THE MENTAL HEALTH OF FRANCOPHONE MINORITIES:

AN OVERVIEW FROM THE CANADIAN COMMUNITY HEALTH SURVEY – MENTAL HEALTH 2012

ADAPTATION OF *PORTRAIT STATISTIQUE DE LA SANTÉ MENTALE DES QUÉBÉCOIS. RÉSULTATS DE L'ENQUÊTE SUR LA SANTÉ DANS LES COLLECTIVITÉS CANADIENNES – SANTÉ MENTALE 2012*

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HIGHLIGHTS

This report, *The Mental Health of Francophone Minorities: An Overview from the Canadian Community Health Survey*, presents the situation of a series of indicators for mental disorders and substance use disorders, optimal and suboptimal mental health, and the use of mental health resources in 2002 and 2012. It also allows us to assess the influence of some key social determinants that affect mental health. This secondary analysis of the CCHS – Mental Health is the first complete publication on the subject and fills an information gap regarding official-language minority populations, which are often insufficiently documented. It will also allow us to identify avenues for research to better understand the impact of minority situations, particularly on health, access to services, and the quality of official-language minority services.

However, given that the CCHS – Mental Health is already based on a smaller sample of Canada's population and that it accentuates considerably once broken down by official-language minority group, much data remains confidential or has large variation coefficients, meaning that it must be interpreted with caution due to the high variability of estimates.

Generally speaking, when the mental health of the Francophone minority population is compared to the Anglophone majority, a few differences are observable.

The Francophone minority appears to be more deeply affected by depression (a situation that has remained stable over the two study periods), is more likely to score high on the Psychological Distress Index (a situation that improved slightly in 2012), and, in 2002, had a higher number of suicide attempts (a situation that improved in 2012). Women, people with the lowest educational levels, those with the lowest incomes, and people living alone and in urban areas are overrepresented for those three mental health problems.

In 2002, the sense of belonging to the community was significantly lower in the Francophone minority than in the Anglophone majority; however, it rose for both groups in 2012.

The significant prevalence of mental disorders and substance use disorders, when taken as a whole (38% for the Francophone minority and 32% for Canada as a whole), indicates that there is genuine cause for concern about the public's mental health and a need to foster the growth of communities.

However, mental health and mental illness are unfortunately often not deemed to be priorities. Rigorous consideration for mental health would allow us to concentrate on prevention models, timely interventions, improved access, elimination of inequalities and the incorporation of social determinants in the transformation of mental health care and policies, with respect for official-language minority communities. It is an issue of equity and service quality.

FOREWORD

The Canadian constitution (*Constitution Act*, 1982) and the *Official Languages Act* (1969) have made Canada a bilingual country. English and French have equality of status and equal rights and privileges as to their use in Parliament and the Government of Canada. This guarantees the linguistic rights of Canadian citizens: a right to education, justice, and communication in the official language of their choice. Of all Canada's provinces, only Quebec has French as an official language and New Brunswick is officially bilingual. In Canada's other provinces, French is found to be the language spoken by what is called an official language minority (1,126,535 people), just as English is spoken in Quebec by a minority (1,545,310 people) (Statistics Canada, 2016 Census of Population).

The Government of Canada's implementation of an *Action Plan for Official Languages* in 2003 allowed for an update on the health and social services issues in official-language minority communities with regard to needs assessment, understanding of health determinants, service quality and access, and access to professionals in the minority official language. However, national health data is not broken down by official-language minority population, meaning that the situation of a portion of the Canadian population was under-documented. However, research in the field has demonstrated that Francophone minority communities present a contrasting profile based on their specific demographic and socio-economic situations. In general, they are older, have less education, and are less represented in the labour market. They are more concentrated in the regions, where development and access to social resources are more difficult (Bouchard and Leis, 2008). These living conditions have an impact on the health of communities, which highlighted the minority language situation as a determinant of diminished health (Bouchard et al., 2009, 2011).

This report establishes an overview of the mental health of Francophones in official-language minority communities, based on data from the Canadian Community Health Survey — Mental Health 2012. It is an adaptation of the *Portrait statistique de la santé mentale des Québécois. Résultats de l'Enquête sur la santé dans les collectivités canadiennes — Santé mentale 2012*, (@ Gouvernement du Québec, Institut de la Statistique du Québec, 2015).

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INTRODUCTION

There can be no health without mental health, declared Ban Ki-moon, Secretary General of the United Nations in his message for World Mental Health Day 2008 (Dietrich et al., 2012). In fact, the World Health Organization (WHO) recognizes mental health as an integral part of health and defines it as follows:

> "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2016).

However, one in three people, possibly more, experience a disruption of that state of well-being during their lives (Vigo et al., 2016). The Mental Health Commission of Canada (MHCC) states that in Canada, one in five people is dealing with a mental illness. It even estimates that one in two people will experience a mental illness before age 40 (MHCC, 2012). To illustrate the scale of the issue, some authors have pointed out that twice as many people suffer from mental disorders as from heart conditions or type 2 diabetes (Smetanin et al., 2011; MHCC, 2017).

The human and health impact of mental illness has also been well documented: reduced life expectancy, increased chronic disease burden, debilitating limitations, and repercussions on family, employment, finances, and day-to-day activities (MHCC, 2017; Roberts and Grimes, 2011).

Although most studies consider the importance of social determinants on the existence of mental health problems, none of the data has been broken down based on membership in an official-language minority community — a factor acknowledged as having an impact on health (Bouchard et al., 2009). The impact of language and communication on access to, quality and security of care takes on a much greater scope within the Canadian context, where two official languages co-exist. It is with this premise in mind that we will attempt to provide an overview of mental health in the Francophone minority population using data from the Canadian Community Health Survey (CCHS – MH 2012).

Chapter 1 – THE CCHS – MENTAL HEALTH 2012

The Canadian Community Health Survey on Mental Health (CCHS – MH) was conducted by Statistics Canada on two occasions: in 2002 and in 2012. Since some indicators have changed from one cycle to the next, comparisons are limited. The information provided here refers to the 2012 survey, since it is the main instrument used in this study.

1.1 Objectives

The major objectives of the CHSS – Mental Health 2012 are as follows (Statistics Canada, 2013):

- Assess the physical and mental health status of Canadians;
- Document the use of and access to mental health services, assistance received from the sufferer's entourage, and perceived and unmet needs;
- Assess functioning, ability, and disability in relation to mental health and illness;
- Examine links between mental health and social, demographic, geographic, and economic variables or characteristics;
- Evaluate changes in patterns of mental health, service use, and functioning from the 2002 CCHS on Mental Health and Well-being.

To meet these objectives, the CCHS - MH questionnaire was created as part of a consultation process between Statistics Canada's Health Analysis Division, Health Canada, the Public Health Agency of Canada, the Mental Health Commission of Canada, provincial health ministries and experts from various government bodies, and academia.

1.2 Methodology

The CCHS – Mental Health was conducted with people aged 15 years or older and living at home in all 10 of Canada's provinces. As a result, persons living on reserves and other Indigenous settlements, full-time members of the Canadian Forces, and the institutionalized population were excluded. The survey thus covered around 97% of the population aged 15 and over living in Canada. Data was collected from respondents between January and December 2012. Computer-assisted interviews, whose average duration was 56 minutes, were primarily conducted face-to-face.[1] The response rate was 68.9%, which corresponds to a sample of 25,113 people representing 28.3 million Canadians (Statistics Canada, 2013b).

This analysis is based on a sub-sample of 1,028 Francophones and 19,496 Anglophones living outside the province of Quebec (2012) and 1,868 Francophones and 29,246 Anglophones living outside the province of Quebec (2002). Survey sampling weight was applied so that the results are representative of the Canadian public, along with bootstrap weight to account for underestimation of typical errors attributable to complex surveys (Rust and Rao, 1996).

The results obtained in this report are drawn from data analyzed using Statistics Canada's confidential microdata files due to the linguistic variables that had to be used to define the Francophone minority population (see figure 1.1). The results are presented in proportions (%). In addition, the prevalence of a given indicator, presented for the entire Francophone minority population, is compared with one that was observed for the Anglophone majority outside of Quebec and for Canada as a whole. The chi-square test was used to compare the proportions between the minority Francophone population and the Anglophone majority. The result of this

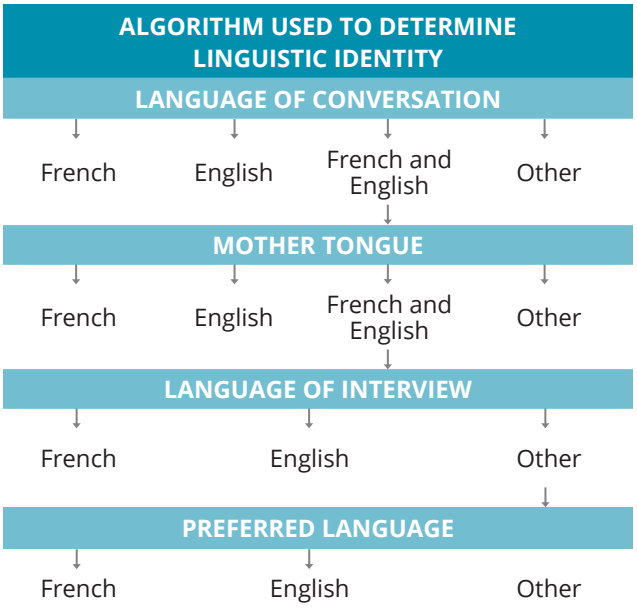
1. Telephone interviews were conducted for 13% of respondents.

test (p-value) was not presented, but the upper and lower bounds of the confidence intervals at 95% accompanied the estimates. Statistical tests were performed at the 5% threshold and the ** symbol was added to tables to make it possible to quickly identify any significant differences. Analyses were performed using SAS software, v. 9.4.

Definition of the Francophone official-language minority population

Francophone linguistic identity was determined using an algorithm by which individuals could be selected based on four CCHS variables: language of conversation, mother tongue, language of interview, and preferred language of contact during the survey. At each stage, individuals were sorted based on their language proficiency, with bilingual persons eventually redistributing into Francophones and Anglophones (Bouchard et al., 2009).

Figure 1.1



The analyses in this report were conducted at the Carleton, Ottawa, Outaouais Research Data Centre (COOL RDC), a member of the Canadian Research Data Centre Network (CRDCN). The network is supported by the Social Sciences and Humanities Research Council (SSHRC), the Canadian Institutes of Health Research (CIHR), the Canada Foundation for Innovation (CFI) and Statistics Canada.

Advisories

» In this report, the masculine form is used for ease of reading, without prejudice for the feminine form.

» In the tables, the term "Canada as a whole" refers to Canada's ten provinces.

Conventional signs

x Confidential data

ND Not available

... Not applicable

** Significant difference from the Anglophone majority, at 5% threshold

E Coefficient of variation between 16.6% and 33.3%; to be interpreted with caution due to high variability of estimates.

F Coefficient of variation greater than 33.3%; inaccurate estimate provided only for indicative purposes, since the data does not meet Statistics Canada's quality standards for this statistical program.

1.3 Survey content

MENTAL HEALTH, WELL-BEING, DISTRESS, STRESS

- Positive mental health ◊
- Social provisions scale ◊
- Spirituality
- Distress
- Negative social interactions ◊
- Sources of stress
- Work stress
- Suicidal ideation and suicide attempts

PHYSICAL HEALTH AND DETERMINANTS OF HEALTH

- General health
- Pain and discomfort ◊
- Chronic conditions
- Self-reported height and weight
- Physical activity ◊
- Smoking ◊

MENTAL DISORDERS

- Filter questions for mental disorders (screening)
- Depression
- Bipolar disorder (modules: hypomania and mania)
- Generalized anxiety disorder ◊

DISABILITIES/LIMITED ACTIVITIES

- Disabilities in the past two weeks
- WHO Disability Assessment Schedule (HAD) ◊
  Taking medication and using services
- Medication use
- Calling upon appropriate mental health services
- Perceived need for care ◊

SUBSTANCE USE AND ADDICTION

- Alcohol – abuse and addiction
- Drugs – abuse and addiction
  (with the possibility of isolating cannabis)
  Problematic situations and contexts
- Childhood experiences ◊
- Mental health experiences (stigmatization) ◊
- Effect of mental health on families ◊
- Contact with police ◊

SOCIO-DEMOGRAPHIC CHARACTERISTICS

- Socio-demographic information: age, sex, immigration status, country of birth, language, household composition, etc.
- Labour force
- Education
- Income
- Administrative information related to the survey

◊ The lozenge indicates new modules that were present in the 2012 survey.

1.4 Definition of cross variables

SOCIODEMOGRAPHIC CHARACTERISTICS	
MARITAL STATUS	Information on the respondent's marital status. The following question was used to classify people based on six marital statuses: 1. What is your marital status? *Married, living together as married, widowed, separated, divorced, single, or never married?*
EDUCATION	Information on the highest level of education completed. The indicator includes 10 levels that were grouped into four categories: 1) partial secondary education (Grade 8 or less, Grade 9 or 10, Grade 11); 2) high school diploma (no post-secondary education); 3) post-secondary and college-level education (commerce certificate or diploma from a trade or apprenticeship school, diploma or certificate from a community college, Cegep, nursing sciences school or other); 4) university degree/certificate (university degree lower than a bachelor's, bachelor's degree, postgraduate diploma/certificate). 1. Do you have a high school diploma or equivalent? 2. What was the highest elementary or secondary grade that you completed? 3. Did you take any other courses leading to an attestation, certificate or diploma from an educational institution? 4. What is the most advanced certificate, diploma or degree that you have received?
HOUSEHOLD INCOME LEVEL	Total income of all members of the household, from all sources, presented in quintiles. The measure was constructed using the adjusted total household income ratio at the low income threshold, which corresponds to the sizes of households and a given community. This measure provides a proportional comparison of a household's income with all incomes from the responding households in the province. The following question was used to determine household income: 1. To the best of your knowledge, what do you estimate to be the total income of all the members of your household, from all sources, before taxes and after deductions, over the last 12 months?
EMPLOYMENT	The respondent's situation regarding employment. Two categories are possible for employment: 1) yes (working at a job or for a company; has a job, but is not working – absent); 2) no (does not have a job, suffering from a permanent disability). The following questions were used to establish the employment situation: 1. In the past week, have you worked at a job or for a company, regardless of the number of hours worked? 2. In the past week, did you have a job or a company from which you were absent?
URBAN AND RURAL	This variable identifies whether the respondent lives in an urban or rural area. Urban areas are permanently built-up areas that have a population concentration of 1,000 or more and a population density of 400 or more per square kilometre, based on population figures from the current census.
LIVING ALONE	The respondent's living arrangement based on information describing the family ties that exist between the respondent and household members. The "person living alone" category was isolated to construct this indicator.

HEALTH CHARACTERISTICS	
MENTAL HEALTH	The presence or absence of a mental disorder or substance use disorder was established using a modified version of the classification in the Composite International Diagnostic Interview (WHO-CIDI) created by the World Health Organization. This internationally recognized instrument can be administered by interviewers who are not health professionals and is used to establish the presence of mental disorders or substance use disorders. The measure of these various disorders stems from a series of questions dealing with emotions, symptoms and the severity, intensity and impact associated with each of them. Mental disorders and substance use disorders that are identified using this instrument are not based on a clinical diagnosis.
MENTAL DISORDER	Having had at least one of the following disorders in the 12 months preceding the survey: depression, bipolar disorder or generalized anxiety disorder.
ALCOHOL ABUSE OR ADDICTION	Alcohol abuse is defined by a recurrent pattern of use where at least one of the following occurs: failure to meet major obligations at work, school or home; use in hazardous situations; recurrent alcohol-related problems; or continued use despite social or interpersonal problems caused or intensified by alcohol. Alcohol addiction is characterized by a recurrent pattern of use where at least three of the following symptoms occur: increased tolerance, withdrawal symptoms, increased consumption, unsuccessful attempts to quit, a lot of time lost recovering or using, reduced activities and continued use despite persistent physical or psychological problems caused or intensified by alcohol use. Alcohol abuse is included in the addiction indicators. In other words, there can be no addiction without abuse.
CANNABIS ABUSE OR ADDICTION	Cannabis abuse is defined by a recurrent pattern of use where at least one of the following occurs: failure to fulfill major roles at work, school or home; use in physically hazardous situations; recurrent cannabis-related problems; or continued use despite social or interpersonal problems caused or intensified by cannabis. Cannabis addiction is characterized by a recurrent pattern of use where at least three of the following symptoms occur: increased tolerance, withdrawal, increased consumption, unsuccessful attempts to quit, a lot of time lost recovering or using, reduced activities and continued use despite persistent physical or psychological problems caused or intensified by cannabis use. Cannabis abuse is included in the addiction indicators. In other words, there can be no addiction without abuse.
MEDICATIONS	Using prescription or over-the-counter medication for problems related to emotions, mental health or alcohol or drug use. The following question was used to determine the presence or absence of prescription or non-prescription drug use: 1. Over the last 12 months, have you taken medication for problems related to your emotions, mental health or drug or alcohol use?

