

CAPE Special Issue

Unmet Need for the Treatment of Depression in Atlantic Canada

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Objective: Most people with depression do not receive treatment, even though effective interventions are available. Population-based data can assist health service planners to improve access to mental health services. This study aimed to examine the determinants of untreated depression in Canada's Atlantic provinces.

Method: This study used data from the Canadian Community Health Survey Cycle 1.1. Logistic regression models explored the prevalence of depression and associated patterns of mental health service use among population subgroups.

Results: Of the respondents, 7.3% experienced major depression in the previous year, as measured by the Composite International Diagnostic Interview Short Form. Individuals with the following characteristics were at increased risk for depression: female sex; widowed, separated, or divorced marital status; low income; and 2 or more comorbid medical conditions. Only 40% of respondents with probable depression reported any consultation about their condition with a general practitioner or mental health specialist. Less than one-quarter of Atlantic Canadians with depression reported receiving levels of care consistent with practice guidelines. Vulnerable groups, including older individuals, people with low levels of education, and those living in rural areas, were significantly less likely to receive treatment in either primary or specialty care.

Conclusions: These findings suggest inequitable access to services and the need to target interventions to at-risk populations by raising awareness among the public and health care providers. Health systems in the Atlantic region must work toward achieving consistent longitudinal care for a larger proportion of individuals suffering from depression by studying the underlying factors for service use among underserved groups.

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Clinical Implications

- Although 90% of individuals with depression have contact with their GP in the year of their episode, only one-quarter report receiving care that is consistent with treatment guidelines.
- There has been a recent focus on developing services for children, adolescents, and seniors: our study suggests that middle-aged subjects are the age group least likely to receive care, even after their reduced level of need is controlled for.
- The needs of underserved groups, such as those with lower levels of education or in rural settings, need more attention, as does communication between primary and specialist care: in our study, 71% of depression patients receiving specialist care had not seen their GP for a mental health problem in the same year.

Limitations

- Cross-sectional survey data cannot imply causality.
- Depression and service use data are all self-reported, so clinical diagnoses and treatment quality cannot be measured directly.
- Questions in the CCHS 1.1 preclude the construction of consecutive sequences of mental health-related contacts and make it impossible to distinguish between telephone and in-person consultations.

Key Words: *major depression, depressive disorders, treatment utilization, statistical and numerical data*

Between 4% and 10% of Canadians will experience major depression in a 12-month period (1,2), with a lifetime prevalence of up to 15% among men and 24% among women (3). The WHO's measure of disability-adjusted life years indicates that depression is the leading cause of disease burden in economically developed countries such as Canada (4). The escalating prevalence of depression is especially concerning because depressive symptoms have been shown to predict increased health care costs in Canadian populations (5).

Although 80% to 90% of people with depression can be treated successfully (6), most people with potentially remediable depression do not receive treatment (7). Understanding the factors that determine unmet need for the treatment of depression would allow professionals and policy-makers to close the gap between need for, and receipt of, mental health services. This study of depression in Canada's Atlantic provinces identifies the characteristics associated with unmet need for treatment in this region.

Methods

We analyzed data from the CCHS 1.1, which included respondents from Nova Scotia, New Brunswick, Prince Edward Island, and Newfoundland. We performed analyses on the master data file at Statistics Canada's Atlantic Research Data Centre, using SAS Version 8.2 (8). Because of the complex sampling strategy employed for the CCHS, we computed measures of variance and statistical significance using the SAS "Bootvar" program and bootstrap weights calculated for this data set. Sample size calculations indicated that our sample had sufficient statistical power according to published values for Canadian populations for both the prevalence of depression and numbers seeking treatment.

We defined depression as a positive screen for major depressive disorder in the previous year according to the CIDI-SF. Previous work with the scale has established that 5 or more

symptoms indicate a 90% probability of major depression in the 12 months prior to the interview. Field and reappraisal trials have confirmed the reliability and validity of diagnoses of depression made with the CIDI-SF (9–11).

