system, but we don't know where we we're headed or when we'll get out.* ***Denis Aumais***

- *It's a bit exaggerated to say that there is no exit point. There is one. In our outpatient clinics, we have nearly 7 000 active files and we close as many files as we open, so there is turnover. It's rather abusive to suggest that the patients referred to us are caught in a big trap.* ***André Luyet***
- *The problems we are facing in terms of support to be given patients and relationships with patients are quite different from what they were 10 years ago. In the wake of deinstitutionalization, we have many fewer beds. Hospital-based services are offered within a very brief lapse of time. Since the complete range of follow-up that should take place in the community is unavailable, some patients get lost in the system.* ***Jacques Hendlisz***

Adverse effects?

- *We must look at the cultural, historic trend toward overprotection. If there are other ways of doing things, we must consider them. We would like to see even more receptiveness in this regard. We live in a changing society and services must be reviewed constantly. We are learning more about community organizations. There are initiatives taken in the community network that complement hospital services and both should be combined for the greater public good. The two sectors should certainly not be separated. They deserve to be linked to offer services to this clientele.* ***André Luyet***
- *The Americans say: Ask someone who has spent time in a psychiatric hospital and who receives follow-up in the community who his friends are. The individual will immediately name the staff of community groups or volunteers but not people whom one meets in normal relationships. Our treatments and ways of doing things in the community sector are not ideal. We should ensure that the patient can live independently and establish his own relationships. However, our ideology means that we are behind the patient when he needs us, with the result that he is followed-up for 25 years. We continue to talk about rehabilitation, but that is not what the patient needs. When a patient is discharged after spending 10 years in the hospital, he can be rehabilitated, but not for 30 years. The patient must be able to find sheltered employment.*

  How many community organizations or hospitals have employment counsellors? How many of us are putting pressure on governments to amend legislation so that an individual attempting to return to the labour market is not penalized by the loss of income used to buy medication, and so on? The system is structured in such a way as to support patients in a manner that no longer reflects the deinstitutionalization model. Despite our best intentions at the hospital, in the community and at the regional board, we are supporting a system that does not reflect our ideals.

  In Québec, we have undertaken deinstitutionalization and our reform while maintaining the same inadequate concepts concerning patient treatment. We have not changed our philosophy or our mentality.

  If our philosophy is to ensure that the patient is autonomous, we are doing very little to keep him autonomous. We are doing everything to maintain ties with him. We must ensure that the necessary infrastructure exists in the community. ***Jacques Hendlisz***

Informal caregivers

- *Caregivers are truly suffering and we must say so.* ***André Luyet***
- *It is hardly surprising that informal caregivers are suffering, since helping someone without the means to do so causes suffering. Training allows psychiatrists,*

psychologists and physicians to see as many patients as they do in a day without cracking up. I am rather worried that so much responsibility is given to people without providing them with the necessary support. ***Rose-Marie Charest***

- *We underestimate the important need for support of informal caregivers (psychological distress) in conjunction with home care services. Our clientele information systems do not encourage this practice.* ***Daniel Fecteau***

Health promotion and disease prevention

- *What is psychological well-being? When does it become a pathology? Everyone experiences mental suffering, but for 33% of the population, such suffering is a pathology. If we want people to consult health professionals, we must inform them. People need to be guided in this network. They need help that is not always professional help. How can they know this? We have a lot to do in terms of information - a great deal of information can play a preventive role. We could inform people of the kinds of assistance to which they have access. We do not take mental health seriously enough because of a question of definition. When it becomes a question of the risk of suicide, costs to employers and costs to society, then we start to take the problem seriously.* ***Rose-Marie Charest***
- *Much has been said about the secondary prevention of mental illness. One has the impression that needs are almost infinite and that physical and human resources are finite. The problem is a major one. Mention has been made of tertiary prevention and the rehabilitation of patients suffering from mental illness. However, little mention has been made of primary prevention. If we focused on the family and the education of children, this would perhaps be one of the best ways to prevent mental illness or, at least, to reduce its impact. Resources and support aimed at families are probably one of the extremely important elements that are sorely lacking in our society and to which we should attach much greater importance.* ***Paul Lefort***
- *The response to the problem is not exclusive to health. Living conditions are a contributing factor. We must set the example if we are to successfully encourage others to act so that our health and education systems adapt to thousands of individual needs.* ***Chislain Goulet***
- *We must stop thinking of prevention simply as a phase in which we prevent someone from falling ill to include the phase in which someone is already ill and we try to prevent his condition form worsening. We always emphasize severe, long-term disorders, but we must support those suffering from transient problems before they become severe, long-term ones.* ***Denis Aumais***
- *Promotion and prevention efforts (public campaigns) appear very white, middle class to me. We must develop new strategies.* ***Daniel Fecteau***