PHYSICAL HEALTH	
PERCEIVED PHYSICAL HEALTH	The perception of physical health, often called "self-perceived health" provides a subjective measure of the status of physical health. This is an indicator that is frequently used in surveys that complements the information provided by other health indicators. The following question was used to determine perceived physical health: 1. In general, would you say your physical health is: *Excellent, very good, good, fair or poor?*
EXERCISE	People who have engaged in moderate to high-intensity exercise in the past seven days. It is specified that even moderate exercise must raise breathing and heart rates. Exercise can take place during recreational activities, work, housework or travel. For example, brisk walking and cycling on one's commute are two possible options.
PAIN AND ILLNESS	People who typically experience pain or discomfort. Respondents were asked to exclude short-term conditions, such as a cold or flu. Respondents who reported typically experiencing pain or discomfort were asked how many activities were limited by the conditions—none, a few, several or most.
CHRONIC HEALTH CONDITION	People suffering from one or more chronic health conditions. A chronic health condition is defined as a state that persists or is expected to persist for six months or more and that was diagnosed by a health professional. The following health conditions were included in the survey: *Asthma, arthritis or osteoarthritis (excluding fibromyalgia), other back pain, hypertension, migraines, chronic bronchitis, emphysema or chronic lung disease or COPD, diabetes, epilepsy, heart disease, cancer, stroke-related disorders, bowel diseases such as Crohn's disease, ulcerative colitis, irritable bowel syndrome or incontinence, Alzheimer's disease or any other form of dementia, chronic fatigue syndrome, multiple chemical sensitivities, schizophrenia, mood disorders such as depression, bipolar disorder, mania or dysthymia, anxiety disorders such as phobias, obsessive compulsive disorders or panic disorders, post-traumatic stress disorder, learning disorders, attention-deficit disorder, eating disorders such as anorexia or bulimia, or any other long-term physical or mental health condition diagnosed by a health professional.*

Chapter 2 – MENTAL DISORDERS AND SUBSTANCE USE DISORDERS

As mentioned in the previous chapter, some of the main objectives of the CCHS – Mental Health 2012 sought to examine the links between mental disorders, substance use disorders and social, demographic, geographic, and economic characteristics of affected people. With respect to mental disorders in the strict sense, it should be noted that only three disorders were measured in the 2012 survey: depression, bipolar disorder, and generalized anxiety disorder. Regarding substance use disorders, the survey focused on abuse and addiction to alcohol, cannabis, and other drugs.[1]

The questions used to measure the prevalence of mental disorders and substance use disorders are taken from a modified version of the classification in the Composite International Diagnostic Interview (WHO-CIDI); this WHO-recognized instrument was modified to meet the needs and adapt to the context of the CCHS – Mental Health. The WHO-CIDI, which is a standardized questionnaire that is used to assess mental disorders and substance use disorders, is based on the definitions and criteria in the DSM-IV[2] and the ICD-10.[3] In population surveys, such as the CCHS – Mental Health, the WHO-CIDI is a very useful instrument, since it can be administered by interviewers who are not health professionals. It must be remembered that mental disorders or alcohol or drug use disorders that are identified using the WHO-CIDI are not based on a clinical diagnosis.

It should also be noted that the prevalence of mental disorders and substance use disorders established by the survey must be considered to be underestimated, since the survey does not measure all mental disorders or abuse and addiction-type disorders and given that some population subgroups are excluded[4] (Pearson et al., 2013).

In this chapter, the results are presented by sex, age, and levels of household income. In addition, increases in the presence or absence of mental disorders or substance use disorders and health indicators (perceived physical health, physical activity, pain or discomfort, and chronic health conditions) inform the results.

In conclusion, it must be emphasized that the comparison with the results of the 2002 survey is limited to the results dealing with depression. For bipolar disorder, a change made to the definition in the WHO-CIDI required the construction of a new indicator, meaning that the variables from 2012 can be compared with those from 2002. For abuse and addiction to alcohol and cannabis, the thresholds were modified in the 2012 survey, making it impossible to compare the 2012 and 2002 estimates. As for the indicators for abuse and addiction to other drugs (excluding cannabis), in 2012 they included information on non-medical use of medication, which was not the case in 2002. Lastly, generalized anxiety disorder was a new module in the 2012 survey.

2.1 Mental disorders

2.1.1 Depression

WHAT IS BEING MEASURED?

Over a period of at least two weeks, measurements were taken of any feelings of sadness, loss of interest or pleasure in normal activities, which

1. "Other drugs" include club drugs, cocaine, heroin, solvents, other illicit drugs mentioned by the individuals, and non-medical use of prescription drugs such as sedatives, painkillers or stimulants.
2. The DSM abbreviation indicates the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association. This is a psychiatric reference manual that sets out the criteria and symptoms to be used in making a diagnosis.
3. ICD-10 is an international classification of diseases created by the WHO and used for diagnostic purposes in epidemiology, service organization and some clinical contexts (WHO, 1994).
4. The sub-groups screened out of the study are: persons living on Indian reservations and in other indigenous communities, full-time members of the Canadian Forces, and individuals residing in institutions.

are associated with certain symptoms, such as reduced energy, changes in sleep and appetite, difficulty concentrating, feelings of guilt, and feelings of hopelessness or suicidal ideation. Sadness and hopelessness undermine the ability to work and study, and harm social relationships. It becomes very difficult to complete day-to-day tasks and, in severe cases, life may lose all meaning.

Comparison with the CCHS – Mental Health 2002: The indicator is comparable.

WHAT DO THE RESULTS SAY?

For the minority Francophone population as a whole

Just over 14 percent (14.4%) of the minority Francophone population aged 15 years or older has experienced depression during their life. This proportion has slightly increased since 2002 (14.1%). These proportions are higher than the Canadian average (11.3% and 12.2%, respectively). Furthermore, in 2012, the prevalence rate in the minority Francophone population (14.4%) was significantly higher than that of the Anglophone majority outside of Quebec (10.9%).

Sex

Minority Francophone women were more likely than men to have experienced depression in their lifetime (17.9% vs. 10.2%). This difference was also observed in 2002 (16.5% vs. 11.7%).

Age

In 2012, a greater proportion of people aged 50 and over from the Francophone minority experienced depression over their lifetimes (15.9%) compared to 30-49 year-olds (12.8%) and 15-29 year-olds (12.2%). However, in 2002, the 30-49 age group had the highest prevalence (16.6%), followed by the 50 plus age group (12.4%) and the 15-29 age group (12%).

Household income level

The proportion of people from the Francophone minority who were in the poorest income quintile (19.6%) were more likely to have reported depression than the richest income quintile (10.2%). As this was a new indicator it was not possible to compare the results with the 2002 survey.

Living environment

In 2012, people from the Francophone minority living in urban areas were more likely, to have experienced depression in their life (15.4%) than those living in rural areas (11.7%). The prevalences were comparable in 2002. This difference was also present for the 12 months preceding the survey, 6.3% in urban areas vs. 1.4% in rural areas.

Table 2.1

PREVALENCE OF DEPRESSION OVER A LIFETIME OR IN THE 12 MONTHS PRECEDING THE SURVEY BASED ON SEX AND AGE, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE OF QUEBEC AND IN CANADA AS A WHOLE, 2002 AND 2012

	LIFETIME				12 MONTHS			
	2002		2012		2002		2012	
	%	Confidence interval (95%)	%	Confidence interval (95%)	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX								
Male	11.7	[8.3 ; 15.1]	10.2	[6.3 ; 14.1] E	2.7	[1.6 ; 3.8] E	4.1	[1.1 ; 7.1] F
Female	16.5	[13.7 ; 19.2]	17.9	[12.4 ; 23.4]	6.4	[4.6 ; 8.2]	5.6	[2.4 ; 8.9] E
AGE								
15-29 years	12.0	[7.1 ; 17] E	12.2	[4.3 ; 20] E	4.7	[1.7 ; 7.7] E	6.2	[0.5 ; 11.9] F
30-49 years	16.6	[12.9 ; 20.3]	12.8	[7 ; 18.7] E	6.1	[4.1 ; 8.1] E	6.9	[2.1 ; 11.7] F
50 and over	12.4	[9.7 ; 15.1]	15.9	[11.2 ; 20.7]	2.9	[1.8 ; 4] E	3.3	[0.7 ; 5.9] F
HOUSEHOLD INCOME LEVEL								
Quintile 1 – lowest	ND	...	19.6	[12.6 ; 26.5] E	ND	...	x	...
Quintile 2	ND	...	19.3	[9 ; 29.6] E	ND	...	x	...
Quintile 3	ND	...	10	[3.5 ; 16.5] E	ND	...	x	...
Quintile 4	ND	...	15	[7.4 ; 22.6] E	ND	...	x	...
Quintile 5 – highest	ND	...	10.2	[3.2 ; 17.3] F	ND	...	x	...
LIVING ENVIRONMENT								
Urban	14.8	[12.1 ; 17.6]	15.4	[11.2 ; 19.6]	4.6	[3.2 ; 6]	6.3	[3.3 ; 9.3] E
Rural	12.3	[9.8 ; 15.5]	11.7	[6.9 ; 16.5] E	4.3	[2.5 ; 6.1] E	1.4	[0.5 ; 2.3] E
Francophone minority (outside QC)	14.1 **	[12 ; 16.1]	14.4 **	[11.1 ; 17.6]	4.5	[3.4 ; 5.6]	4.9	[2.7 ; 7.1] E
Anglophone majority (outside QC)	11.3	[10.8 ; 11.9]	10.9	[10.1 ; 11.6]	4.7	[4.4 ; 5.1]	4.8	[4.3 ; 5.3]
All of Canada	12.2	[11.7 ; 12.6]	11.3	[10.6 ; 11.9]	4.8	[4.5 ; 5.1]	4.7	[4.3 ; 5.1]

x Confidential data
ND Data unavailable
... Not applicable
** Significant difference from the Anglophone majority at the 5% threshold
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2002 and 2012, microdata file. Adapted by Bouchard et al., 2019

2.1.2 Bipolar disorder

WHAT IS BEING MEASURED?

Over a period at least seven days (or fewer if the person is hospitalized), the presence of symptoms of type I bipolar disorder and type II bipolar disorder was measured. Aside from any major depression that is typically present, these disorders include episodes of mania (type I bipolar disorder) or hypomania (type II bipolar disorder). Manic episodes often feature excessive joy, overexcitement, irritability, and heightened energy leading to an increase in activity, all of which is accompanied by a combination of other symptoms, such as racing thoughts, overconfidence, excessive need to talk, overspending, reduced need for sleep and a tendency towards impulsive and reckless behaviour. Hypomania is included in type II bipolar disorder and is characterized by an attenuated form of mania.

No comparison possible with the CCHS – Mental Health 2002: New indicator for 2012.

WHAT DO THE RESULTS SAY?

The proportion of Francophones in minority aged 15 and over who experienced bipolar disorder in their lifetime was 1.7% compared to 2.8% for the English-speaking majority and 2.6% for the entire Canadian population. Estimates for gender, age, and living environment are imprecise and are provided for illustrative purposes only.

Table 2.2

PREVALENCE OF BIPOLAR DISORDER OVER A LIFETIME OR IN THE 12 MONTHS PRECEDING THE SURVEY BASED ON SEX AND AGE, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE OF QUEBEC AND IN CANADA AS A WHOLE, 2012

	LIFETIME		12 MONTHS	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	0.8	[0 ; 1.6] F	0.4	[0 ; 0.8] F
Female	2.6	[0.8 ; 4.3] F	1.1	[0.1 ; 2.2] F
AGE				
15-29 years	ND	...	ND	...
30-49 years	ND	...	ND	...
50 and over	ND	...	ND	...
LIVING ENVIRONMENT				
Urban	1.8	[0.5 ; 3.1] F	0.7	[0 ; 1.3] F
Rural	1.5	[0 ; 3.2] F	1.1	[0 ; 2.5] F
Francophone minority (outside QC)	1.7	[0.7 ; 2.8] E	0.8	[0.2 ; 1.4] F
Anglophone majority (outside QC)	2.8	[2.4 ; 3.2]	1.7	[1.4 ; 2]
All of Canada	2.6	[2.3 ; 2.9]	1.5	[1.3 ; 1.7]

x Confidential data
... Not applicable
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

2.1.3 Generalized anxiety disorder

WHAT IS BEING MEASURED?

We measured the presence of frequent excessive worries that are persistent, difficult to control, and last for at least six months. Anxiety about events or activities is very intense and disrupts day-to-day life, as well as family, professional, and social activities. Symptoms of generalized anxiety disorder are agitation or the feeling of being overexcited or on edge, fatigue, difficulty concentrating, irritability, muscle tension or pain, trembling, headaches, disrupted sleep (difficulty falling asleep or interrupted, restless or non-restful sleep), excessive perspiration, palpitations, shortness of breath, and a range of gastrointestinal issues.

No comparison possible with the CCHS – Mental Health 2002: New indicator for 2012.

WHAT DO THE RESULTS SAY?

In the minority Francophone population aged 15 years or older, the proportions of people who experienced generalized anxiety disorder over their lifetime or in the 12 months preceding the survey were 10.7% and 2.4%, respectively. For the entire Canadian population, the proportions are 8.7% and 2.6%. For the Anglophone majority outside of Quebec, the proportions are 8.4% and 2.7%.

Sex

Minority Francophone women were more likely than men to have experienced generalized anxiety disorder in their lifetime (16.1% vs. 4.3%).

Age

People from the Francophone minority aged 50 years and older are more likely to have experienced generalized anxiety disorder over their lifetime (13.1%).

Household income level

The proportion of people from the Francophone minority who were in the poorest income quintile (13.3%) were more likely to have reported generalized anxiety disorder than the richest (9.6%).

Living environment

The prevalence of generalized anxiety disorder in the course of life is higher in the Francophone minority living in urban areas (11.3%) than in rural areas (9%).

Table 2.3

PREVALENCE OF GENERALIZED ANXIETY DISORDERS OVER A LIFETIME OR IN THE 12 MONTHS PRECEDING THE SURVEY BASED ON SEX AND AGE, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE OF QUEBEC AND IN CANADA AS A WHOLE, 2012

	LIFETIME		12 MONTHS	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	4.3	[1.9 ; 6.6] E	1.1	[0.3 ; 1.9] F
Female	16.1	[11.3 ; 20.9]	3.5	[0.9 ; 6.2] F
AGE				
15-29 years	6.1	[1.7 ; 10.5] F	1.6	[0 ; 3.3] F
30-49 years	8.9	[4.3 ; 13.5] E	2.7	[0 ; 5.4] F
50 and over	13.1	[8.3 ; 17.9] E	2.5	[0.2 ; 4.8] F
HOUSEHOLD INCOME LEVEL				
Quintile 1 – lowest	13.3	[6.7 ; 19.9] E	x	...
Quintile 2	9.5	[3.8 ; 15.2] E	x	...
Quintile 3	7.3	[1.6 ; 13] F	x	...
Quintile 4	14.3	[6.9 ; 21.8] E	x	...
Quintile 5 – highest	9.6	[3.4 ; 15.8] E	x	...
LIVING ENVIRONMENT				
Urban	11.3	[7.7 ; 14.9]	2.8	[0.8 ; 4.9] F
Rural	9	[4.5 ; 13.5] E	1.4	[0.2 ; 2.5] F
Francophone minority (outside QC)	10.7	[7.8 ; 13.5]	2.4	[0.9 ; 3.9] E
Anglophone majority (outside QC)	8.4	[7.8 ; 9.1]	2.7	[2.3 ; 3]
All of Canada	8.7	[8.1 ; 9.2]	2.6	[2.3 ; 2.8]

x Confidential data
... Not applicable
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

2.2 Substance use disorders

MEASURE AND DEFINITION OF ABUSE AND ADDICTION IN THE CCHS – MENTAL HEALTH 2012

The CCHS – Mental Health 2012 placed great importance on disorders involving the use of alcohol and illegal drugs, such as cannabis or other drugs, and included non-medical use of medication. The questions sought to establish the presence of abuse or addiction issues over a lifetime and in the 12 months preceding the survey interview. As with mental disorders, the concepts of abuse and addiction are based on a range of criteria primarily drawn from the classification in the Composite International Diagnostic Interview (WHO-CIDI) (Pearson et al., 2013). However, Statistics Canada made a few changes to the WHO-CIDI questionnaire regarding the screening thresholds for abuse of cannabis and other drugs, as well as the thresholds for alcohol and cannabis addiction. The changes were made to reduce the response burden for participants and take into consideration the needs expressed by the authorities and experts consulted (Statistics Canada, 2013).