We first investigated determinants of depression, using univariate and multivariate logistic regression to test for multicollinearity and potential interaction terms. We then investigated use of mental health services among respondents whose CIDI-SF scores indicated probable depression. Respondents were asked whether, in the past 12 months, they had seen a health professional or consulted by telephone about their emotional or mental health. All applicable health professionals (that is, family doctor, psychiatrist, psychologist, nurse, social worker, or other) were recorded, along with the number of times these services were sought. We distinguished between respondents who consulted primary care practitioners (family doctors) and those who consulted mental health specialists, although these categories were not mutually exclusive.

We then classified respondents with depression into the following 2 groups: 1) depression with "met need" or 2) depression with "unmet need," according to their self-reported use of any health services. We used Andersen's Behavioural Model of Health Care Use (12) to select potential predictors of unmet need. This framework considers individuals' use of health services as a function of their predisposition to use services, of factors that impede or facilitate use, and of their need for care. In the model, predisposing characteristics are not directly responsible for the use of health services, but they may be indicators of an inclination to use services more frequently or of a biological imperative that makes people more likely to need treatment. Enabling resources are social factors that play a role in an individual's access to, awareness of, and willingness to seek treatment. These assets may reflect the individuals themselves or the communities in which they live. Measures of need can be considered signalling characteristics that result from the severity of an illness. Need indicates affected individuals' perceptions of symptoms and pain and their judgment of whether their illness requires medical attention. Need also includes professional judgment about the individual's health status. We entered explanatory variables into logistic regression models of met and unmet need.

Finally, we determined whether individuals suffering from depression were receiving levels of care consistent with current practice guidelines used in other studies (13–15). We used the definition created by Diverty and Beaudet (16), according to which 4 or more visits to a GP or mental health specialist for psychological problems within 12 months of a diagnosis of depression constitutes adequate treatment. We selected this measure for comparability with their Canadian study (16) that also used Statistics Canada data.

Abbreviations used in this article

CCHS 1.1	Canadian Community Health Survey Cycle 1.1
CG	comparison group
CI	confidence interval
CIDI-SF	Composite International Diagnostic Interview Short Form
CV	coefficient of variation
GP	general practitioner
OR	odds ratio

	% (weighted)	OR (adjusted)	95%CI for OR	P value for adjusted OR
Table 1 Probable depression (based on CIDI to SF score) in Atlantic Canada, 2000 to 2001				
Predisposing characteristics				
Age (years)				
12 to 19	7.5	0.90	0.68–1.21	0.4954
20 to 44	8.9	CG		
45 to 64	6.9*	0.51	0.43–0.61	0.0000
65+	2.8*	0.10	0.07–0.14	0.0000
Sex				
Male	5.1	CG		
Female	9.4*	1.72	1.45–2.05	0.0000
Marital status				
Married or common law	5.7	CG		
Widowed, separated, divorced	12.0*	2.08	1.67–2.59	0.0000
Single	8.6*	1.35	1.07–1.70	0.0121
Province				
NS	8.7	CG		
NB	7.7	0.91	0.76–1.08	0.2610
NL	4.7*	0.53	0.42–0.66	0.0000
PEI	5.8*	0.74	0.59–0.92	0.0069
Immigrant				
Born in Canada	7.4	CG		
Immigrant	4.6 ^{*M}	0.70	0.42–1.17	0.1692
Enabling characteristics				
Income				
Lowest	13.0*	1.24	1.01–1.51	0.0378
Lower middle	7.4	CG		
Upper middle	6.4	0.93	0.77–1.13	0.4825
Upper	5.0*	0.87	0.66 to 1.14	0.3007
Urban or rural status				
Urban	7.9	CG		
Rural	6.4*	0.87	0.74–1.01	0.0733
Social support				
Low social support	22.7	CG		
Medium social support	16.3	1.40	1.00–1.97	0.0498
High social support	6.2*	0.55	0.41–0.75	0.0001
GP visits				
No visits	4.2	CG		
1 to 3 visits	5.2	1.16	0.87–1.53	0.3075
4+ visits	12.0*	1.93	1.44–2.60	0.0000