The workplace and mental health

- *If we want to reduce the number of cases of burn-out, we must not only reduce the number of hours of work but also give people control over their work environment. We must empower them. Powerlessness almost always triggers burn-out.* ***Rose-Marie Charest***
- *Among growing problems, mention should be made of anxiety disorders stemming from difficult socio-economic conditions. We see people who are unemployed for a long time beginning to develop such disorders.* ***Daniel Fecteau***

3 Consolidate Initiatives in Favour of Mental Health

*The three objectives of the health and social services system — **prevent, cure, and care** — apply equally to the mental health and general health sectors. It is essential to actively pursue each of these three objectives in order to revitalize our initiatives geared to the mental health of Montrealers.*

In our fourth report on the health of Montrealers, we have sought to shed light on a hidden reality and to communicate important, sometimes troubling facts to decision-makers, which society as a whole must acknowledge and act upon.

If we have decided to do so, it is, first and foremost, because the problems are highly prevalent or frequent. Mental disorders are a major cause of distress and disability, to the same degree as main health problems such as cardiovascular disease and cancer. It was also timely to deal with this health issue because of the problems the Québec health care system is experiencing in making the appropriate use of recognized, proven measures. Our decision was also motivated by the overwhelming consequences of mental disorders for patients and their loved ones. Such consequences could be avoided, at least in part, if the right conditions existed in our health care system to properly apply existing knowledge and the attendant services.

Mental health and mental disorders, like other health problems, can benefit from a preventive management approach. Solid scientific evidence points to several courses of action which are open to us and whose implementation would be quite possible given the relative diversity of resources and knowledge available in Montréal. By preventive management, we mean the willingness and ability to act sufficiently early on in the development of mental disorders to prevent a deterioration in individual health and well-being and the resulting disabilities. Preventive management in the realm of mental health is not only possible but is also necessary.

The mental health of Montrealers is a daunting challenge for the community and a public health issue in the truest sense. We can do better with the resources available than we are now doing. We all share responsibility for achieving this goal. It is in this spirit that we have sought to call upon interveners in the community and invite them to coordinate their contributions by renewing our efforts and concentrating them on the concerns examined in this section.

A new perspective supported by solid data

Our report is appearing at a time when scientific breakthroughs are calling into question received wisdom concerning the causes and efficacy of treatment of the main mental disorders. We are learning more and more about the physiology of brain function and now better understand certain biological or genetic causes of mental disorders and certain risk factors (emotional deprivation, disruptive events, and so on) or protection factors (resilience, social support, and so on). Moreover, studies show the efficacy of various therapeutic approaches be they biopharmacological or psychological or a combination of both. After more than 50 years of research and advances in understanding and treating patients suffering from mental disorders, it is becoming increasingly clear that we can better manage this situation. Furthermore, some studies show that it is possible to act at the source to prevent mental disorders. For this reason, in 1999, the US Surgeon General published his first annual report on mental health. WHO devoted its 2001 annual report to mental health.

Transient disorders are the main unmet need among Montrealers.