It must be noted that the "screening thresholds" are limits above and below which a given characteristic is deemed to be present in an individual—in this case, abuse or addiction. Thus, to separate out survey participants for whom additional questions on potential abuse or addiction were warranted, all respondents were asked a series of basic questions. If the basic question response results exceeded the screening threshold, further questions focusing on potential abuse or addiction were asked. The various screening thresholds applied to abuse and addiction indicators measured in the survey are detailed in each of the relevant sections; definitions of the concepts used are presented in the text box.

ABUSE AND ADDICTION CRITERIA USED IN THE CCHS – MENTAL HEALTH 2012

Abuse of alcohol, cannabis and other drugs
Abuse is present when at least one of the four following undesirable consequences is observed:

- Inability to meet major obligations at home, work, or school due to recurrent substance use;
- Repeated use in situations where it may be physically dangerous (such as while operating a vehicle);
- Continued use despite having persistent or recurrent social or interpersonal problems caused/exacerbated by the substance used;
- More than one arrest for behaviour linked to substance use (such as impaired driving or drug trafficking).

Addiction to alcohol, cannabis, and other drugs
Addiction to alcohol, cannabis, or other drugs is present if at least three of the following symptoms (or situations) are present:

- Increased tolerance (larger quantities needed to obtain desired effect);
- Withdrawal symptoms (change in physical or mental behaviour resulting from a reduction in the substance's concentration in the blood);
- Increased use (using product for longer or in greater quantities than prescribed);
- Persistent desire or unsuccessful attempts to reduce or control substance use;
- Spending a lot of time obtaining, using, or recovering from the effects of the substance;
- Limiting or avoiding important social, professional, or recreational activities because of substance abuse;
- Continued use despite physical or psychological problems caused or exacerbated by it.

2.2.1 Alcohol abuse or addiction

WHAT IS BEING MEASURED?

Alcohol abuse or addiction over a lifetime or in the 12 months preceding the survey was deemed to be present if respondents replied in the affirmative to the criteria that define the abuse and addiction situations listed in the above box. A number of situations (screening thresholds) made it possible to select individuals who would be asked questions to confirm or rule out alcohol abuse and addiction.[1] For this indicator, a person responding in the affirmative to the "addiction" criteria is excluded from the "abuse" category.

No comparison possible with the CCHS – Mental Health 2002: there were significant differences in the thresholds used to create this indicator in 2012.

WHAT DO THE RESULTS SAY?[2]

Nearly 19% of the minority Francophone population aged 15 and over has experienced alcohol abuse or addiction in their lifetime. This proportion is higher than that of Canada as a whole (17.9%), but lower than that of the Anglophone population (19.6%). With respect to the 12 months preceding the survey, the proportion of people affected is 1.6%, about half the rate for both Canada as a whole (3.1%) and the Anglophone majority (3.4%). The difference between Francophone minority and Anglophone majority is significant.

Sex

During their lifetime, Francophone minority men are more likely to experience alcohol abuse or addiction than are women (28.5% vs. 10.6%).

Age

When the study's three age groups are compared, Francophone minority people aged 30-49 are more likely to be affected by alcohol abuse or addiction over their lifetime (24%).

Household income level

Over a lifetime, Francophone minority individuals in the highest income bracket were the most affected by alcohol abuse or addiction (24.8%), as compared to those in the lowest bracket (15.6%).

Living environment

During their lifetime, people from the Francophone minority living in rural areas are more likely to be affected by alcohol abuse or addiction (20.8%) as compared to those who live in rural areas (18.1%).

1. Situations used to select individuals who would be asked further questions to confirm or rule out alcohol abuse or addiction:
   Abuse: 1) having at least 12 alcoholic drinks in one year ; and 2) having at least one drink a week during their year of heaviest use; or 3) if the person drinks less than once a week, habitually having at least three drinks in a single sitting.
   Addiction: 1) having at least 12 alcoholic drinks in one year ; and 2) drinking at least four times a week during their year of heaviest use; or 3) if the person drinks fewer than four times a week, habitually having at least five drinks in a single sitting.
2. Cross-tabulation with household income is presented at the end of this chapter (table 2.4).

Table 2.4

PREVALENCE OF ALCOHOL ABUSE OR ADDICTION OVER A LIFETIME OR IN THE 12 MONTHS PRECEDING THE SURVEY BASED ON SEX AND AGE, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE OF QUEBEC AND IN CANADA AS A WHOLE, 2012

	LIFETIME		12 MONTHS	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	28.5	[21.7 ; 35.4]	x	...
Female	10.6	[4.9 ; 16.4] E	x	...
AGE				
15-29 years	6.1	[1.7 ; 10.5] F	1.6	[0 ; 3.3] F
30-49 years	24	[14.5 ; 33.5] E	1.9	[0.1 ; 3.7] F
50 and over	18.5	[12.6 ; 24.3]	0.5	[0 ; 1] F
HOUSEHOLD INCOME LEVEL				
Quintile 1 – lowest	15.6	[8.3 ; 22.8] E	x	...
Quintile 2	11.1	[5.1 ; 17.2] E	x	...
Quintile 3	22.5	[9.9 ; 35.1] E	x	...
Quintile 4	18.2	[11.5 ; 25] E	x	...
Quintile 5 – highest	24.8	[14.5 ; 35.1] E	x	...
LIVING ENVIRONMENT				
Urban	18.1	[12.8 ; 23.5]	1.9	[0.6;3.2] F
Rural	20.8	[12.5 ; 29.1] E	0.7	[0.1;1.3] F
Francophone minority (outside QC)	18.9	[14.3 ; 23.4]	1.6	[0.6 ; 2.5] E
Anglophone majority (outside QC)	19.6	[18.7 ; 20.6]	3.4	[2.9 ; 3.8]
All of Canada	17.9	[17.1 ; 18.6]	3.1	[2.8 ; 3.5]

x Confidential data
... Not applicable
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

2.2.2 Cannabis abuse or addiction

WHAT IS BEING MEASURED?

Cannabis abuse or addiction over a lifetime or in the 12 months preceding the survey was deemed to be present if respondents replied in the affirmative to the criteria that define the abuse and addiction situations listed in the previously mentioned box. Two situations (screening thresholds) made it possible to select individuals who would be asked questions to confirm or rule out cannabis abuse or addiction.[1] For this indicator, a person responding in the affirmative to the "addiction" criteria is excluded from the "abuse" category.

No comparison possible with the CCHS – Mental Health 2002: New indicator for 2012.

1. Situations used to select individuals who would be asked questions to confirm or rule out cannabis abuse or addiction:
Abuse: having used marijuana or hashish at least once in their lives.
Addiction: having used marijuana or hashish 50 or more times in their lives.

WHAT DO THE RESULTS SAY?[2]

The proportions of minority Francophones experiencing cannabis abuse or addiction over their lifetime and in the 12 months preceding the survey are 6.5% and 1.4%, respectively. These results were similar to those observed for Canada as a whole (6.8% and 1.3%) and those of the Anglophone majority outside of Quebec (7% and 1.3%).

Sex

Men were more likely to experience cannabis abuse or addiction over their lifetimes (10.4%).

Age

People in the 30-49 age group are the most likely to be affected by cannabis abuse or addiction in their lifetime (9.7%).

Living environment

People from the Francophone minority living in urban areas are more likely to be affected by cannabis abuse or addiction over their lifetime (7.6%).

Table 2.5

PREVALENCE OF CANNABIS ABUSE OR ADDICTION OVER A LIFETIME OR IN THE 12 MONTHS PRECEDING THE SURVEY BASED ON SEX AND AGE, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE OF QUEBEC AND IN CANADA AS A WHOLE, 2012

	LIFETIME		12 MONTHS	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	10.4	[6 ; 14.8] E	x	...
Female	3.1	[0.6 ; 5.7] F	x	...
AGE				
15-29 years	8.5	[3.5 ; 13.5] E	5.5	[1.2 ; 9.7] F
30-49 years	9.7	[3.9 ; 15.6] E	1.2	[0 ; 2.8] F
50 and over	3.9	[1.3 ; 6.6] F	0.2	[0 ; 0.6] F
LIVING ENVIRONMENT				
Urban	7.6	[4.3 ; 10.9] E	ND	...
Rural	3.7	[1.1 ; 6.3] F	ND	...
Francophone minority (outside QC)	6.5	[4.1 ; 8.9] E	1.4	[0.5 ; 2.3] F
Anglophone majority (outside QC)	7	[6.4 ; 7.6]	1.3	[1.1 ; 1.5]
All of Canada	6.8	[6.2 ; 7.3]	1.3	[1.1 ; 1.5]

x Confidential data
... Not applicable
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

2. Because of the small numbers, cross-tabulation with household income could not be provided.

2.2.3 Abuse of or addiction to other drugs

WHAT IS BEING MEASURED?

Abuse of or addiction to other drugs over a lifetime or in the 12 months preceding the survey was deemed to be present if respondents replied in the affirmative to the criteria defining the abuse or addiction situations listed in the previously mentioned box. One situation (screening threshold) made it possible to select people who would be asked questions to confirm or rule out abuse of or addiction to other drugs.[1] For this indicator, a person responding in the affirmative to the "addiction" criteria is excluded from the "abuse" category.

With respect to "other drugs" (excluding cannabis), Statistics Canada included substances such as club drugs,[2] cocaine, heroin, solvents and other illicit drugs mentioned by respondents, as well as non-medical use of prescription medication (such as sedatives, analgesics, and stimulants).[3]

No comparison possible with the CCHS – Mental Health 2002: New indicator for 2012.

WHAT DO THE RESULTS SAY?[4]

The proportion of Francophone minority persons affected by situations of abuse or dependence on other drugs over their lifetime is 2.4%, and is significantly lower than the majority of Anglophones outside Quebec and that of all of Canada (4%).

Sex

Men in the Francophone minority are more likely than women to experience these types of situations in their lifetime (4% vs. 1.1%).

Living environment

Francophone minority persons living in urban areas are most affected (3%).

1. Situation used to select individuals who would be asked questions to confirm or rule out abuse of or addiction to other drugs:
   Abuse: having used marijuana or hashish more than once in their lives.
   Addiction: having used marijuana or hashish 50 or more times in their lives.
2. Club drugs mean ecstasy (MDMA) or ketamine.
3. According to documentation provided by Statistics Canada, including the questionnaire used for the survey, the expression "non-medical use" can include taking medication without the recommendation of a health care professional, but also taking higher doses than prescribed and using medications for purposes other than prescribed.
4. Because of the small numbers, cross-tabulation with household income could not be provided.

Table 2.6

PREVALENCE OF ABUSE OF OR ADDICTION TO OTHER DRUGS OVER A LIFETIME AND IN THE 12 MONTHS PRECEDING THE SURVEY BASED ON SEX AND AGE, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE QUEBEC AND IN CANADA AS A WHOLE, 2012

	LIFETIME		12 MONTHS	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	4	[1.7 ; 6.2] E	ND	...
Female	1.1	[0.4 ; 1.8] E	ND	...
AGE				
15-29 years	2.3	[0.2 ; 4.4] F	ND	...
30-49 years	3.6	[0.8 ; 6.5] F	ND	...
50 and over	1.7	[0.7 ; 2.7] E	ND	...
LIVING ENVIRONMENT				
Urban	3	[1.4 ; 4.6] E	ND	...
Rural	0.9	[0.2 ; 1.7] F	ND	...
Francophone minority (outside QC)	2.4 **	[1.3 ; 3.6] E	0.2	[0 ; 0.5] F
Anglophone majority (outside QC)	4	[3.6 ; 4.4]	0.8	[0.6 ; 0.9]
All of Canada	4	[3.6 ; 4.3]	0.7	[0.5 ; 0.8]

x Confidential data
... Not applicable
** Significant difference from the Anglophone majority at the 5% threshold
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

2.3 Overall prevalence of mental disorders and substance use disorders measured in the CCHS – Mental Health 2012

WHAT DO THE RESULTS SAY?

Mental disorders[1]

In the minority Francophone population aged 15 years and up, the prevalence of all mental disorders over a lifetime was 19.8%, while prevalence in the 12 months preceding the survey was 5.9%. For Canada as a whole, the rates were 16.7% and 6.5%, respectively. For the Anglophone majority outside Quebec, the rates were 16% and 6.8%, respectively. There was a significant difference in prevalence for the 12 months preceding the survey.

Substance use disorder[2]

In 2012, lifetime prevalence of substance use disorders in the minority Francophone population was 22.3%. This proportion was slightly higher than the rate for the rest of Canada (21.2%) but lower than that of the Anglophone majority outside Quebec (22.7%).

Prevalences for the 12 months preceding the survey were 3.1% in the Francophone minority, 4.6% for the Anglophone majority, and 4.3% for Canada as a whole.

Mental disorders and substance use disorders[3]

Over a lifetime, the proportion of people with a mental or substance use disorder is higher in the minority Francophone population aged 15 years and up (37.8%) than in the same age group in the Anglophone majority and in Canada as a whole (32.9% and 32.2%, respectively). For the 12 months preceding the survey, the relationship was reversed, with rates of 8.5%, 10.3%, and 9.8%, respectively.

1. Depressive episode, bipolar disorder or generalized anxiety disorder.
2. Alcohol, cannabis or other drug abuse or addiction.
3. Depressive episode, bipolar disorder, generalized anxiety disorder, and alcohol, cannabis or other drug abuse or addiction.

Table 2.7

PREVALENCE OF MENTAL DISORDERS[1] AND SUBSTANCE USE DISORDERS[2] OVER A LIFETIME AND IN THE 12 MONTHS PRECEDING THE SURVEY, BY SEX AND AGE, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE OF QUEBEC AND IN CANADA AS A WHOLE, 2012				
	LIFETIME		12 MONTHS	
MENTAL DISORDER[1]	%	Confidence interval (95%)	%	Confidence interval (95%)
Francophone minority (outside QC)	19.8	[16.2 ; 23.3]	5.9**	[3.7 ; 8.2] E
Anglophone majority (outside QC)	16	[15.2 ; 16.8]	6.8	[6.2 ; 7.3]
All of Canada	16.7	[15.9 ; 17.4]	6.5	[6 ; 6.9]
SUBSTANCE USE DISORDER[2]				
Francophone minority (outside QC)	22.3	[17.6 ; 27]	3.1	[1.8 ; 4.5] E
Anglophone majority (outside QC)	22.7	[21.6 ; 23.7]	4.6	[4.1 ; 5]
All of Canada	21.2	[20.3 ; 22]	4.3	[3.9 ; 4.7]
MENTAL DISORDER OR SUBSTANCE USE DISORDER[3]				
Francophone minority (outside QC)	37.8	[32.7 ; 42.9]	8.5	[6.1 ; 11]
Anglophone majority (outside QC)	32.9	[31.7 ; 34.1]	10.3	[9.6 ; 10.9]
All of Canada	32.2	[31.2 ; 33.3]	9.8	[9.2 ; 10.3]

1. Depressive episode, bipolar disorder or generalized anxiety disorder
2. Alcohol, cannabis or other drug abuse or addiction
3. Depressive episode, bipolar disorder, generalized anxiety disorder, and alcohol, cannabis or other drug abuse or addiction

** Significant difference from the Anglophone majority at the 5% threshold

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

2.4 Some physical health indicators based on the presence or absence of a mental or substance use disorder

Mental health is not only key to an individual's overall health, but numerous studies have shown that mental health affects physical health, and conversely, physical health affects mental health (CSBE, 2012a). Thus, people dealing with mental disorders have a higher risk of developing physical illnesses while being in worse health overall. Moreover, it has also been shown that people with chronic health conditions or who suffer pain or discomfort are more vulnerable when it comes to mental health.