Table 1 continued				
	% (weighted)	OR (adjusted)	95%CI for OR	P value for adjusted OR
Need characteristics				
Self-perceived health				
Poor or fair	15.3*	1.72	1.40–2.11	0.0000
Good	8.7	CG		
Very good	5.7*	0.73	0.59–0.89	0.0025
Excellent	3.0*	0.43	0.33–0.57	0.0000
Chronic medical condition				
None	4.2	CG		
1 condition	5.5*	1.04	0.81–1.34	0.7628
2+ conditions	11.0*	1.58	1.28–1.95	0.0000
Disability days (in last 14)				
None	5.4	CG		
1 or 2 days	11.6*	1.59	1.21 to 2.09	0.0009
3+ days	18.4*	2.04	1.69 to 2.47	0.0000
*P < 0.05 in univariate logistic regression				
All CVs are between 0% and 16.5%, indicating an acceptable degree of variability, unless marked. A CV between 16.5% and 33.3% is marked with an M, indicating a marginal estimate.				
Variables for ethnicity (white or visible minority) and education were also entered into the model, with no significant differences found between response levels.				

Results

Sample

All 17 836 respondents resided in Canada's Atlantic provinces: 39.4% in Nova Scotia, 31.7% in New Brunswick, 23.1% in Newfoundland and Labrador, and 5.8% in Prince Edward Island. Respondents were 48.8% male, with 12.9% being aged 12 to 19 years, 43.4% aged 20 to 44 years, 29.4% aged 45 to 64 years, and 14.4% aged 65 years or over. In total, 59.5% of respondents were married; 11.8% were widowed, separated or divorced; and 28.7% were single. Most respondents described themselves as white (96.8%), and 44.0% lived in rural areas, according to their residential postal code.

Variables Associated With Depression

Of Atlantic Canadians, 1312 (7.3%; 95%CI, 6.1% to 8.8%) experienced an episode of major depression in the 12 months prior to interview. After we controlled for other variables, the predisposing factors of sex, age, marital status, and province of residence remained significantly associated with depression (Table 1). We observed statistically significant relations with enabling factors that included income adequacy, frequency of visits with a GP, and emotional and informational social support. Among the need characteristics, self-reported

health, chronic medical conditions, and disability days were associated with depression.