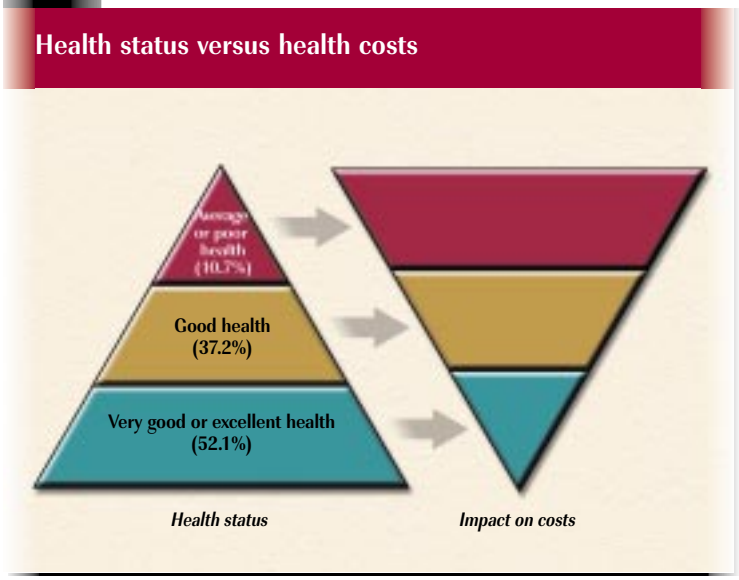
The data presented in the first chapters lead us to conclude, broadly speaking, that Montrealers' needs are not properly matched with the services provided. Our study suggests that transient disorders are the most frequent and that individuals and the professionals they consult all too often overlook them. Transient disorders are the main unmet need among Montrealers. In addition, our data suggest that the management of persistent disorders continues to be the raison d'être of the mental health network. While this network serves as a gateway to specialized services, it falls short from the standpoint of proposals to achieve genuine social reintegration. Our observations suggest that prevention in mental health gets short shrift in terms of regional service delivery and that it is in the nascent stage.

Prevent, cure, care. Since 1999, the DSP has put at the heart of its mission the need to integrate these three objectives into the health system's policy directions. The Clair Commission also adopted this theme earlier this year. In our region, the imbalance between each of the three objectives is blatant (see diagram).

Different types of intervention with respect to mental health are, indeed, disproportionate(v): in relation to the management of patients suffering from a serious, often persistent mental disorder, the specialized network pays much less attention to transient disorders, managed, above all, by front-line professionals and the private sector in clinical psychology. Virtually no effort is made with regard to mental health prevention aimed at adults.

Schema 3

Health status versus health costs



This will hardly be surprising to those whose professional or personal interests make them attentive observers of practices in our health care system. Similar remarks can be made with regard to the health care system overall. What is striking, however, is that for historic and administrative reasons, the mental health network is dedicated, above all, to serious, persistent disorders, in respect of which the network often provides front-, second- and third-line services to the detriment of access to specialized services by individuals suffering from transient disorders or persistent psychological distress.

The mental health network was one of the first integrated service networks to be established in our territory and it focused its initiatives and confined their scope to a sub-group of needs and, at the same time, reduced access for a large group of individuals suffering from less severe but much more frequent problems.

Specialized psychiatric services are broken down into six sub-regions and are divided into sectors within the sub-regions. A gap has developed in relation to the "other" health and social services system, which takes care of routine services. Moreover, collaboration with the front-line network and other community facilities is not carried out systematically.

(v) Quantitative data are unavailable to assess the costs or the level of resources devoted to each of these objectives.

The information available reveals unequal distribution of resources from one sub-region to the next and from one sector to the next as well as disparities in performance between the sub-regions.

The information available reveals unequal distribution of resources from one sub-region to the next and from one sector to the next...

While the network has been a precursor with respect to the integration of services, problems persist. Our research suggests that the fulfilment of this coordination role continues to be problematical. At present, cooperation is developing, but much remains to be done to harmonize organization and better manage activities from the standpoint of each intervener's contribution and role.

A worrisome diagnosis of access

Montrealers' mental health care needs are considerable. One person in five is directly affected, as are his loved ones. Another observation that will come as a surprise to some although it reflects observations made in other countries is that only half of the individuals with needs are actually obtaining services. One person in two has no contact either with his GP, a psychologist, a psychiatrist or another mental health specialist. This revealing figure is a reminder of how much remains to be done with respect to access to services, including community-based activities. It should also be noted that 70% of individuals requiring care do not appear to receive optimum care.

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As we have seen, proven measures exist and we have at our disposal an enviable pool of human resources to implement them. However, the gap to be closed is significant and demands that we rethink our approaches. Without this calling into question, we will not be able to truly cope with the enormous suffering and disability that mental disorders cause.

Work, an emerging challenge

Our research has revealed that psychological distress and mental disorders in the workplace have reached epidemic proportions and that little is known about this recent phenomenon. Is it the vulnerability of certain individuals that becomes apparent in the workplace or are working conditions the cause of malfunction among those who contend

with such conditions on a daily basis? This ambiguity explains the limited recognition of the problem among staff and employers, joint sector-based associations and even the Commission de la santé et de la sécurité du travail.

Prevention is desirable and, obviously, possible, as certain evidence shows. Theories confirmed by research explain why the workplace can be pathogenic and how the reorganization of work can remedy the situation. Some measures are known, but we must evaluate various facets of work organization. We need additional studies to better understand the relationships between personal conditions and working conditions.