In this section, the presence or absence of mental disorders or substance use disorders are cross-tabulated with physical health indicators, such as perceived physical health and the presence of at least one chronic health condition.

2.4.1 Physical health indicators

WHAT DO THE RESULTS SAY?

Perceived physical health

The proportion of minority Francophones who rate their physical health as fair or poor is higher among those suffering from mental or substance use disorders[1] than among those with no issues (23.4% vs. 14.2%).

Chronic health conditions

Francophone minority persons dealing with mental or substance use disorders were more likely to have a chronic health condition than were those without such disorders (73.6% vs. 59.3%).

Table 2.8

PRESENCE OR ABSENCE OF A MENTAL DISORDER OR SUBSTANCE USE DISORDER[1, 2] BASED ON SOME PHYSICAL HEALTH INDICATORS, FRANCOPHONE POPULATION AGED 15 YEARS OR OLDER OUTSIDE QUEBEC, 2012

	MENTAL DISORDER OR SUBSTANCE USE DISORDER			
	ABSENT		PRESENT	
	%	Confidence interval (95%)	%	Confidence interval (95%)
PERCEIVED PHYSICAL HEALTH				
Poor or fair	14.2	[9.9 ; 18.6]	23.4	[11.89 ; 35] E
Good	35	[30 ; 39.9]	23.6	[11.27 ; 35.8] E
Very good or excellent	50.6	[44.7 ; 56.4]	53	[37.94 ; 68.1]
PHYSICAL ACTIVITY[3]				
Yes	73	[67.9 ; 78.2]	78.7	[68.58 ; 88.7]
No	26.8	[21.7 ; 32]	21.4	[11.28 ; 31.4] E
PAIN OR DISCOMFORT				
No pain	76.5	[71.8 ; 81.1]	76.8	[65.84 ; 87.8]
Pain that does not restrict or hardly restricts activities	19.5	[15 ; 24]	18.2	[8.2 ; 28.2] E
Pain that greatly restricts activities[4]	4	[2.1 ; 5.8] E	5	[0.92 ; 9.1] F
CHRONIC HEALTH CONDITION[5]				
Yes	59.3	[53.6 ; 65]	73.6	[59.01 ; 88.1]
No	40.7	[35.1 ; 46.4]	26.4	[11.86 ; 41] E

1. In the past 12 months
2. Depressive episode, bipolar disorder, generalized anxiety disorder, and alcohol, cannabis or other drug abuse or addiction
3. In the past 7 days
4. This category includes the answer choices "many" and "most" in reference to activities prevented by usually experienced pain or discomfort
5. At least one chronic health problem

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

1. Depressive episode, bipolar disorder, generalized anxiety disorder, and alcohol, cannabis or other drug abuse or addiction.

THE TAKEAWAY

MENTAL DISORDERS AND SUBSTANCE USE DISORDERS IN THE MINORITY FRANCOPHONE POPULATION

Proportionately, in 2012, the survey showed that:

- Of the mental disorders measured in the survey:
  - Depression was the most frequent disorder;
  - More women than men were affected by depression;
  - People living in urban areas were more affected than those living in rural areas.
- With regard to substance use disorders:
  - Alcohol abuse or addiction was the most frequent disorder;
  - Over a lifetime, more men than women were affected by alcohol, cannabis or other drug abuse or addiction.
- More people with mental or substance use disorders than those without such disorders:
  - Rate their physical health as fair or poor;
  - Have at least one chronic health condition.

THE CCHS – MENTAL HEALTH 2012 SHOWED OVER A LIFETIME, IN THE MINORITY FRANCOPHONE POPULATION

- Nearly 20% of people suffered from a mental disorder
  - 14.4% had depression
  - 10.7% had generalized anxiety disorder
  - 1.7% had bipolar disorder
- More than 22% of people had a disorder involving the use of alcohol, cannabis or other drugs
  - 18.9% experienced alcohol abuse or addiction
  - 6.5% experienced cannabis abuse or addiction
  - 2.4% experienced abuse of or addiction to other drugs

Table A2.1

SYNTHESIS OF MENTAL DISORDER AND SUBSTANCE USE DISORDER PREVALENCE OVER A LIFETIME AND IN THE 12 MONTHS PRECEDING THE SURVEY, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY, ANGLOPHONE MAJORITY AND CANADA AS A WHOLE, 2012

	LIFETIME		12 MONTHS	
	%	Confidence interval (95%)	%	Confidence interval (95%)
MENTAL DISORDER[1]				
Francophone minority (outside QC)	19.8	[16.2 ; 23.3]	5.9 **	[3.7 ; 8.2] E
Anglophone majority (outside QC)	16	[15.2 ; 16.8]	6.8	[6.2 ; 7.3]
All of Canada	16.7	[15.9 ; 17.4]	6.5	[6 ; 6.9]
DEPRESSION				
Francophone minority (outside QC)	14.4 **	[11.1 ; 17.6]	4.9	[2.7 ; 7.1] E
Anglophone majority (outside QC)	10.9	[10.1 ; 11.6]	4.8	[4.3 ; 5.3]
All of Canada	11.3	[10.6 ; 11.9]	4.7	[4.3 ; 5.1]
BIPOLAR DISORDER				
Francophone minority (outside QC)	1.7	[0.7 ; 2.8] E	0.8	[0.2 ; 1.4] F
Anglophone majority (outside QC)	2.8	[2.4 ; 3.2]	1.7	[1.4; 2]
All of Canada	2.6	[2.3 ; 2.9]	1.5	[1.3 ; 1.7]
GENERALIZED ANXIETY DISORDER				
Francophone minority (outside QC)	10.7	[7.8 ; 13.5]	2.4	[0.9 ; 3.9] E
Anglophone majority (outside QC)	8.4	[7.8 ; 9.1]	2.7	[2.3 ; 3]
All of Canada	8.7	[8.1 ; 9.2]	2.6	[2.3 ; 2.8]
SUBSTANCE USE DISORDER[2]				
Francophone minority (outside QC)	22.3	[17.6 ; 27]	3.1	[1.8 ; 4.5] E
Anglophone majority (outside QC)	22.7	[21.6 ; 23.7]	4.6	[4.1 ; 5]
All of Canada	21.2	[20.3 ; 22]	4.3	[3.9 ; 4.7]
ALCOHOL ABUSE OR ADDICTION				
Francophone minority (outside QC)	18.9	[14.3 ; 23.4]	1.6	[0.6 ; 2.5] E
Anglophone majority (outside QC)	19.6	[18.7 ; 20.6]	3.4	[2.9 ; 3.8]
All of Canada	17.9	[17.1 ; 18.6]	3.1	[2.8 ; 3.5]
CANNABIS ABUSE OR ADDICTION				
Francophone minority (outside QC)	6.5	[4.1 ; 8.9] E	1.4	[0.5 ; 2.3] F
Anglophone majority (outside QC)	7	[6.4 ; 7.6]	1.3	[1.1 ; 1.5]
All of Canada	6.8	[6.2 ; 7.3]	1.3	[1.1 ; 1.5]
ABUSE OF OR ADDICTION TO OTHER DRUGS				
Francophone minority (outside QC)	2.4 **	[1.3 ; 3.6] E	0.2	[0 ; 0.5] F
Anglophone majority (outside QC)	4	[3.6; 4.4]	0.8	[0.6 ; 0.9]
All of Canada	4	[3.6 ; 4.3]	0.7	[0.5 ; 0.8]

MENTAL DISORDER OR SUBSTANCE USE DISORDER[1, 2]				
Francophone minority (outside QC)	37.8	[32.7 ; 42.9]	8.5	[6.1 ; 11]
Anglophone majority (outside QC)	32.9	[31.7 ; 34.1]	10.3	[9.6 ; 10.9]
All of Canada	32.2	[31.2 ; 33.3]	9.8	[9.2 ; 10.3]

1. Depressive episode, bipolar disorder or generalized anxiety disorder
2. Alcohol, cannabis or other drug abuse or addiction

** Significant difference from the Anglophone majority at the 5% threshold

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

Chapter 3 – OPTIMAL AND SUBOPTIMAL MENTAL HEALTH

3.1 Indicators of optimal mental health

The World Health Organization (WHO) describes mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2014). In this sense, optimal mental health, which is related to the concept of well-being, refers to psychological, social and environmental resources that allow the individual and communities to live a "satisfying" life, to develop, and to overcome adversity. In the definition proposed by the Public Health Agency of Canada, "positive mental health", considered in the broad sense, is associated with five factors: ability to enjoy life, dealing with life's challenges, emotional well-being, spiritual well-being, and social connections and respect for culture, equity, social justice and personal dignity (Canadian Institute for Health Information, 2009).

Historically, the concept of "mental health" was inextricably linked to that of "mental illness", as if they were two poles of the same continuum (Joubert, 2009). The concept of optimal mental health, in its broad sense, has transformed this paradigm by adding what could be considered an extension of the continuum, ranging from optimal mental health to suboptimal mental health, without slipping into mental disorder (Joubert, 2009). This means that someone suffering from a mental disorder could present various elements of optimal mental health if they are able to lead a satisfying life despite their mental disorder.

Because there is not currently any standardized method of gauging optimal mental health, the main general population health surveys measure it by means of indicators such as perceived mental health, satisfaction with life, spiritual values, a sense of belonging to a community, and social support. In *CCHS – Mental Health, 2012*, one of the primary objectives is to measure elements that can be associated with "well-being." Consequently, numerous indicators that can be linked to optimal mental health are included in the survey and presented in this report. They are: perception of one's mental health, satisfaction with life, positive mental health,[1] ability to cope with life events, sense of belonging to a local community, and the Social Provisions Scale.

In this chapter, various cross-tabulation variables[2] have been adopted. Among sociodemographic characteristics, most indicators have been cross-tabulated with gender, age, marital status, education level, household income quintile, living environment, employment or unemployment, and living alone. Among health characteristics, the indicators may have been cross-tabulated with mental disorders,[3] alcohol abuse or addiction, cannabis abuse or addiction, medication use, perceived physical health, exercise, pain or discomfort, and chronic health problems.

3.1.1 Perceiving one's mental health as excellent or very good

WHAT IS BEING MEASURED?

Perceived mental health is measured by means of the following question:

> Q. In general, would you say your mental health is:
>
> A. Excellent, very good, good, fair or poor

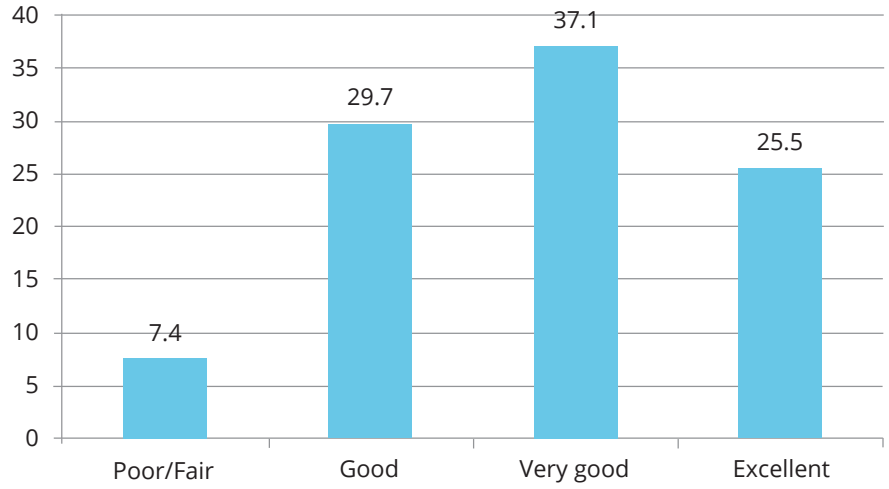
The figure below breaks down the population by four answer categories. For the following analysis, the "excellent" and "very good" categories are grouped together to document optimal mental health.

Comparison with CCHS – Mental Health, 2002: indicator is comparable.

1. Statistics Canada has named one of the survey modules "positive mental health." This module copies the abridged questionnaire from the *Mental Health Continuum Short-Form* developed by Dr. Corey Keyes and does not constitute a measurement that summarizes all the indicators serving to gauge optimal mental health or positive mental health in its broad sense.
2. See section 1.4 for definitions of cross-tabulation variables.
3. This indicator includes persons with at least one of the following: depressive episode, bipolar disorder or generalized anxiety disorder.

Figure 3.1

PERCEIVED MENTAL HEALTH, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012



Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

WHAT DO THE RESULTS SAY?

SOCIODEMOGRAPHIC CHARACTERISTICS

For the entire Francophone minority population

Nearly two thirds (62.6%) of the Francophone minority population aged 15 and over considered their mental health to be excellent or very good in 2012.

In both 2012 and 2002, fewer members of the Francophone minority population assessed their mental health as excellent or very good compared to the population of the rest of Canada (62.6% vs. 65.1% in 2012 and 65% vs. 67% in 2002). The same situation applies in comparison with the Anglophone majority (62.6% vs. 64.4% in 2012 and 65% vs. 65.9% in 2002), but the differences are not statistically significant.

Marital status

In 2012, more widowed, separated, or divorced persons in the Francophone minority rated their mental health as excellent or very good compared to married/common-law and single persons (67.9% vs. 62.3% and 54.2%, respectively). The same pattern was observed in 2002.

Between 2002 and 2012, the proportion of single persons in the Francophone minority reporting excellent or very good mental health increased (49.4% vs. 54.2%).

Education

In 2012, Francophone minority persons with a university degree were the group with the highest rate of reported excellent or very good mental health (71%). However, between 2002 and 2012, the proportion of the most educated persons assessing their mental health as excellent or very good declined (82% vs. 71%).

Household income level

In 2012, fewer persons in the Francophone minority with income in the bottom two quintiles (1 and 2) reported excellent or very good mental health than persons in the other quintiles (about 51% for quintiles 1 and 2). The proportion rises from 51% in the group with the lowest income to 78.4% in the group with the highest income.

Living environment

Persons in the Francophone minority residing in an urban environment were more liable (66.7%) to consider their mental health as excellent or very good in 2002 than those in a rural environment (61.1%). However, the gap between these two groups narrowed sharply in 2012 (62.8% and 62%, respectively).

Employment

In 2012, employed persons in the Francophone community were more inclined to report their mental health as excellent or very good than were unemployed persons (66.6% vs. 58.7%).

Living alone

In 2012, proportionately fewer persons in the Francophone minority reporting that they live alone regarded their mental health as excellent or very good (58% vs. 63%). A similar situation was observed in 2002.

Table 3.1

PERCENTAGE OF PERSONS PERCEIVING THEIR MENTAL HEALTH AS EXCELLENT OR VERY GOOD, ACCORDING TO CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE QUEBEC AND CANADA AS A WHOLE, 2002 AND 2012

	EXCELLENT OR VERY GOOD MENTAL HEALTH			
	2002		2012	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	68.1	[63.8 ; 72.3]	67.6	[61.1 ; 74.1]
Female	61.8	[57.6 ; 65.9]	58.3	[51 ; 65.6]
AGE				
15-29 years	68	[61 ; 75]	75.3	[67.2 ; 83.4]
30-49 years	67.2	[62.4 ; 72.1]	60.3	[50.3 ; 70.4]
50 and over	61.2	[56.9 ; 65.6]	60.1	[53.1 ; 67]
MARITAL STATUS				
Married/common law	67	[63.3 ; 70.6]	62.3	[55.2 ; 69.5]
Widowed/separated/divorced	69.6	[63.2 ; 75.9]	67.9	[59.6 ; 76.2]
Single	49.4	[43.3 ; 55.5]	54.2	[44.5 ; 63.9]
EDUCATION LEVEL				
< High school diploma	54.1	[48.7 ; 59.5]	60.2	[52 ; 68.5]
High school diploma	67.8	[60.5 ; 75]	64.5	[49.3 ; 79.6]
Postsecondary or college diploma	66.3	[61.3 ; 71.2]	58	[49.4 ; 66.7]
University degree	82.1	[77.1 ; 87.1]	71	[61.1 ; 80.9]
HOUSEHOLD INCOME LEVEL				
Quintile 1 – lowest	ND	...	51.3	[41.9 ; 60.7]
Quintile 2	ND	...	50.7	[39.3 ; 62]
Quintile 3	ND	...	59	[46 ; 72.1]
Quintile 4	ND	...	69.5	[59.8 ; 79.2]
Quintile 5 – highest	ND	...	78.4	[68.8 ; 88]
LIVING ENVIRONMENT				
Urban	66.7	[63 ; 70.4]	62.8	[56.3 ; 69.3]
Rural	61.1	[55.7 ; 66.5]	62	[54 ; 70]
EMPLOYED[1, 2]				
Yes	ND	...	66.6	[59.4 ; 73.7]
No	ND	...	58.7	[50.4 ; 67.1]

LIVING ALONE				
Yes	60.5	[55.7 ; 65.4]	58.1	[50.3 ; 65.8]
No	65.4	[62 ; 68.8]	63.3	[57.1 ; 69.6]
Francophone minority (outside QC)	65	[62 ; 68]	62.6	[57.3 ; 67.9]
Anglophone majority (outside QC)	65.9	[65.1 ; 66.7]	64.4	[63.2 ; 65.6]
All of Canada	67	[66.3 ; 67.7]	65.1	[64 ; 66.1]

1. In the week preceding the interview
2. Excluding persons over age 75

ND No data available

... Not applicable

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2002 and 2012, microdata file. Adapted by Bouchard et al., 2019

MENTAL AND PHYSICAL HEALTH CHARACTERISTICS

Mental health

Persons in the Francophone minority:

» with alcohol abuse or addiction issues,

» with cannabis abuse or addiction issues,

» taking medication,

are less likely to consider their mental health as excellent or very good than persons not in these situations.