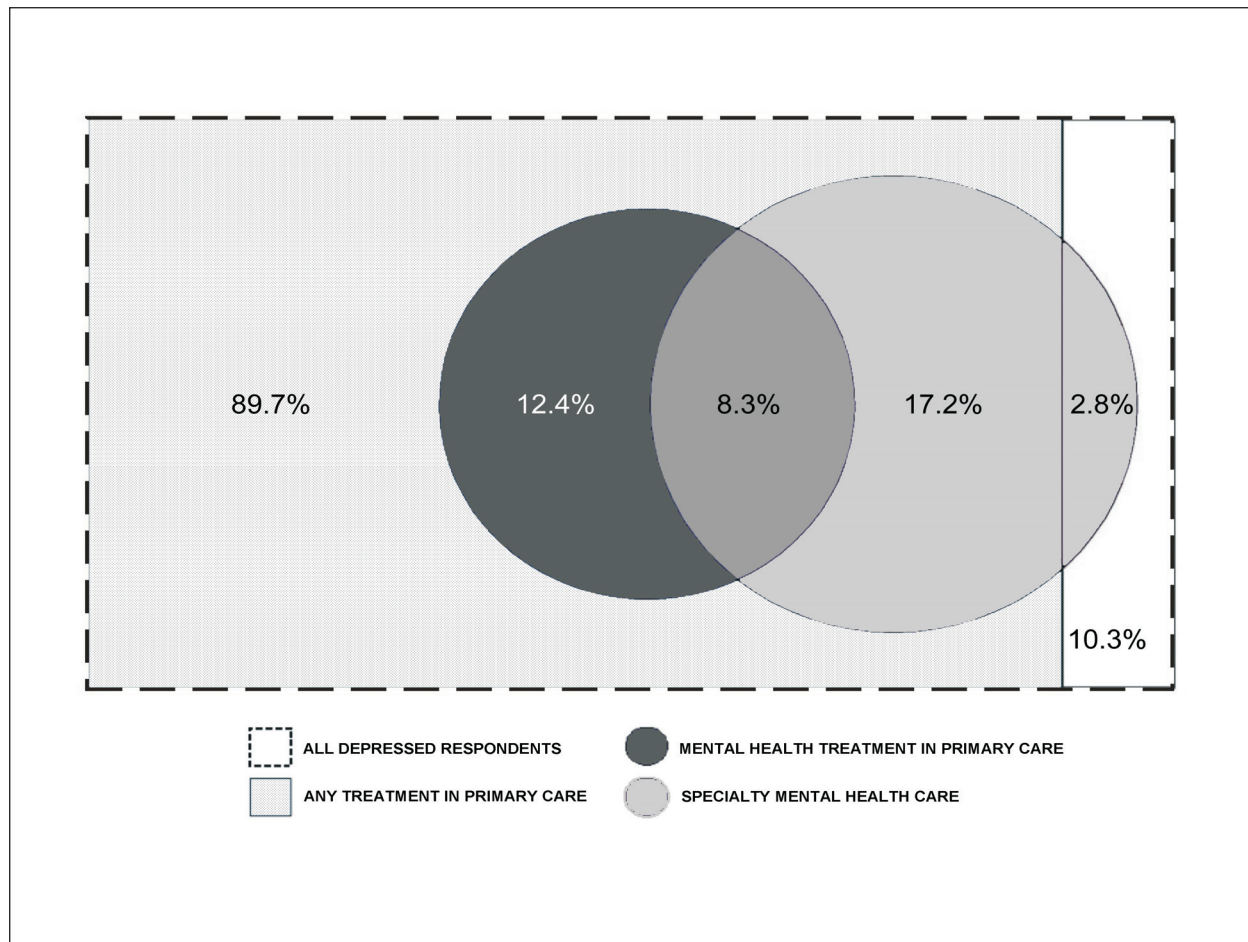
Variables Associated With Met Need in Primary Care

Among respondents whose CIDI-SF scores indicated that they had experienced major depression in the past year, most (89.5%) had seen their family doctor or a GP for some reason in the previous year (Figure 1). However, only one-fifth (20.3%; 95% CI, 17.8% to 22.9%) had consulted their GP for an emotional or mental health reason in the same year, with marked differences between demographic groups in the likelihood of seeking care. These differences persisted even after we controlled for other variables (Table 2). Respondents aged 45 to 64 years had significantly lower odds of receiving care, compared with those aged 20 to 44 years. Other groups significantly more likely to seek care were postsecondary graduates, those with a history of frequent GP visits, and those with chronic depression.

Variables Associated With Met Need in Specialist Care

Almost one-third of respondents suffering from depression (28.1%; 95% CI, 24.8% to 31.4%) reported seeing or speaking to one or more mental health care specialists (such as a psychiatrist, psychologist, nurse, or social worker—

Figure 1 Reports of any treatment in primary care, mental health treatment in primary care, and specialty mental health services by respondents with probable depression



counsellor) on at least one occasion in the previous year. Of this group, 71% did so without consulting a GP about their mental health (Figure 1). Middle-aged respondents and those living in rural areas were significantly less likely to see a mental health specialist (Table 3). By contrast, depression-specific need variables (that is, chronic depression and suicidal ideation) were significantly associated with over twice the odds of specialty mental health care. Among the 28% of respondents who reported using specialty mental health services, more (specifically, 11.7% of all respondents with depression) described consulting a psychiatrist, compared with any other specialty. Social workers (consulted by 10.1%) and psychologists (consulted by 7.7%) were the next most frequently used mental health professionals.

Variables Associated With Unmet or Insufficiently Met Need

Nearly 60% (95% CI, 56.1% to 63.2%) of respondents with depression reported “unmet need,” defined as no visits either to a GP for mental health reasons or to a mental health specialist. Respondents over age 45 years reported significantly higher levels of unmet mental health need even after we

controlled for other variables (Table 4). By contrast, those who had frequent GP contact for other health reasons or who experienced chronic depression or suicidal thoughts were one-half as likely to report unmet need.