The emerging problem of mental health in the workplace could become increasingly important as it affects all persons working in the city, whether or not they reside in Montréal. Now considered a research priority by the Department, our team must focus more intensively in the future on better defining the problem and its main symptoms, vulnerable groups, the types of enterprises most at risk, the relative importance of individual and collective factors, and so on. However, beyond the health care system, the problem demands genuine cooperation between employers, employees and researchers.

Where do we go from here?

We believe that the mental health system in the Montréal area must be reorganized in light of the preventive management of disease, which consists in intervening early on where possible. Such reorganization depends, by and large, on the circulation of information and the integration of services. Moreover, it centres on an analysis of problems and measures of proven utility and implies the systematic application of such measures and follow-up in respect of results. This understanding of preventive management would make it possible to consolidate initiatives and reduce obstacles.

Obstacles appear to arise from institutional logic and problems of governance. The almost complete autonomy of each hospital, CLSC, community group and medical clinic limits the system's ability to organize itself coherently.

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This situation confirms a self-perpetuating, defeatist attitude among health professionals who, while they have effective solutions to offer, are incapable of implementing them under the existing system of governance. It is noteworthy that informal caregivers claim to spend a disproportionate amount of time managing, on behalf of care receivers, access to services offered by various institutions and community organizations in the absence of ongoing collaboration.

Maintaining mental health

Prevent, **cure** and **care** are three objectives at the heart of the preventive management approach and it is essential to examine the balance, or imbalance, between them. This rebalancing must take into account the reorganization of front-line services and demands the redefinition of second- and third-line services, which must efficiently deliver specialized health care. Patients can then return to front-line services and those delivered by the community network. This new dynamic must rely on the concerted effort of decision-makers in the public, private and community sectors, and on the public at large.

Certain principles could serve as guidelines. Below are the guidelines that appear regularly in research and in our reflections:

- Rely on protection factors
- Act early on in order to reduce risks
- Minimize obstacles to access to services
- Integrate first-, second- and third-line services
- Inform and train
- Empower the workplace
- Provide the mental health system with the appropriate system of governance

In light of the foregoing guidelines, we propose broad solutions that warrant consideration by interveners who must act if the mental health of Montrealers is to improve.

Step up research

Researchers and funding agencies must also react to the observations presented in this report. Several avenues should be explored more thoroughly. For example, what are the obstacles to access, how can they be overcome, and how can the continuity and efficacy of collaboration between each level of service be broadened? Research can contribute significantly to enlightening decision-making with respect to the renewal of our approaches.

Mental health in the workplace also warrants closer attention. In particular, we must develop tools, better document the mental health of workers and better understand work organization methods that are the most likely to promote health or cause stress. Priority should be given to broadening knowledge of protection factors and organizational risk factors beyond the individual. We believe that the Institut de recherche en santé et sécurité au travail, in collaboration with the Commission de la santé et de la sécurité au travail and the Institut national de santé publique, are key players in this respect. Mention should also be made of the partnership role that decision-makers in the workplace should play.

Cooperation must first be established in respect of the problems and their causes in order to develop and evaluate in a timely manner the necessary remedial measures. Moreover, our observations suggest that public employee assistance programs should be tested in small and medium-sized enterprises that do not have at their disposal the means to offer such programs.

The research mentioned earlier must take into account more basic research, especially research aimed at deciphering the genetic factors underlying mental disorders and those pertaining to psychotherapeutic and pharmacological tools that will lead to even more effective intervention in the future.

Inform the public

The individual is the best judge of questions of such critical importance as health and psychological well-being. Everyone acknowledges how important mental health is to the quality of life. However, we must encourage the public to recognize that persistent distress warrants attention. If we are to overcome the obstacles to access to mental health care, we must heighten public awareness of the issue.

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It is also necessary to emphasize the importance of widely accessible strategies. Adapting to the 21st century means developing essential skills in order to deal with tension, stressful events and ways of reducing or mitigating adverse effects. Tools have been developed in this respect but their implementation is incomplete.

We must rediscover the crucial, even therapeutic role of the confidant. To confide in an esteemed loved one is an essential strategy for maintaining mental health. "Friends can be good medicine," as the popular saying goes.