Physical health

Persons in the Francophone minority:

» considering their physical health as excellent or very good,

» engaging in physical activity,

» pain-free,

» without chronic health problems,

reported excellent or very good mental health in greater numbers than persons classifying themselves in the other categories for these indicators.

The more activities are limited by pain or discomfort, the less likely persons are to rate their mental health as excellent or very good.

Table 3.2

PERCENTAGE OF PERSONS PERCEIVING THEIR MENTAL HEALTH AS EXCELLENT OR VERY GOOD, ACCORDING TO CERTAIN HEALTH CHARACTERISTICS, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012

	EXCELLENT OR VERY GOOD MENTAL HEALTH	
	%	Confidence interval (95%)
MENTAL HEALTH		
MENTAL DISORDER[1, 2]		
Yes	ND	...
No	ND	...
ALCOHOL ABUSE OR ADDICTION[2]		
Yes	59.5	[32.7 ; 86.3] [E]
No	62.6	[57.2 ; 68]
CANNABIS ABUSE OR ADDICTION[2]		
Yes	60.3	[29.8 ; 90.7] [E]
No	62.6	[57.3 ; 67.9]

MEDICATION USE[2, 3]		
Yes	22	[12.1 ; 31.9] [E]
No	67.3	[61.9 ; 72.6]
PHYSICAL HEALTH		
PERCEIVED PHYSICAL HEALTH		
Fair or poor	25.4	[16.7 ; 34.1] [E]
Good	46.9	[37 ; 56.8]
Very good or excellent	83.1	[77.5 ; 88.8]
EXERCISE[4]		
Yes	66.6	[60.5 ; 72.6]
No	51.2	[41.3 ; 61.1]
PAIN OR DISCOMFORT		
No pain	67.1	[61.2 ; 73]
Pain limiting activity little or not at all	53.8	[41.9 ; 65.8]
Pain limiting activity a good deal[5]	20.3	[6.6 ; 33.9] [F]
CHRONIC HEALTH PROBLEM[6]		
Yes	51.2	[45.2 ; 57.2]
No	80.9	[75.1 ; 86.8]

1. Depressive episode, bipolar disorder or generalized anxiety disorder
2. In the last 12 months
3. Taking prescribed or unprescribed medication for problems related to emotions, mental health or use of drugs or alcohol
4. In the last 7 days
5. This category includes the answer choices "many" and "most" in reference to activities prevented by usually experienced pain or discomfort
6. At least one chronic health problem

ND No data available
... Not applicable
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

3.1.2 Being satisfied or very satisfied with one's life

WHAT IS BEING MEASURED?

Self-rating of satisfaction with life is measured on a scale of 0 to 10 using the following question:

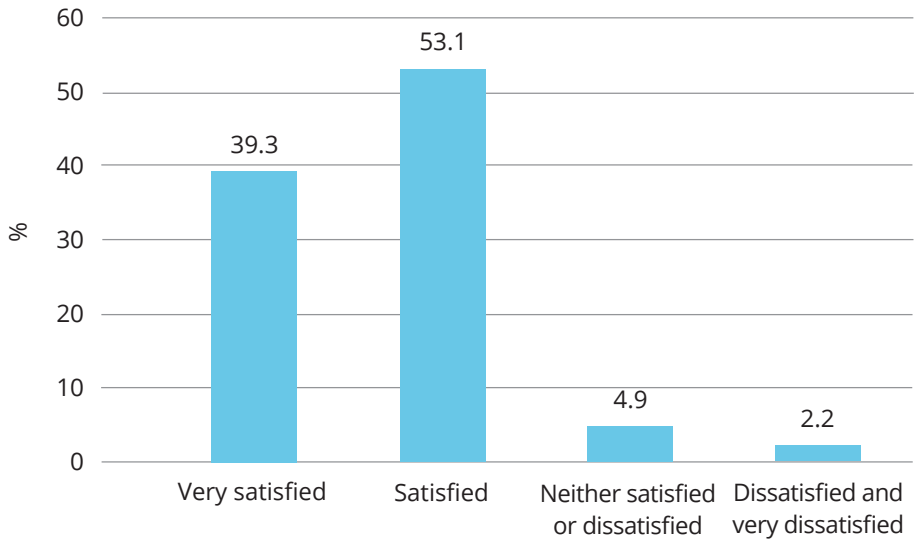
> Q. On a scale of 0 to 10, with 0 being "Very dissatisfied" and 10 being "Very satisfied," how do you feel about your life as a whole right now?
>
> A. 0 or 1 (very dissatisfied) 2 to 4 (dissatisfied) 5 (neither satisfied nor dissatisfied) 6 to 8 (satisfied) 9 or 10 (very satisfied)

The figure below breaks down the population according to four categories. For the following analysis, the categories "satisfied" and "very satisfied" (6, 7, 8 and 9, 10) are grouped together to document optimal mental health.

No comparison possible with CCHS – Mental Health, 2002: The question and answer choices are different.

Figure 3.2

SATISFACTION WITH LIFE, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012



Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

WHAT DO THE RESULTS SAY?

SOCIODEMOGRAPHIC CHARACTERISTICS

For the entire Francophone minority population

According to the thresholds defined by Statistics Canada, a very large proportion of the Francophone minority population aged 15 and over (92.4%) consider themselves satisfied or very satisfied with their life. A slightly lower proportion of the Anglophone and Canadian populations consider themselves satisfied or very satisfied with their life (91.2% and 91.8%, respectively).

Age

Fewer persons aged 15 to 29 in the Francophone minority report being satisfied or very satisfied with their life compared to persons in the other age groups.

Marital status

Persons in the Francophone minority who are married or common-law are more likely to report being satisfied or very satisfied with their life (94.7%) than persons who are widowed, separated or divorced (88.8%), as well as persons who are single (85.8%).

Education

A greater proportion of the most educated persons in the Francophone minority report being satisfied or very satisfied with their life.

Household income level

Fewer persons in the Francophone minority with income in the bottom quintile (1) report being satisfied or very satisfied with their life than persons in the other quintiles.

Living environment

A greater proportion of persons in the Francophone minority who reside in an urban environment report being satisfied or very satisfied with their life (92.9% vs. 91%).

Employment

Employed persons in the Francophone minority are more inclined to be satisfied or very satisfied with their life than persons who are unemployed (94.8% vs. 90.4%).

Living alone

Persons in the Francophone minority who live alone are less likely to consider themselves satisfied or very satisfied with their life than persons living with others (86.3% vs. 93.6%).

Table 3.3

PERCENTAGE OF PERSONS WHO ARE SATISFIED OR VERY SATISFIED WITH THEIR LIFE, ACCORDING TO CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE QUEBEC AND CANADA AS A WHOLE, 2012		
	SATISFIED OR VERY SATISFIED WITH LIFE	
	%	Confidence interval (95%)
SEX		
Male	92.9	[90 ; 95.8]
Female	92	[88.8 ; 95.1]
AGE		
15-29 years	98.5	[96.8 ; 100.3]
30-49 years	92.3	[87.9 ; 96.6]
50 and over	90.6	[87.4 ; 93.8]
MARITAL STATUS		
Married/common law	94.7	[92.4 ; 97.1]
Widowed/separated/divorced	88.8	[83.2 ; 94.3]
Single	85.8	[79.5 ; 92.2]
EDUCATION LEVEL		
< High school diploma	89.6	[84.9 ; 94.3]
High school diploma	88.6	[79.3 ; 97.9]
Postsecondary or college diploma	93.6	[90.6 ; 96.5]
University degree	95	[91.2 ; 98.8]
HOUSEHOLD INCOME LEVEL		
Quintile 1 – lowest	79.3	[71.8 ; 86.9]
Quintile 2	88.1	[81 ; 95.3]
Quintile 3	97.6	[95.4 ; 99.8]
Quintile 4	96.1	[92.7 ; 99.4]
Quintile 5 – highest	97.3	[95 ; 99.6]
LIVING ENVIRONMENT		
Urban	92.9	[90.4 ; 95.5]
Rural	91	[87 ; 95]
EMPLOYED[1, 2]		
Yes	94.8	[92.1 ; 97.5]
No	90.4	[86.7 ; 94.1]
LIVING ALONE		
Yes	86.3	[81.4 ; 91.2]
No	93.6	[91.2 ; 95.9]
Francophone minority (outside QC)	92.4	[90.2 ; 94.6]
Anglophone majority (outside QC)	91.2	[90.5 ; 91.8]
All of Canada	91.8	[91.3 ; 92.4]

1. In the week preceding the interview
2. Excluding persons over age 75

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

MENTAL AND PHYSICAL HEALTH CHARACTERISTICS

Mental health

Persons in the Francophone minority:

» with a mental disorder,

» with cannabis abuse or addiction issues,

» taking medication,

are less likely to feel satisfied or very satisfied with their life than persons who do not have a disorder and who are not taking medication.

Physical health

Persons in the Francophone minority who:

» rate their physical health as excellent or very good,

» engage in physical activity,

» are pain-free,

» have no chronic health problems,

report being more satisfied or very satisfied with their life than persons in the other categories for these indicators.

Table 3.4

PERCENTAGE OF PERSONS WHO ARE SATISFIED OR VERY SATISFIED WITH THEIR LIFE, ACCORDING TOCERTAIN HEALTH CHARACTERISTICS, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012

	SATISFIED OR VERY SATISFIED WITH LIFE	
	%	Confidence interval (95%)
MENTAL HEALTH		
MENTAL DISORDER[1, 2]		
Yes	76.9	[61.7 ; 92]
No	93.7	[91.5 ; 95.9]
ALCOHOL ABUSE OR ADDICTION[2]		
Yes	94	[85.2 ; 102.9]
No	92.7	[90.4 ; 94.9]
CANNABIS ABUSE OR ADDICTION[2]		
Yes	81.8	[51.9 ; 111.7] [E]
No	92.6	[90.4 ; 94.8]
MEDICATION USE[2, 3]		
Yes	77.3	[66.9 ; 87.7]
No	94.2	[92.1 ; 96.3]
PHYSICAL HEALTH		
PERCEIVED PHYSICAL HEALTH		
Fair or poor	75.6	[66.6 ; 84.6]
Good	93.5	[89.7 ; 97.4]
Very good or excellent	96.5	[94.2 ; 98.8]
EXERCISE[4]		
Yes	95.3	[93.3 ; 97.3]
No	84.5	[78.7 ; 90.3]
PAIN OR DISCOMFORT		
No pain	94.6	[92.4 ; 96.8]
Pain limiting activity little or not at all	89.5	[83.7 ; 95.2]
Pain limiting activity a good deal[5]	65.3	[46 ; 84.7]

CHRONIC HEALTH PROBLEM [6]		
Yes	89.5	[86.5 ; 92.6]
No	97	[94.4 ; 99.6]

1. Depressive episode, bipolar disorder or generalized anxiety disorder
2. In the last 12 months
3. Taking prescribed or unprescribed medication for problems related to emotions, mental health or use of drugs or alcohol
4. In the last 7 days
5. This category includes the answer choices "many" and "most" in reference to activities prevented by usually experienced pain or discomfort
6. At least one chronic health problem

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

3.1.3 Flourishing mental health

WHAT IS BEING MEASURED?

Using the 14 questions in the short form of the Mental Health Continuum developed by Keyes (2002), emotional well-being and some aspects of psychological and social functioning were measured to divide the population into the following three categories:

Mental health can be:

Flourishing: high level of emotional well-being and positive functioning

Languishing: low level of emotional well-being and positive functioning

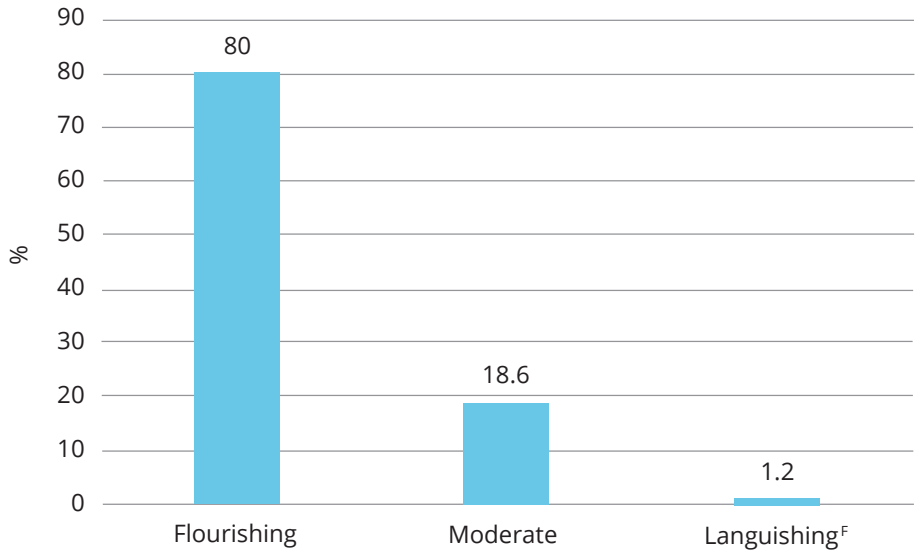
Moderately good: neither flourishing nor languishing.

For the following analysis, the category flourishing is introduced to document optimal mental health.

No possible comparison with the CCHS – Mental Health, 2002: New indicator in 2012.

Figure 3.3

POSITIVE MENTAL HEALTH, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012



F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

MENTAL HEALTH CONTINUUM – SHORT FORM (MHC-SF) KEYES (2002)

Choice of answer for each of the 14 questions: every day, almost every day, about two or three times a week, about once a week, once or twice, or never

Emotional well-being

In the past month, how often did you feel ...

1. happy?
2. interested in life?
3. satisfied with life?

Positive functioning

In the past month, how often did you feel ...

1. that you had something important to contribute to society? (social contribution)
2. that you belonged to a community (like a social group, your neighbourhood, your city, your school)? (social integration)
3. that our society is becoming a better place for people like you? (social growth)
4. that people are basically good? (social acceptance)
5. that the way our society works makes sense to you? (social coherence)
6. that you like most parts of your personality? (self-acceptance)
7. that you were good at managing the responsibilities of your daily life? (environmental mastery)
8. that you had warm and trusting relationships with others? (positive relations with others)
9. that you had experiences that challenge you to grow and become a better person? (personal growth)
10. that you can think or express your own ideas and opinions? (autonomy)
11. that your life has a sense of direction or meaning to it? (purpose in life)

Answers to the short form of the Mental Health Continuum are organized to classify the population into the following three mental health categories:

» **Flourishing mental health** requires the answer “almost every day” or “every day” to at least one of the three questions on emotional well-being, and at least six of the 11 questions on positive functioning.

» **Languishing mental health** requires the answer “once or twice” or “never” to at least one of the three questions on emotional well-being, and at least six of the 11 questions on positive functioning.

» **Moderately good mental health** refers to mental health that isi neither flourishing nor languishing.

WHAT DO THE RESULTS SAY?