While most respondents with depression reported no visits for a mental health reason, some respondents indicated that they had consulted a GP or mental health specialist in the previous year. Still, 15.7% of subjects with depression (95% CI, 13.1% to 18.2%) reported only insufficiently met need, defined as 1 to 3 visits for mental health reasons. Only 24.4% (95%CI, 21.4% to 27.4%) of subjects with depression reported receiving care that was consistent with the guideline of 4 or more visits for mental health reasons to either a GP or a mental health specialist.

Discussion

Comparison With Previous Studies

Our finding that 7.3% of respondents met CIDI-SF criteria for major depression in the previous 12 months is similar to findings in previous Canadian studies, which reported that the

Table 2 Receipt of mental health treatment in primary care among respondents with depression

	% (weighted)	OR (adjusted)	95%CI for OR	P value for adjusted OR
Predisposing characteristics				
Age (years)				
12–19	‡8.26*	0.55	0.24–1.28	0.1662
20–44	23.2	CG		
45–64	20.6	0.65	0.44–0.97	0.0354
65+	‡20.75	0.75	0.27–2.13	0.5936
Sex				
Male	15.8	CG		
Female	22.7*	1.23	0.80–1.91	0.3419
Marital status				
Married or common law	24.7	CG		
Widowed, separated, divorced	22.6	1.00	0.63–1.59	0.9914
Single	13.1*	0.72	0.42–1.24	0.2320
Enabling characteristics				
Education				
< High school	14.3	CG		
High school graduation	12.9	0.67	0.36–1.25	0.2071
Some postsecondary	‡19.41	1.12	0.49–2.55	0.7938
Postsecondary graduation	28.0*	1.66	1.01–2.73	0.0436
GP visits				
1–3 visits	10.7	CG		
4+ visits	30.1*	3.99	2.66–5.97	0.0000
Need characteristics				
Chronic medical condition				
None	10.8	CG		
1 condition	18.7	1.34	0.67–2.69	0.4027
2+ conditions	23.9*	1.33	0.77–2.27	0.3038
Disability days (in last 14)				
None	17.2	CG		
1 or 2 days	27.1*	1.48	0.85–2.57	0.1656
3+ days	24.7*	1.01	0.66–1.54	0.9645
Length of depression				
Acute depression	10.0	CG		
Chronic depression	23.5*	2.13	1.29–3.51	0.0033

†unweighted cell size insufficient (< 5) to release estimate, ‡5 ≤ unweighted cell size < 30, *P < 0.05 in univariate logistic regression

All CVs are between 0% and 16.5%, indicating an acceptable degree of variability, unless marked. A CV between 16.5% and 33.3% is marked with an M, indicating a marginal estimate.

Variables for province of residence, income adequacy, urban or rural status, social support, self-perceived health, and suicidal ideation were also entered into the model, with no significant differences found between response levels.