Consulting a health professional can make a difference and this message deserves broader dissemination. Seeking assistance to deal with psychological distress should be no more out of the ordinary than consulting for any abnormal physical symptom although, as we have seen, such is clearly not the case. We must demystify mental illness and mental disorders by emphasizing the biological foundations of mental health and by normalizing as much as possible the attendant problems.

As we indicated in our 2000 annual report, the public is seeking increasingly to obtain information to guide health choices and gain access to facilities that can help maintain good health. Consequently, we must foster the dissemination of information on key mental health problems, especially in French. It is incumbent upon interveners in the health care system to restore individual empowerment in respect of health, a process that will depend, among other things, on the synthesis of information and its efficient transmission to those who need it. Information on the resources available in the community must also be an integral part of the information disseminated.

… we must foster the dissemination of information on the key mental health problems, especially in French.

Support caregivers

Family members and friends play a key role in caring for individuals suffering from mental health problems. In order to assume the role of caregivers, loved ones also need support. However, it appears that many caregivers do not receive the desired services because of inadequate support resources and problems in gaining access to these services. The lack of support is even more obvious when the caregiver is not a relative of the care receiver and hardly any intervention is aimed at the families and loved ones of new patients. It appears that the link between the caregiver, the health care team and community agencies does not always function properly as communication is sometimes unsatisfactory.

Research confirms that caregivers need moral or psychological support more than instrumental support and that the caregiver's experience of providing care is closely linked to his commitment to the caregiving relationship. The role of the caregiver in dealing with the care receiver demands a constant reassessment of the former's commitment to the latter and constant review of the reconciliation of caregiving, remunerative work, and family and personal life.

The difficulty in reconciling commitment and detachment in the caregiving relationship is a major concern for the caregiver.

The difficulty in reconciling commitment and detachment in the caregiving relationship is a major concern for the caregiver. Measures aimed at facilitating the caregiver's task should seek to strike such a balance to enable the caregiver to take into account his own needs instead of focusing solely on the care receiver's needs. The introduction of measures aimed at the care receiver's social integration, e.g. access to education, employment and adapted recreational activities, socialization and self-help activities, and so on, could facilitate the caregiver's task. We can assume that such measures would be beneficial not only for care receivers but also for the loved ones who support them.

We must recognize that the commitment of loved ones is voluntary and reflects a free, enlightened choice. Loved ones must have an opportunity to reassess the nature and scope of their commitment. They must be regarded simultaneously as the "attendants" of care receivers and "clients"

of the health care system who have specific needs stemming from their commitment. However, it must be acknowledged that the free choice of loved ones in respect of their commitment is only possible insofar as alternatives are available. This is one of the major challenges that must be met in the coming years.

Front-line professionals: improve detection and intervene sooner

The data published in this report remind us of the importance of intervening early on when mental disorders occur and of the obligation to do better in this respect, given the considerable number of individuals whose problems remain undiagnosed when they have contact with the health care system.

This responsibility falls to front-line services and, above all, to general practitioners. While recently trained physicians are better equipped to intervene in the realm of mental health, organizational obstacles all too often prevent them even now from doing so. Awareness, ongoing training, more systematic recourse to proven detection procedures and decision support tools are undoubtedly useful avenues. Recourse to an increasingly effective range of pharmacological products will also be profitable. What is crucial, however, is to be able to rely on collaborators such as psychologists and psychiatrists in specialized services and in the community network. Front-line services must be linked with other resources and much remains to be done.

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It is as though we had to reverse the dynamic, i.e. start with front-line services before turning to specialized services, instead of relying on a model in which the hospital is the focal point of the organization of services in the community. Why not take part in the initiative now under way to reorganize front-line services in conjunction with the implementation of the Département régional de médecine générale and family medecine groups? The establishment of corridors that give front-line professionals access to specialized services and the community network should be a development priority in respect of the organization of services under the forthcoming plan of the regional board.

Specialized services genuinely centred on second- and third-line professionals

In the course of our analysis, we have noted the fairly enviable level of specialized resources in the realm of mental health available in the region. We have also noted that these resources focus, by and large, on caring for patients suffering from chronic disorders. Interveners note that, all too often, they are responsible for front-, second- and third-line services in respect of this clientele and that they would be more useful if they were able to focus on specialized levels of intervention.

… it is imperative to decompartmentalize the specialized psychiatry network to open it up to other resources in the health care system, including front-line services.