SOCIODEMOGRAPHIC CHARACTERISTICS

For the entire Francophone minority population

A very large proportion of the Francophone minority population aged 15 and over (80%) is in flourishing mental health according to the short form of the Mental Health Continuum scale. This proportion is 76.5% in Canada as a whole, and 76.4% in the Anglophone majority outside Quebec.

Marital status

A greater proportion of the Francophone minority who are married or in a common-law relation ship are in flourishing mental health (80.8%) than persons who are widowed, separated, or divorced (78.9%), or single (77%).

Education

The survey shows no significant difference among persons in the Francophone minority in flourishing mental health based on their education level.

Household income level

Fewer persons in the Francophone minority with an income in the lowest quintiles (1 and 2) are in flourishing mental health than persons in the other quintiles.

Employment

A greater proportion of persons in the Franco-phone minority who are employed are in flourishing mental health than persons who are unemployed (79.8% vs. 77.9%), when all other variables are held constant.

Living alone

Persons living alone are less likely to be in flourishing mental health than persons living with others (73.8% vs. 81.3%).

Table 3.5

PERCENTAGE OF PERSONS IN FLOURISHING MENTAL HEALTH, ACCORDING TO CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE QUEBEC AND CANADA AS A WHOLE, 2012

	FLOURISHING MENTAL HEALTH	
	%	Confidence interval (95%)
SEX		
Male	80.5	[74.6 ; 86.4]
Female	79.5	[74.2 ; 84.8]
AGE		
15-29 years	85	[78.1 ; 91.9]
30-49 years	80.4	[73.2 ; 87.5]
50 and over	78.2	[72.3 ; 84]
MARITAL STATUS		
Married/common law	80.8	[75.7 ; 86]
Widowed/separated/divorced	78.9	[72.2 ; 85.7]
Single	77	[68.9 ; 85.1]

EDUCATION		
< High school diploma	81.3	[74.7 ; 87.8]
High school diploma	79.4	[68.2 ; 90.5]
Postsecondary or college diploma	78.8	[71.8 ; 85.8]
University degree	81	[73.6 ; 88.5]
HOUSEHOLD INCOME LEVEL		
Quintile 1 – lowest	75	[67.3 ; 82.8]
Quintile 2	74.6	[63.2 ; 86]
Quintile 3	81.4	[72.9 ; 89.9]
Quintile 4	83.7	[75.8 ; 91.6]
Quintile 5 – highest	83.3	[75.4 ; 91.3]
LIVING ENVIRONMENT		
Urban	78.1	[73 ; 83.2]
Rural	84.6	[79.7 ; 89.5]
EMPLOYED[1, 2]		
Yes	79.8	[74.4 ; 85.3]
No	77.9	[71.3 ; 84.6]
LIVING ALONE		
Yes	73.8	[67.1 ; 80.6]
No	81.3	[76.8 ; 85.8]
Francophone minorities (outside QC)	80	[76 ; 83.9]
Anglophone majority (outside QC)	76.4	[75.4 ; 77.4]
All of Canada	76.5	[75.6 ; 77.4]

1. In the week preceding the interview
2. Excluding persons over age 75

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

MENTAL AND PHYSICAL HEALTH CHARACTERISTICS

Mental health

Persons in the Francophone minority:

» with a mental disorder,

» with alcohol abuse or addiction issues,

» with cannabis abuse or addiction issues,

» who take medication,

are less likely to be in flourishing mental health than persons not in these situations.

Physical health

Persons in the Francophone minority who:

» rate their physical health as excellent or very good,

» are pain-free,

» have no chronic health problems,

are more likely to display flourishing mental health than persons classifying themselves in the other categories for these indicators.

Table 3.6

PERCENTAGE OF PERSONS IN FLOURISHING MENTAL HEALTH, ACCORDING TO CERTAIN HEALTH CHARACTERISTICS, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012		
MENTAL HEALTH	%	Confidence interval (95%)
MENTAL DISORDER[1, 2]		
Yes	36.4	[16.4 ; 56.4] [E]
No	83.1	[79.2 ; 87]
ALCOHOL ABUSE OR ADDICTION[2]		
Yes	60.7	[30.3 ; 91] [E]
No	80	[75.9 ; 84]
CANNABIS ABUSE OR ADDICTION[2]		
Yes	62.4	[28.3 ; 96.4] [E]
No	80.4	[76.4 ; 84.4]
MEDICATION USE[2, 3]		
Yes	57	[45.9 ; 68.2]
No	82.6	[78.6 ; 86.7]
PHYSICAL HEALTH		
PERCEIVED PHYSICAL HEALTH		
Fair or poor	65.9	[54.8 ; 77]
Good	78.8	[71.8 ; 85.7]
Very good or excellent	84.8	[79.4 ; 90.1]
EXERCISE[4]		
Yes	82.4	[77.9 ; 86.8]
No	73.4	[65.6 ; 81.2]
PAIN OR DISCOMFORT		
No pain	81.7	[77 ; 86.4]
Pain limiting activity little or not at all	77.8	[69.5 ; 86.2]
Pain limiting activity a good deal[5]	58.5	[38.5 ; 78.5] [E]
CHRONIC HEALTH PROBLEM[6]		
Yes	78.5	[73.8 ; 83.2]
No	82.4	[75.5 ; 89.3]

1. Depressive episode, bipolar disorder or generalized anxiety disorder
2. In the last 12 months
3. Taking prescribed or unprescribed medication for problems related to emotions, mental health or use of drugs or alcohol
4. In the last 7 days
5. This category includes the answer choices "many" and "most" in reference to activities prevented by usually experienced pain or discomfort
6. At least one chronic health problem

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

3.1.4 Assessing one's ability to handle the day-to-day demands of life

WHAT IS BEING MEASURED?

A person's perception of his or her ability to deal with the daily demands of life is being measured, by means of the following question:

> Q. In general, how would you rate your ability to handle the day-to-day demands in your life, for example, handling work, family and volunteer responsibilities? Would you say your ability is...
>
> A. Excellent, very good, good, fair or poor

The figure below breaks down the population according to four answer categories. For the following analysis, the categories "very good" and "excellent" are grouped together to document optimal mental health.

Comparison with the CCHS – Mental Health, 2002: Indicator is comparable.

WHAT DO THE RESULTS SAY?

SOCIODEMOGRAPHIC CHARACTERISTICS

For the entire Francophone minority population

In 2012, 66% of the Francophone minority population aged 15 and over felt that their ability to handle the day-to-day demands of life was excellent or very good. This proportion was similar in 2002 (66.5%). For all Canadians, this proportion was 68.5% in 2012 and 68.1% in 2002. For the Anglophone majority outside Quebec, the proportion was 67.6% in 2012 and 67.4% in 2002.

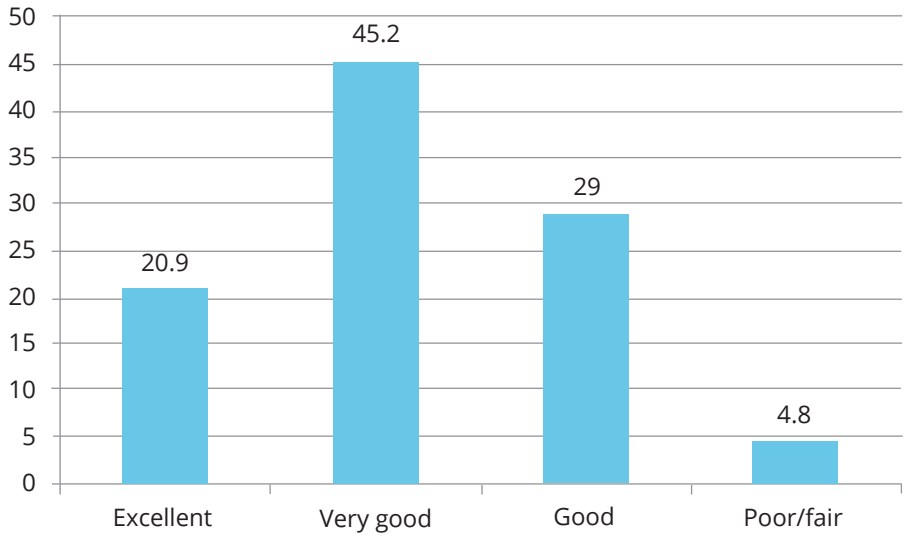
Sex and age

In 2012, males in the Francophone minority were more likely than females to say that their ability to handle the daily demands of life was excellent or very good (70.1% vs. 62.6% for females).

In 2012, fewer persons in the Francophone minority aged 50 and over estimated that their ability to handle the day-to-day demands of life

Figure 3.4

PERCEPTION OF ONE'S ABILITY TO HANDLE THE DAY-TO-DAY DEMANDS OF LIFE, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012



Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

was excellent or very good (61.3%) compared with persons aged 15 to 29 (71.2%) or 30 to 49 (71.3%). Similar trends were observed in 2002, but the differences between the groups were less pronounced.

Marital status

In 2012, the proportion of persons in the Francophone minority considering themselves to have excellent or very good ability to handle the day-to-day demands of life was higher among persons who were widowed, separated, or divorced (68.5%) than persons married or in common-law relationships (65.6%) as well as single persons (63.8%).

Education

In 2012, persons in the Francophone minority without a high school diploma were less likely to rate their ability to handle the day-to-day demands of life as excellent or very good (57.3%) than persons with a higher level of education (62.9% to 75.4%).

Household income level

A greater proportion of persons (82.3%) in the Francophone minority with an income in the fifth (highest) quintile report having excellent or very good ability to handle the day-to-day demands of life compared with persons in the other four quintiles (49.6% to 69%). However, the gradient among these four groups is not conspicuous.

Living environment

In 2012, persons in the Francophone minority living in an urban environment were more likely to feel they have excellent or very good ability to deal with the daily demands of life than persons living in a rural environment (69.4% vs. 57.6%). This difference was less pronounced in 2002.

Employment

Employed persons in the Francophone minority are more likely to feel that they have excellent or very good ability to handle the day-to-day demands of life than those who are unemployed (68.3% vs. 65.4%).

Living alone

In 2012, persons in the Francophone minority living alone were less inclined to rate their ability to deal with the daily demands of life as excellent or very good than those living with other persons (64.1% vs. 66.3%). The same difference was noted in 2002, with a larger gap between the two groups.

Table 3.7

PERCENTAGE OF PERSONS CONSIDERING THEMSELVES TO HAVE EXCELLENT OR VERY GOOD ABILITY TO HANDLE THE DAY-TO-DAY DEMANDS OF LIFE, ACCORDING TO CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE QUEBEC AND CANADA AS A WHOLE, 2002 AND 2012

	EXCELLENT OR VERY GOOD ABILITY			
	2002		2012	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	67.3	[62.4 ; 72.1]	70.1	[63.8 ; 76.4]
Female	65.6	[61.74 ; 69.5]	62.6	[55.6 ; 69.6]
AGE				
15-29 years	69.3	[62.42 ; 76.1]	71.2	[62.4 ; 80.1]
30-49 years	67.4	[61.67 ; 73]	71.3	[61.7 ; 81]
50 and over	64.2	[60.4 ; 68.1]	61.3	[54.6 ; 67.9]
MARITAL STATUS				
Married/common law	67.8	[63.9 ; 71.8]	65.6	[58.9 ; 72.4]
Widowed/separated/divorced	67.5	[61.27 ; 73.8]	68.5	[60.8 ; 76.1]
Single	58.6	[52.86 ; 64.3]	63.8	[55.1 ; 72.5]

EDUCATION				
< High school diploma	56.9	[51.4 ; 62.4]	57.3	[48.9 ; 65.7]
High school diploma	68.4	[59.7 ; 77.1]	62.9	[47.3 ; 78.5]
Postsecondary or college diploma	71.8	[66.8 ; 76.8]	66.1	[57.5 ; 74.7]
University degree	74.3	[67.6 ; 80.9]	75.4	[66.2 ; 84.6]
HOUSEHOLD INCOME LEVEL				
Quintile 1 – lowest	ND	...	61	[52 ; 69.9]
Quintile 2	ND	...	49.6	[37.9 ; 61.2]
Quintile 3	ND	...	64.7	[51.6 ; 77.8]
Quintile 4	ND	...	69	[59.5 ; 78.6]
Quintile 5 – highest	ND	...	82.3	[72.8 ; 91.8]
LIVING ENVIRONMENT				
Urban	67.1	[63.4 ; 70.9]	69.4	[63.5 ; 75.3]
Rural	64.9	[59.6 ; 70.3]	57.6	[50.1 ; 65]
EMPLOYED[1,2]				
Yes	ND	...	68.3	[61 ; 75.6]
No	ND	...	65.4	[58.2 ; 72.6]
LIVING ALONE				
Yes	63.8	[58.83 ; 68.8]	64.1	[56.5 ; 71.7]
No	66.7	[63.15 ; 70.3]	66.3	[60.6 ; 71.9]
Francophone minority (outside QC)	66.5	[63.3. 69.6]	66	[61.1 ; 70.9]
Anglophone majority (outside QC)	67.4	[66.6 ; 68.1]	67.6	[66.6 ; 68.7]
All of Canada	68.1	[67.5 ; 68.8]	68.5	[67.6 ; 69.3]

1. In the week preceding the interview
2. Excluding persons over age 75

ND No data available

... Not applicable

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

MENTAL AND PHYSICAL HEALTH CHARACTERISTICS

Mental health

Persons in the Francophone minority:

» with a mental disorder,

» taking medication,

are less likely to report excellent or very good ability to handle the day-to-day demands of life than persons not in these situations.

Physical health

Persons in the Francophone minority who:

» consider their physical health to be excellent or very good,

» exercise,

» are pain-free,

» have no chronic health problems,

are more likely to consider themselves to have excellent or very good ability to handle the day-to-day demands of life than those in the other categories for these indicators.

Table 3.8

PERCENTAGE OF PERSONS CONSIDERING THAT THEY HAVE EXCELLENT OR VERY GOOD ABILITY TO HANDLE THE DAY-TO-DAY DEMANDS OF LIFE, ACCORDING TO CERTAIN HEALTH CHARACTERISTICS, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012		
	EXCELLENT OR VERY GOOD ABILITY	
	%	Confidence interval (95%)
MENTAL HEALTH		
MENTAL DISORDER[1, 2]		
Yes	35	[14.3 ; 55.7] [E]
No	67.9	[62.9 ; 72.9]
ALCOHOL ABUSE OR ADDICTION[2]		
Yes	x	...
No	x	...
CANNABIS ABUSE OR ADDICTION[2]		
Yes	x	...
No	x	...
MEDICATION USE[2, 3]		
Yes	48	[35.7 ; 60.2]
No	68.2	[63 ; 73.4]
PHYSICAL HEALTH		
PERCEIVED PHYSICAL HEALTH		
Fair or poor	44.1	[32.1 ; 56.1]
Good	56.5	[48.3 ; 64.8]
Very good or excellent	78.3	[72.7 ; 84]
EXERCISE[4]		
Yes	68.5	[62.9 ; 74]
No	58.9	[49.8 ; 67.9]
PAIN OR DISCOMFORT		
No pain	69.2	[63.7 ; 74.8]
Pain limiting activity little or not at all	61.4	[50.6 ; 72.3]
Pain limiting activity a good deal[5]	28.3	[10.6 ; 46]
CHRONIC HEALTH PROBLEM[6]		
Yes	57	[51.1 ; 62.9]
No	80.6	[73.9 ; 87.3]

1. Depressive episode, bipolar disorder or generalized anxiety disorder
2. In the last 12 months
3. Taking prescribed or unprescribed medication for problems related to emotions, mental health or use of drugs or alcohol
4. In the last 7 days
5. This category includes the answer choices "many" and "most" in reference to activities prevented by usually experienced pain or discomfort
6. At least one chronic health problem

x Confidential data
... Not applicable
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

3.1.5 Assessing one's ability to handle unexpected and difficult problems

WHAT IS BEING MEASURED?

The person's perception of his or her ability to handle unexpected and difficult problems is being measured, by means of the following question:

> Q. In general, how would you rate your ability to handle unexpected and difficult problems, such as a family or personal crisis? Would you say your ability is...
>
> A. Excellent, very good, good, fair or poor

The figure below breaks down the population according to four answer categories. For the following analysis, the categories "very good" and "excellent" are grouped together to document optimal mental health.

Comparison with CCHS — Mental Health, 2002: Indicator is comparable.

WHAT DO THE RESULTS SAY?