Table 3 Receipt of specialty mental health care among respondents with depression				
	% (weighted)	OR (adjusted)	95%CI for OR	P value for adjusted OR
Predisposing characteristics				
Age (years)				
12–19	30.9	1.41	0.79–2.51	0.2418
20–44	31.2	CG		
45–64	24.5	0.61	0.41–0.92	0.0177
65+	‡9.17	0.19	0.02–1.61	0.1283
Sex				
Male	28.0	CG		
Female	28.1	0.93	0.64–1.36	0.7055
Enabling characteristics				
Education				
< High school	24.0	CG		
High school graduation	22.5	0.82	0.48–1.40	0.4682
Some postsecondary	33.3	1.07	0.54–2.13	0.8464
Postsecondary graduation	32.3*	1.41	0.92–2.18	0.1165
Urban or rural status				
Urban	32.2	CG		
Rural	21.7*	0.57	0.41–0.80	0.0011
GP visits				
No visits	‡24.60	CG		
1 to 3 visits	20.0	0.63	0.30–1.35	0.2366
4+ visits	33.8*	1.18	0.56–2.48	0.6686
Need characteristics				
Self-perceived health				
Poor or fair	29.3	0.81	0.52–1.26	0.3454
Good	31.4	CG		
Very good	25.8	0.87	0.58–1.31	0.5190
Excellent	19.8*	0.73	0.38–1.40	0.3431
Chronic medical condition				
None	20.4	CG		
1 condition	26.6	1.14	0.67–1.94	0.6267
2+ conditions	31.0*	1.49	0.91–2.45	0.1162
Disability days (in last 14)				
None	23.6	CG		
1 or 2 days	34.4	1.27	0.72–2.24	0.3997
3+ days	35.3*	1.42	0.96–2.11	0.0791
Length of depression				
Acute depression	15.1	CG		
Chronic depression	31.8*	2.42	1.48–3.94	0.0004
Suicidal ideation				
No suicidal thoughts	25.5	CG		
Thoughts of suicide	44.1*	2.27	1.48–3.48	0.0002

†unweighted cell size insufficient (< 5) to release estimate, ‡5 ≤ unweighted cell size < 30, *P < 0.05 in univariate logistic regression
 All CVs are between 0% and 16.5%, indicating an acceptable degree of variability, unless marked. A CV between 16.5% and 33.3% is marked with an M, indicating a marginal estimate.
 Variables for marital status, province of residence, income adequacy, and social support were also entered into the model, with no significant differences found between response levels.

	% (weighted)	OR (adjusted)	95%CI for OR	P value for adjusted OR
Table 4 Receipt of no care for mental health reasons among respondents with depression				
Predisposing characteristics				
Age (years)				
12–19	66.5*	1.13	0.63–2.01	0.6799
20–44	55.7	CG		
45–64	61.3	1.52	1.06–2.17	0.0222
65+	72.7	2.37	1.11–5.03	0.0252
Sex				
Male	64.0	CG		
Female	57.4	0.84	0.59–1.20	0.3364
Enabling characteristics				
Education				
< High school	66.5	CG		
High school graduation	69.9	1.45	0.88–2.42	0.1479
Some postsecondary	56.4	0.91	0.46–1.82	0.7985
Postsecondary graduation	50.8*	0.63	0.42–0.95	0.0292
Urban or rural status				
Urban	56.9	CG		
Rural	64.0*	1.27	0.92–1.75	0.1405
GP visits				
No visits	75.2	CG		
1–3 visits	71.7	1.07	0.50–2.29	0.8642
4+ visits	49.2*	0.45	0.21–0.94	0.0336
Need characteristics				
Self-perceived health				
Poor or fair	57.9	1.27	0.84–1.91	0.2550
Good	56.1	CG		
Very good	62.3	1.07	0.72–1.58	0.7490
Excellent	69.1*	1.23	0.67–2.26	0.4947
Chronic medical condition				
None	72.4	CG		
1 condition	60.2*	0.71	0.43–1.15	0.1651
2+ conditions	55.3*	0.67	0.42–1.06	0.0868
Disability days (in last 14)				
None	65.7	CG		
1 or 2 days	50.1*	0.68	0.40–1.16	0.1611
3+ days	50.2*	0.70	0.48–1.00	0.0510
Length of depression				
Acute depression	76.9	CG		
Chronic depression	54.7*	0.45	0.30–0.67	0.0001
Suicidal ideation				
No suicidal thoughts	62.0	CG		
Thoughts of suicide	44.8*	0.47	0.31–0.72	0.0005
* $P < 0.05$ in univariate logistic regression				
All CVs are between 0% and 16.5%, indicating an acceptable degree of variability, unless marked. A CV between 16.5% and 33.3% is marked with an M, indicating a marginal estimate.				
Variables for marital status, province of residence, income adequacy, and social support were also entered into the model, with no significant differences found between response levels.				

prevalence of depression as defined by the CIDI was between 4% and 6% (1,2,17). This prevalence estimate is almost identical to the rate of probable depression found in the national sample for this cycle of the CCHS (18). As found in other studies, the prevalence of depression was almost double among women, compared with men (19). The finding that the prevalence of depression was lower among older respondents (those aged 45 years and over) is also consistent with recent reports of declining rates with increasing age (2,15,20–23). Possible explanations include a reduced susceptibility to depression that may be attributable to decreased emotional responsiveness, increased emotional control, immunization to stressful experiences, or reporting bias among older people, who may be less likely to disclose depression (17,23).