To this end, it is imperative to decompartmentalize the specialized psychiatry network to open it up to other resources in the health care system, including front-line services. In addition to a shared care approach, the recognition of expertise through initiatives designed to summarize knowledge, intervention support, supervision and ongoing training will help draw closer together the expertise of interveners in the community while freeing up experts to engage in tasks better suited to their skills.

We cannot overlook the fact that the mental health field clearly illustrates the notion of two-tiered services. Perhaps because of society's tendency to gloss over the mental health issue in everyday concerns, it must be noted that most psychology services are not insured by the public health care system. The private network is well developed and only those with the means or with insurance that reimburses part of the cost have access to it. Considering that the underprivileged have the greatest needs, the result is clearly unfair access to services depending on the social group.

… we must aim for the objective of maintaining individual autonomy and fostering patients' full participation in community life…

Be that as it may, whether we rely on the public or private network, we must aim to maintain individual autonomy and foster patients' full participation in community life instead of keeping patients captive in a mental health network. Specialized professionals will achieve results when their treatment enables patients to traverse difficult periods in their lives and regain their autonomy and ability to function normally, or as normally as possible, in the community.

Community organizations, a decisive presence

Initiatives in the community sector have increased in the wake of the shift to ambulatory care and the attendant move to deinstitutionalization. Alternative mental health resources have developed and represent a significant part of community resources in the Montréal area. Community organizations have often demanded that services be better adapted to the needs of individuals in distress and their loved ones. They have also acted as a social laboratory and a catalyst for innovative measures. Such initiatives have led to innovation from the standpoint of practices and ways of managing mental health problems. In qualitative terms, the decisive contribution of community organizations to the renewal of practices in the realm of mental health is unquestionable. However, it is regrettable that it is not always possible to quantify the importance of this effort.

They have also acted as a social laboratory and a catalyst for innovative measures.

The contribution made by community organizations raises the question of funding. Representatives of these organizations maintain that the latter are finding it increasingly difficult to fully assume their role and that funding problems have force them to curtail access and services. With the shift from institutional to community resources, especially residential services, it would be desirable to stabilize or even increase funding for community organizations. Under the circumstances, the challenge facing these organizations is to continue to offer services while maintaining the autonomy necessary to remain truly active in society in order to provide a counterweight to the government.

Managers: learn to manage complexity

The renewal of governance will depend, first and foremost, on managers.

Our research shows that the method of organizing services in itself determines the quality of health care and the health care system's ability to react. Furthermore, our data suggest that the time has come to revitalize the system, although change cannot occur without relying on managers' skills.

Managers are facing situations that are more complex than in the past and it is up to them to create conditions that foster teamwork. Each intervener must understand the part he plays in a dynamic where

responsibilities regarding intervention are shared. To this end, we need managers who act as intermediaries and are aware not only of the scientific values underpinning professional practice but also the feelings and tension that often arise when working with patients suffering from mental disorders.

The renewal of governance will depend, first and foremost, on managers. First, organization methods must be reviewed in order to optimize the quality and efficacy of the services divided into sectors in each sub-region, and this in close collaboration with front-line professionals and community resources, while relying on research. Another challenge will consist in ensuring the cooperation of general practitioners. The coordinated administration of multipartite service agreements also poses a daunting challenge. The assessment of results and accountability will only be possible with the full collaboration of managers who are working as agents of change.

Another challenge will consist in ensuring the cooperation of general practitioners.

Mental health also needs help from elected representatives

Our research leads us to emphasize the relevance of rethinking overall mental health policy in Québec. We must rely on new objectives encompassing the entire range of challenges - prevent, cure and care. This policy direction prompts us to reconsider past achievements, which are centred too exclusively on the management of severe, chronic disorders and a largely institutional approach. New policies must not only centre on more comprehensive objectives but also propose the means to attain them by adopting the same populational approach that we advocated in respect of the research underpinning this report.

In addition to this new mental health policy, we wish to reassert the relevance of two factors that are crucial to mental health and the development of our community's potential. The first factor is the imperative of heightening awareness of prevention among very young and young children through substantial efforts to promote their early, optimum development. The second factor concerns the adoption of a vigorous plan to combat poverty. Social inequality continues to be, and may increasingly become, a decisive factor with respect to population

health, in response to which the health care system can hardly act alone. Government social policy is the genuine solution and we continue to hope that the intensification of the measures announced to combat poverty will lead to concrete spinoff in the numerous Montréal neighbourhoods that are in need.

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