SOCIODEMOGRAPHIC CHARACTERISTICS

For the entire Francophone minority population

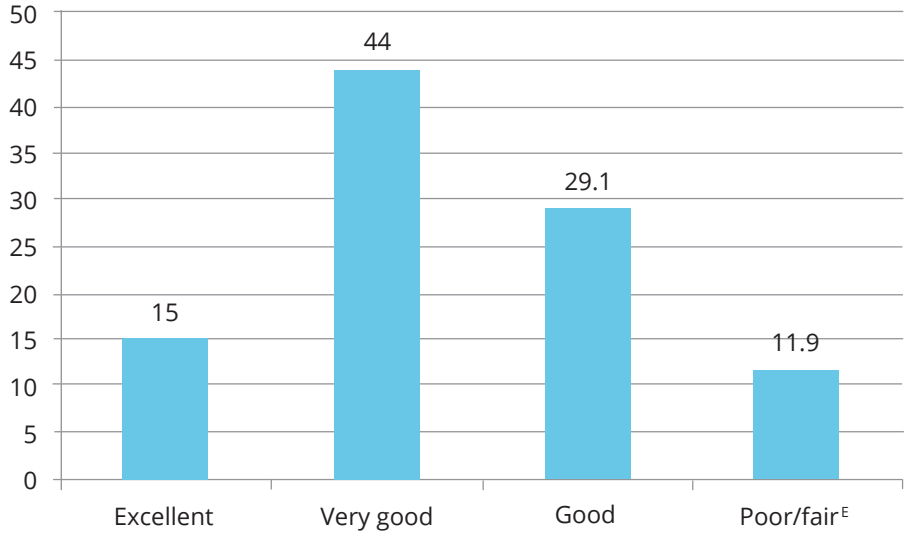
In 2012, 58.9% of the Francophone minority population reported having excellent or very good ability to handle unexpected and difficult problems. The proportion for the Francophone minority is similar to the Canada proportion (60.6%). Furthermore, there is no statistically significant difference with the Anglophone majority outside Quebec (61.8%).

Sex and age

In 2002, a greater proportion of males compared to females in the Francophone minority considered themselves to have excellent or very good ability to handle unexpected and difficult problems (61% vs. 55.2%). However, this gap dwindled by 2012 (59.3% vs. 58.6%).

Figure 3.5

PERCEPTION OF ONE'S ABILITY TO HANDLE UNEXPECTED AND DIFFICULT PROBLEMS, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012



E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

Persons aged 50 and over in the Francophone minority are less likely to make this statement than those aged 30-49 and 15-29 (52.9% vs. 68.8% and 59.5%, respectively in 2012).

Marital status

Single persons in the Francophone minority are more likely to feel they have excellent or very good ability to handle unexpected and difficult problems (61.7%) than married or common-law persons (59.1%) as well as persons aged 50 and over (52.9%).

Education

Persons in the Francophone minority who do not hold a high school diploma are less likely to report excellent or very good ability to handle unexpected and difficult problems (47.4%, in both 2002 and 2012) than those with a higher level of education (59.7% to 64.2% in 2012, and 59.3% to 68.2% in 2002). However, the gradient among levels of higher schooling is very clear in 2002 and more ambiguous in 2012.

Household income level

In 2012, there was a higher proportion of persons in the Francophone minority with an income in the highest quintile (65.8%) who rated their ability to handle unexpected and difficult problems as excellent or very good than persons with an income in the four lower quintiles (46.7%, 55.8%, 61% and 62.3%, respectively for quintiles 1, 2, 3 and 4). The gradient is conspicuous.

Living environment

In 2012, persons in the Francophone minority living in an urban environment were more inclined to rate their ability to handle unexpected and difficult problems as excellent or very good than persons residing in a rural environment (61.2% vs. 53.4%). This difference between the proportions was less pronounced in 2002.

Employment

In 2012, employed persons in the Francophone minority were more inclined to feel they had excellent or very good ability to handle unexpected and difficult problems than persons who were unemployed (62.8% vs. 54.8%).

Living alone

In 2012, persons in the Francophone minority living alone were less likely to rate their ability to handle unexpected and difficult problems as excellent or very good than those living with other persons (61.9% vs. 58.6%). On the other hand, in 2002, there was virtually no difference between these two groups.

Table 3.9

PERCENTAGE OF PERSONS CONSIDERING THEY HAVE EXCELLENT OR VERY GOOD ABILITY TO HANDLE UNEXPECTED AND DIFFICULT PROBLEMS, ACCORDING TO CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE QUEBEC AND CANADA AS A WHOLE, 2002 AND 2012

	EXCELLENT OR VERY GOOD ABILITY			
	2002		2012	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	61	[56.02 ; 65.9]	59.3	[52.2 ; 66.5]
Female	55.2	[51.22 ; 59.3]	58.6	[52.8 ; 64.5]
AGE				
15-29 years	55	[48.3 ; 61.7]	59.5	[49.2 ; 69.7]
30-49 years	59.3	[53.53 ; 65.1]	68.8	[60.4 ; 77.1]
50 and over	58.4	[54.09 ; 62.8]	52.9	[46.5 ; 59.3]

MARITAL STATUS				
Married/common law	59.4	[55.18 ; 63.6]	59.1	[52.8 ; 65.5]
Widowed/separated/divorced	55.4	[49.23 ; 61.6]	56.7	[48 ; 65.5]
Single	56	[50.04 ; 62]	61.7	[53 ; 70.3]
EDUCATION				
< High school diploma	47.4	[42.1 ; 52.6]	47.4	[39.1 ; 55.8]
High school diploma	59.3	[52.5 ; 66.1]	64.2	[50.2 ; 78.3]
Postsecondary or college diploma	63.6	[58.2 ; 69.1]	63.3	[55.7 ; 71]
University degree	68.2	[61.4 ; 75]	59.7	[49.4 ; 69.9]
HOUSEHOLD INCOME LEVEL				
Quintile 1 – lowest	ND	...	46.7	[37.6 ; 55.8]
Quintile 2	ND	...	55.8	[44.9 ; 66.6]
Quintile 3	ND	...	61	[49.4 ; 72.6]
Quintile 4	ND	...	62.3	[52.5 ; 72.1]
Quintile 5 – highest	ND	...	65.8	[54.4 ; 77.3]
LIVING ENVIRONMENT				
Urban	59.5	[55.6 ; 63.5]	61.2	[55.7 ; 66.6]
Rural	55.1	[50.1 ; 60]	53.4	[45.4 ; 61.5]
EMPLOYED [1,2]				
Yes	ND	...	62.8	[56.3 ; 69.3]
No	ND	...	54.8	[47 ; 62.5]
VIVRE SEUL				
Yes	58.2	[53.3 ; 63.1]	61.9	[54.3 ; 69.6]
No	58	[54.4 ; 61.5]	58.6	[53.4 ; 63.9]
Francophone minority (outside QC)	58.1	[54.9 ; 61.3]	58.9	[54.4 ; 63.5]
Anglophone majority (outside QC)	61	[60.2 ; 61.8]	61.8	[60.6 ; 63]
All of Canada	60.3	[59.5 ; 61]	60.6	[59.6 ; 61.7]

1. In the week preceding the interview
2. Excluding persons over age 75

ND No data available
... Not applicable

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

MENTAL AND PHYSICAL HEALTH CHARACTERISTICS

Mental health

Persons in the Francophone minority:

» with a mental disorder,

» with alcohol abuse or addiction issues,

» taking medication,

are less inclined to consider their ability to handle unexpected and difficult problems to be excellent or very good than persons not in these situations.

These differences must be interpreted with caution due to small numbers.

Physical health

Persons in the Francophone minority who:

» consider their physical health to be excellent or very good,

» exercise,

» are pain-free,

» have no chronic health problems,

rate their ability to handle unexpected and difficult problems as excellent or very good in greater proportions than those classifying themselves in the other categories for these indicators.

Table 3.10

PERCENTAGE OF PERSONS CONSIDERING THEY HAVE EXCELLENT OR VERY GOOD ABILITY TO HANDLE UNEXPECTED AND DIFFICULT PROBLEMS, ACCORDING TO CERTAIN HEALTH CHARACTERISTICS, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012

	EXCELLENT OR VERY GOOD ABILITY	
	%	Confidence interval (95%)
MENTAL HEALTH		
MENTAL DISORDER[1, 2]		
Yes	30.1	[11.6 ; 48.6] [E]
No	61	[56.3 ; 65.6]
ALCOHOL ABUSE OR ADDICTION[2]		
Yes	55.2	[26.2 ; 84.2] [E]
No	59.6	[55 ; 64.2]
CANNABIS ABUSE OR ADDICTION[2]		
Yes	x	...
No	x	...
MEDICATION USE[2, 3]		
Yes	36.4	[23.3 ; 49.4] [E]
No	61.6	[56.9 ; 66.3]
PHYSICAL HEALTH		
PERCEIVED PHYSICAL HEALTH		
Fair or poor	42.3	[29 ; 55.6]
Good	51.7	[42.2 ; 61.2]
Very good or excellent	68.2	[62.1 ; 74.4]
EXERCISE[4]		
Yes	60.7	[55.4 ; 66]
No	54	[45.6 ; 62.5]

PAIN OR DISCOMFORT		
No pain	61.8	[56.7 ; 67]
Pain limiting activity little or not at all	52.2	[39.9 ; 64.6]
Pain limiting activity a good deal[5]	37	[18.1 ; 56] E
CHRONIC HEALTH PROBLEM[6]		
Yes	50	[44.2 ; 55.9]
No	73.4	[66.6 ; 80.1]

1. Depressive episode, bipolar disorder or generalized anxiety disorder
2. In the last 12 months
3. Taking prescribed or unprescribed medication for problems related to emotions, mental health or use of drugs or alcohol
4. In the last 7 days
5. This category includes the answer choices "many" and "most" in reference to activities prevented by usually experienced pain or discomfort
6. At least one chronic health problem

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates
x Confidential data
... Not applicable

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

3.1.6 Very strong or somewhat strong sense of belonging to one's community

WHAT IS BEING MEASURED?

A person's sense of belonging to his or her local community is being measured by means of the following question:

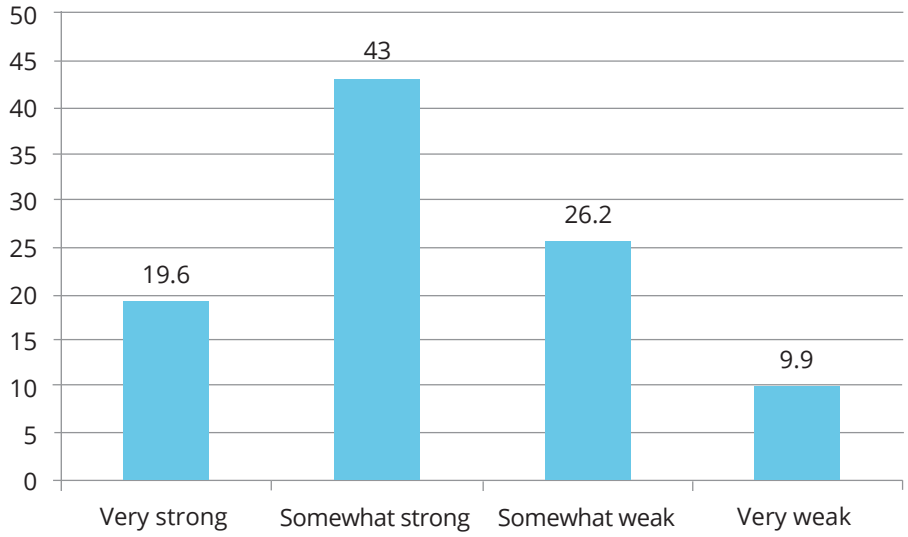
> Q. How would you describe your sense of belonging to your local community?
>
> A. Very strong, somewhat strong, somewhat weak or very weak

The figure below breaks down the population according to four answer categories. For the following analysis, the categories "very strong" and "somewhat strong" are grouped together to document optimal mental health.

Comparison with *CCHS — Mental Health, 2002*: Indicator is comparable.

Figure 3.6

SENSE OF BELONGING TO A LOCAL COMMUNITY, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012



Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

WHAT DO THE RESULTS SAY?

SOCIODEMOGRAPHIC CHARACTERISTICS

For the entire Francophone minority population

Nearly two thirds of the Francophone minority population aged 15 and over (62.5%) express a very strong or somewhat strong sense of belonging to their local community. This proportion has risen since 2002 (55.1%), rendering it now comparable to the rate for the Anglophone minority in Quebec (65.1% in 2012). For Canada as a whole, the proportions were 62.5% in 2012 and 57.9% in 2002.

Age

Persons aged 50 and over in the Francophone minority were more inclined to express a very strong or somewhat strong sense of belonging to their local community, both in 2012 (63.8%) and in 2002 (58.9%) compared with the other age groups.

Marital status

Single persons in the Francophone minority were more likely to express a very strong or somewhat strong sense of belonging to their local community (68.8%) in 2012, whereas 10 years earlier, persons in the married or common-law group had the highest rate.

Table 3.11

PERCENTAGE OF PERSONS WITH A VERY STRONG OR SOMEWHAT STRONG SENSE OF BELONGING TO THEIR LOCAL COMMUNITY, ACCORDING TO CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE QUEBEC AND CANADA AS A WHOLE, 2012

	VERY STRONG OR SOMEWHAT STRONG SENSE OF BELONGING			
	2002		2012	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	55.2	[50.1 ; 60.3]	61	[54 ; 68.1]
Female	55.1	[50.9 ; 59.3]	63.8	[56.9 ; 70.6]
AGE				
15-29 years	49.4	[42.6 ; 56.2]	61.3	[50 ; 72.7]
30-49 years	54.1	[48.4 ; 59.8]	61	[51 ; 71]
50 and over	58.9	[54.4 ; 63.3]	63.8	[56.9 ; 70.7]
MARITAL STATUS				
Married/common law	57.3	[53.1 ; 61.6]	62.6	[55.8 ; 69.4]
Widowed/separated/divorced	51.6	[45.4 ; 57.8]	58.5	[49.3 ; 67.8]
Single	49.7	[43.6 ; 55.9]	68.8	[59.6 ; 78.1]
EDUCATION				
< High school diploma	55.3	[50 ; 60.5]	66.9	[58.6 ; 75.2]
High school diploma	53.1	[45.9 ; 60.4]	51.1	[34.3 ; 68]
Postsecondary or college diploma	55	[49.3 ; 60.8]	64.9	[56.9 ; 72.9]
University degree	59.2	[51.5 ; 66.9]	60.5	[49.5 ; 71.5]

HOUSEHOLD INCOME LEVEL				
Quintile 1 – lowest	ND	...	62.4	[53.7 ; 71.1]
Quintile 2	ND	...	66.1	[55.9 ; 76.4]
Quintile 3	ND	...	71.1	[61.3 ; 80.9]
Quintile 4	ND	...	60.7	[50.9 ; 70.5]
Quintile 5 – highest	ND	...	52.4	[40 ; 64.7]
LIVING ENVIRONMENT				
Urban	53	[48.7 ; 57.2]	62.9	[56.6 ; 69.2]
Rural	59.9	[55 ; 64.8]	61.6	[53.7 ; 69.5]
EMPLOYED[1, 2]				
Yes	ND	...	60.2	[53.3 ; 67]
No	ND	...	62	[53.6 ; 70.4]
VIVRE SEUL				
Yes	53	[47.6 ; 58.3]	61.8	[54.1 ; 69.5]
No	55.5	[51.7 ; 59.2]	62.8	[56.7 ; 68.8]
Francophone minority (outside QC)	55.1 **	[51.8 ; 58.5]	62.5	[57.3 ; 67.7]
Anglophone majority (outside QC)	60.7	[59.9 ; 61.5]	65.1	[63.9 ; 66.3]
All of Canada	57.9	[57.2 ; 58.7]	62.5	[61.4 ; 63.5]

1. In the week preceding the interview
2. Excluding persons over age 75

ND No data available
... Not applicable
** Significant difference from the Anglophone majority at the 5% threshold

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

MENTAL AND PHYSICAL HEALTH CHARACTERISTICS

Mental health

Persons in the Francophone minority:

» with a mental disorder,

» with cannabis abuse or addiction issues,

» taking medication,

are less likely to express a very strong or somewhat strong sense of belonging to their local community than persons not in these situations.

Physical health

Persons in the Francophone minority who:

» consider their physical health to be excellent or very good,

» exercise,

are more likely to express a very strong or somewhat strong sense of belonging to their local community than persons classifying themselves in the other categories for these indicators.