Our study confirms earlier work showing, despite differences in methodology, that only a few depression patients report receiving care that is consistent with treatment guidelines (13–16). Especially disconcerting is our finding that vulnerable groups, which include older individuals and those with infrequent contact with the health care system, are less likely to report appropriate treatment for their depression.

Predictors of Treatment in Specialist Care

Receipt of specialty mental health care was strongly associated with 2 need variables suggesting greater illness severity: the presence of suicidal thoughts in the past year and chronicity of depression. A finding not unique to Atlantic Canada, but salient in a rural part of the country, was that respondents with depression in rural settings were only 57% as likely to receive specialist care as were their urban counterparts. Previous studies, including some based on Canadian samples, have not observed urban–rural differences in service use for depression (24–26), although an Arkansas study noted that rural subjects made significantly fewer specialty care consultations for depression (27). Research on the impact of geographic accessibility to treatment for depression showed that travel time to providers was significantly associated with fewer consultations and decreased likelihood of receiving guideline-concordant care (28). Interventions to increase accessibility and decrease the stigma associated with depression in rural parts of our region might improve rates of service use. Better links between GPs and mental health specialists would also help.

Predictors of Treatment in Primary Care

Respondents suffering from depression who received treatment in primary care also tended to have experienced longer periods of depression and were less likely to be in the group aged 45 to 64 years. Additional factors found to be associated with care for depression included level of education and the number of reported visits with a GP or family doctor in the previous year. In Atlantic Canada, it seems that depression

patients with the highest levels of education are most likely to receive mental health care from their GP. A high level of education may give patients more credibility when discussing mental health concerns, or it may enable them to be better self-advocates for care. Higher education may also result in better health literacy or awareness of depression and its symptoms. The association between increased contact with GPs and a higher likelihood of receiving treatment for depression has been reported previously (16,26). The reference group, comprising people who visit their GP less frequently, may represent those who are unfamiliar with or intimidated by the health care system or who choose to seek help for emotional problems from other sources.

Predictors of Treatment in Any Setting

Respondents with depression who were aged between 45 and 64 years were the least likely of any age group to report receiving services, whether we analyzed for any treatment setting or for primary care and specialist services separately. On a positive note, those who reported depressive symptoms of longer duration were more likely to receive treatment in both general practice and specialty care.

Study Implications

In his model of health care use, Andersen argues that equitable access to health care occurs when demographic and need variables account for most service use (12). In our study, the strongest predictors of receiving care were need variables; individuals most in need of treatment were the most likely to receive it. The finding that an enabling resource such as rural residence or level of education is linked to decreased use of specialty services may signal inequitable access. In effect, other factors, such as social structures, health beliefs, and access to services, may ultimately be determining who receives care (12). When enabling resources are associated with service use, the more fortunate members of society may be favoured, exacerbating the vulnerability of certain groups. To decrease inequity in mental health care, health services planners must be aware of the underlying factors affecting service use among underserved populations.

While it is reassuring that such need characteristics as chronicity of symptoms and suicidal ideation strongly influenced self-reported degree of care for depression, demographic factors such as age, lower levels of education, and rural residence also had an effect. Although there has been a recent focus on developing services for children, adolescents, and seniors, our study suggests that it is middle-aged subjects who are least likely to receive care, even after their reduced level of need is controlled for.

Strengths and Limitations

Cross-sectional data cannot imply temporality or a sequence of events, so we were unable to infer consecutive paths of mental health-related consultations. Although self-reported measures of service and medication use are becoming standard in large population-based studies, such measures may be subject to reporting and recall bias (16). Studies comparing the accuracy of self-reported data with administrative records suggest that the level of agreement for any service use is good, whereas agreement for volume of use, which may be harder for patients to recall, is low (29). This lack of precision may distort results based on a specific definition of treatment adequacy. We were unable to control either for structural factors like the availability of physicians and psychiatrists in a respondent's area or for medication (including prescription antidepressants). Information on antidepressant use would have allowed us to consider the concordance of prescribing and treatment practices with published practice guidelines, which would have been an important addition to existing knowledge of the treatment of depression in this region.

This study's advantages include a large sample that has adequate power to detect true differences between groups and that is representative of Atlantic Canada. As well, the CIDI-SF is an internationally recognized instrument that measures depression with good reliability and validity and that allows meaningful comparisons with previous Canadian and international studies.

Conclusions

Individuals with depression have a high probability of not receiving adequate mental health care. Clearly, health systems in the Atlantic region should work toward achieving consistent longitudinal care for a larger proportion of individuals with depression. This goal is especially important because it is likely that our study's estimates are conservative assessments of the problem's magnitude. Our findings suggest that improving detection and treatment of depression in primary care may be a promising way of improving treatment use in this region, because most people with depression in Atlantic Canada had contact of some kind with their GP during the year in which they experienced a depressive episode. Education and support for primary care physicians treating patients with depression are also necessary as we strive to improve the quality of care these patients receive.

This study may inform the design of further studies that could examine the psychosocial factors behind the decision not to seek treatment and suggest ways to make these services more accessible to people with depression. In particular, this research can lay the groundwork for analyzing Cycle 1.2 of the CCHS, which has been designed specifically to study mental health issues. Mental health services research can

potentially assist in translating our findings and other research findings into strategic directions and policy options and, ultimately, into better care for people living with depression. More work must also be done to combat the deficiencies in income, education, and social support that have been shown to be associated with depression in Atlantic Canada.

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Résumé : Besoin non comblé de traitement de la dépression dans le Canada atlantique

Objectif : La plupart des personnes souffrant de dépression ne reçoivent pas de traitement, même si des interventions efficaces sont disponibles. Des données de la population générale peuvent aider les organisateurs des services de santé à améliorer l'accès aux services de santé mentale. La présente étude visait à examiner les déterminants de la dépression non traitée dans les provinces de l'Atlantique.

Méthode : Cette étude a utilisé les données du cycle 1.1 de l'Enquête sur la santé dans les collectivités canadiennes. Des modèles de régression logistique ont exploré la prévalence de la dépression et les modèles associés d'utilisation des services de santé mentale parmi les sous-groupes de la population.

Résultats : Parmi les répondants, 7,3 % ont vécu une dépression majeure dans l'année écoulée, selon la mesure de la forme abrégée de l'entrevue diagnostique composite internationale. Les personnes présentant les caractéristiques suivantes étaient à risque accru de dépression : sexe féminin; veuf ou veuve, séparé ou divorcé; faible revenu; et 2 affections médicales comorbides ou plus. Seulement 40 % des répondants souffrant de dépression probable ont déclaré une consultation auprès d'un omnipraticien ou d'un spécialiste de la santé mentale, au sujet de leur état. Moins d'un quart des Canadiens de l'Atlantique souffrant de dépression ont déclaré recevoir des soins conformes aux lignes directrices de la pratique. Les groupes vulnérables, y compris les personnes âgées, les gens ayant un faible niveau d'instruction et ceux qui vivent en région rurale, étaient significativement moins susceptibles de recevoir un traitement, que ce soit dans des soins primaires ou spécialisés.

Conclusions : Ces résultats suggèrent un accès inéquitable aux services et un besoin de cibler les interventions sur les populations à risque en sensibilisant le public et les fournisseurs de soins de santé. Les systèmes de santé de la région atlantique doivent s'efforcer d'offrir des soins longitudinaux cohérents à une plus grande proportion de personnes souffrant de dépression, en étudiant les facteurs sous-jacents de l'utilisation des services chez les groupes sous-desservis.