Table 3.12

PERCENTAGE OF PERSONS WITH A VERY STRONG OR SOMEWHAT STRONG SENSE OF BELONGING TO THEIR LOCAL COMMUNITY, ACCORDING TO CERTAIN HEALTH CHARACTERISTICS, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012		
	VERY STRONG OR SOMEWHAT STRONG SENSE OF BELONGING	
	%	Confidence interval (95%)
MENTAL HEALTH		
MENTAL DISORDER[1, 2]		
Yes	52.8	[32.8 ; 72.9] [E]
No	62.7	[57.3 ; 68.1]
ALCOHOL ABUSE OR ADDICTION[2]		
Yes	74.6	[51.5 ; 97.7]
No	62.5	[57.2 ; 67.8]
CANNABIS ABUSE OR ADDICTION[2]		
Yes	49.8	[16.8 ; 82.7] [F]
No	63	[57.7 ; 68.2]
MEDICATION USE[2, 3]		
Yes	43.1	[30.9 ; 55.3]
No	64.8	[59.2 ; 70.3]
PHYSICAL HEALTH		
PERCEIVED PHYSICAL HEALTH		
Fair or poor	57.3	[45.9 ; 68.7]
Good	63.4	[54.1 ; 72.6]
Very good or excellent	63.4	[56.1 ; 70.6]
EXERCISE[4]		
Yes	63.6	[57.5 ; 69.8]
No	59.8	[51.2 ; 68.4]
PAIN OR DISCOMFORT		
No pain	63	[57 ; 69]
Pain limiting activity little or not at all	63.5	[52.2 ; 74.8]
Pain limiting activity a good deal[5]	48.5	[27.2 ; 69.7] [E]
CHRONIC HEALTH PROBLEM[6]		
Yes	63.9	[58 ; 69.9]
No	60.2	[51 ; 69.4]

1. Depressive episode, bipolar disorder or generalized anxiety disorder
2. In the last 12 months
3. Taking prescribed or unprescribed medication for problems related to emotions, mental health or use of drugs or alcohol
4. In the last 7 days
5. This category includes the answer choices "many" and "most" in reference to activities prevented by usually experienced pain or discomfort
6. At least one chronic health problem

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only, since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

3.1.7 Social Provisions Scale

WHAT IS BEING MEASURED?

The person's perceived social support is being measured—specifically, the following five dimensions: attachment, guidance and informational support, reliable alliance, social integration, and reassurance of worth.

The Social Provisions Scale includes 10 statements[1] which replace the questions on social support that were included in the 2002 survey.

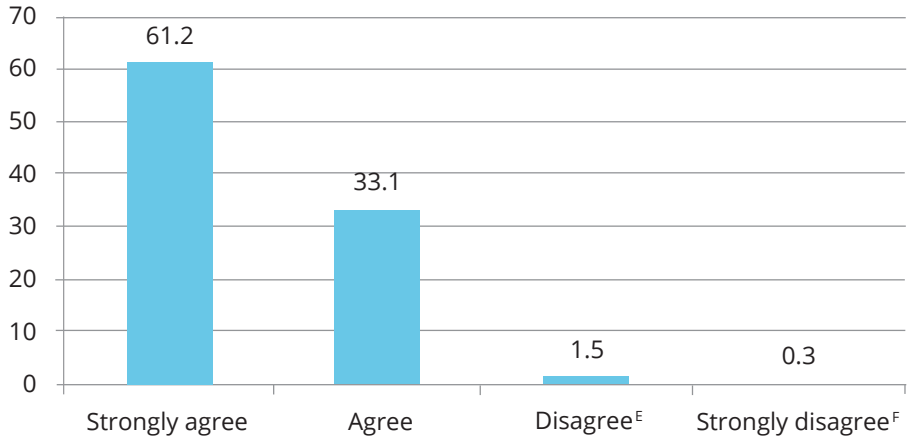
No possible comparison with *CCHS — Mental Health, 2002*: New module in 2012 replacing the social support module in the 2002 survey.

ANALYTICAL METHOD

An approach based on an analysis of the average percentage of statements with which persons reported that they "agree" or "strongly agree" has been adopted.[2] The results are presented for persons aged 15 and over who have a mental disorder or substance use disorder and those who do not (in the 12 months preceding the survey).

Figure 3.7

AVERAGE PROPORTION OF ANSWERS OBTAINED TO THE GLOBAL SOCIAL PROVISIONS SCALE, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012



E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

1. The Social Provisions Scale, initially developed by Cutrona and Russell (1987), had 24 statements rating six dimensions of social relations related to a person's perceived available social support: emotional support, social integration, reassurance of worth, reliable alliance, guidance and informational support, and need to feel useful. The French version of the Cutrona and Russell scale was validated by Caron in 1996 and abridged into 10 statements covering five of the six dimensions (Caron, 2013).
2. Given that no specific directive on the application of thresholds for analyzing the results of the Social Provisions Scale was provided (either by the author of the abridged scale or by Statistics Canada), a preliminary analysis of the distribution of the results of *CCHS – Mental Health 2012* was carried out.

SOCIAL PROVISIONS SCALE MODULE — STATEMENTS CLASSIFIED ACCORDING TO THE FIVE DIMENSIONS

The following statements focus on your usual relations with your friends, family members, co-workers, community members, or any other person. Indicate the extent to which each statement describes your relations with other people.

Attachment

» I have close relationships that provide me with a sense of emotional security and well-being (3).

» I feel a strong emotional bond with at least one other person (8).

Guidance and informational support

» There is someone I could talk to about important decisions in my life (4).

» There is a trustworthy person I could turn to for advice if I were having problems (6).

Reliable alliance

» There are people I can depend on to really help me when I need it (1).

» There are people I can count on in an emergency (10).

Social integration

» There are people who enjoy the same social activities I do (2).

» I feel part of a group of people who share my attitudes and beliefs (7).

Reassurance of worth

» I have relationships where my competence and skill are recognized (5).

» There are people who admire my talents and abilities (9).

Possible answers: Strongly agree, agree, disagree, strongly disagree.

N.B.: The numbers in parentheses indicate the order in which the statements were put to the respondents. Respondents were not informed of relationships among the various statements or the dimensions constructed as part of the Social Provisions Scale.

WHAT DO THE RESULTS SAY?

The average proportion of "agree" or "strongly agree" answers obtained on the global Social Provisions Scale (all 10 statements) is lower for persons in the Francophone minority who have a mental or substance use disorder than for other persons (91% vs. 98%). The same finding applies to the five dimensions of the scale. For example, persons in the Francophone minority with a mental or substance use disorder report a lower average proportion of "agree" or "strongly agree" answers for each dimension of the Social Provisions Scale than others, indicating weaker social support.

However, for the global scale and four dimensions, the proportions observed are above 90% regardless of the presence of a mental or substance use disorder. This indicates a relatively high perceived level of social support across the board. The biggest difference between the two groups is the social integration dimension. Social integration is constructed based on the following two statements: "There are people who enjoy the same social activities I do" and "I feel part of a group of people who share my attitudes and beliefs." For this dimension, the proportions for persons with a mental or substance use disorder are lower than for persons without these disorders (84% vs. 96%).

Table 3.13

AVERAGE PROPORTION OF "AGREE" OR "STRONGLY AGREE" ANSWERS OBTAINED ON THE GLOBAL SOCIAL PROVISIONS SCALE AND FOR EACH DIMENSION, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, WHETHER OR NOT A MENTAL DISORDER OR SUBSTANCE USE DISORDER IS INVOLVED[1,2] 2012

	MENTAL DISORDER OR SUBSTANCE USE DISORDER			
	ABSENCE		PRESENCE	
	%	Confidence interval (95%)	%	Confidence interval (95%)
GLOBAL SOCIAL PROVISIONS SCALE (P < 0.000)	95.3	[93.5 ; 97.1]	88.4	[78.1 ; 98.6]
DIMENSIONS OF THE SCALE				
Attachment (p < 0.000)	98.1	[97.1 ; 99.1]	96.9	[94.7 ; 99.2]
Guidance and informational support (p < 0.000)	98.2	[97.2 ; 99.1]	95.8	[92.3 ; 99.2]
Reliable alliance (p = 0.001)	98.7	[97 ; 100.3]	97.9	[95.5 ; 100.2]
Social integration (p < 0.000)	95.8	[93.9 ; 97.6]	90.9	[84.4 ; 97.3]
Reassurance of worth (p < 0.000)	96.9	[95.7 ; 98]	91.2	[81.9 ; 100.4]

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

THE TAKEAWAY

REGARDING OPTIMAL MENTAL HEALTH

In 2012, all other variables held constant in the Francophone minority population aged 15 and over, the survey showed that:

» Fewer minority Francophones with one of the mental disorders measured in the survey present elements of optimal mental health than persons without these conditions; this applies across all optimal mental health indicators analyzed in this report. This means that fewer of them:

- Perceive their mental health as excellent or very good;
- Report being very satisfied or satisfied with their life;
- Are in flourishing mental health;
- Consider their ability to handle the day-to-day demands of life to be excellent or very good;
- Consider their ability to handle unexpected and difficult problems to be excellent or very good;
- Feel a very strong or somewhat strong sense of belonging to their local community.

Furthermore, minority Francophones displaying one of the mental disorders or substance use disorders measured in the survey report lower results on the Social Provisions Scale than persons who do not have these disorders, although the results are relatively high for all. Among all the scale's dimensions, the difference between the two groups is more marked for social integration and reassurance of worth.

1. Depressive episode, bipolar disorder, generalized anxiety disorder, alcohol, cannabis or other drug abuse or addiction.
2. In the last 12 months.

» Fewer minority Francophones who perceive their physical health as fair or poor, who usually experience pain or discomfort, and who have at least one chronic health problem display positive elements of optimal mental health than persons without such issues. This means that fewer of them:

- Rate their mental health as excellent or very good;
- Report being very satisfied or satisfied with their life;
- Are in flourishing mental health;
- Consider their ability to handle the day-to-day demands of life to be excellent or very good;
- Consider their ability to handle unexpected and difficult problems to be excellent or very good.

» Minority Francophones living in a low-income household (quintile 1), those with a lower level of education, those who are not in employment and those who live alone are generally fewer in number than those who do not live in these situations to:

- Rate their mental health as excellent or very good;
- Report being very satisfied or satisfied with their life;
- Consider their ability to handle the day-to-day demands of life to be excellent or very good;
- Consider their ability to handle unexpected and difficult problems to be excellent or very good.

IN 2012, IN THE **FRANCOPHONE MINORITY** POPULATION AGED 15 AND OVER:

62.6% perceive their mental health as excellent or very good

92.4% say they are very satisfied or satisfied with their life

80% are in so-called flourishing mental health

The vast majority have a high level of social support

66% consider their ability to handle the day-to-day demands of life excellent or very good

58.9% rate their ability to handle unexpected and difficult problems as excellent or very good

62.5% feel a very strong or somewhat strong sense of belonging to their local community

3.2 Indicators of psychological distress, stress and suicidal ideation

In this report, four indicators of suboptimal mental health that are understood as interfering with a generally sought state of mental well-being have been selected for analysis. These are psychological distress, stress felt in day-to-day life, suicidal ideation, and attempted suicide. It should be noted that prevalence estimates for the last two indicators are unreliable owing to low numbers.

These indicators measure "[translation] a deviation from the state of mental or psychological well-being, and suggest the idea of an emerging problem following a disturbance of the relations between the person and his or her environment" (Agence de la santé et des services sociaux de Laval, 2013). There are five elements that fit into the continuum between the two extremes optimal mental health and suboptimal mental health.

3.2.1 Significant psychological distress

WHAT IS BEING MEASURED?

Psychological distress based on a 10-item scale (10 questions), developed by Kessler and known as K10 (Kessler et al., 2002) is being measured. There are five possible answer choices, concerned with the frequency of negative feelings or thoughts in the 30 days preceding the survey.

QUESTIONS IN THE K10 SCALE

In the past month, how often did you feel:

- ... tired for no good reason? (1)
- ... nervous? (2)
- ... so nervous that nothing could calm you down? (3)
- ... desperate? (4)
- ... restless or fidgety? (5)
- ... so restless you could not sit still? (6)
- ... sad or depressed? (7)
- ... so depressed that nothing could cheer you up? (8)
- ... worthless? (10)

In the past month, how often did you feel:

- ... that everything was an effort? (9)

Possible answers: None of the time, a little of the time, some of the time, most of the time, all of the time

N.B.: The numbers in parentheses indicate the order in which the questions were put to the respondents.

ANALYTICAL METHOD

For the analysis, a value from 0 to 4 is assigned to each category of possible answer: 0 indicating that negative feelings or thoughts were present "none of the time", and 4 indicating that they were present "all of the time". Therefore, the higher the score, the more pronounced the distress.

This analysis continues the method applied in the work of the Institut de la statistique du Québec using data from the 2002 mental health survey (Lesage et al., 2010) and from earlier Quebec surveys. Given that the scale's designers have not suggested any thresholds to facilitate data interpretation, and that the scientific literature shows that a threshold applied in one survey cannot generally be applied with a different population, an analysis based on breaking down the population into quintiles proved to be an acceptable compromise (Camirand and Nanhou, 2008). Thus, the top quintile of psychological distress scale scores, specifically, the 20% of the population with the highest scores, serves as a threshold above which it can be assumed that individuals score high on the psychological distress scale. This threshold was set at 9 in the analyses done in 2002. To compare the results of the two surveys, the same threshold was applied in 2012. Given the selected method, it is not possible to interpret the indicator in terms of prevalence of psychological distress, since the threshold used is not a clinical threshold.

Comparison with *CCHS — Mental Health, 2002*: Indicator is comparable.

WHAT DO THE RESULTS SAY?

SOCIODEMOGRAPHIC CHARACTERISTICS

For the entire Francophone minority population

According to the quintile method of analysis, 20.6% of the Francophone minority population scores high on the psychological distress scale, as their score is 9 or above. This proportion has declined slightly since 2002 (23.6%). However, it is higher than in the Anglophone majority outside Quebec (16.3%), a significant difference.

Sex and age

A higher proportion of females than males in the Francophone minority score high on the psychological distress scale (19.1% vs. 15.1%). A similar difference was observed in 2002 (23.1% vs. 17.6%).

With a proportion of 19.4% in 2012, more Francophone minority persons aged 30-49 score high on the psychological distress scale, compared with persons aged 15-29 (17.2%) and those aged 50 and over (16%).

Marital status

Single persons in the Francophone minority are more likely to score high on the psychological distress scale (14.8%) than are persons who are married or living common-law (15.8%) as well as persons who are widowed, separated, or divorced (23.3%).

Education

The differences between the groups are less pronounced, although fewer Francophone minority persons with the highest levels of education appear to score high on the psychological distress scale.

Household income level

A greater proportion of persons in the Francophone minority with an income in the lowest quintile (1) score high on the psychological distress scale than persons with an income in the upper quintiles (27.1% vs. 7.3 to 21.3%). The gradient is very clear for this sociodemographic characteristic.

Living environment

In 2012, Francophone minority persons living in an urban environment were more likely to score high on the psychological distress scale (18.5%) than persons in a rural environment (14.2%).

Employment

Employed persons in the Francophone minority are less likely to score high on the psychological distress scale than are those who are unemployed (14.9% vs. 21.4%).

Living alone

Persons in the Francophone minority who live alone are more likely to score high on the psychological distress scale than persons living with others (18.5% vs. 16.9%).

Table 3.14

PERCENTAGE OF PERSONS SCORING HIGH ON THE PSYCHOLOGICAL DISTRESS SCALE[1] ACCORDING TO CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE QUEBEC AND CANADA AS A WHOLE, 2012

	HIGH PSYCHOLOGICAL DISTRESS SCALE SCORE			
	2002		2012	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	17.6	[13.7 ; 21.5]	15.1	[10.2 ; 20]
Female	23.1	[19.6 ; 26.7]	19.1	[14 ; 24.2]
AGE				
15-29 years	25.8	[18.9 ; 32.7]	17.2	[9 ; 25.3] [E]
30-49 years	21.7	[16.9 ; 26.4]	19.4	[12.6 ; 26.2] [E]
50 and over	16.5	[13 ; 20]	16	[11 ; 20.9]
MARITAL STATUS				
Married/common law	18.7	[15.3 ; 22.1]	15.8	[11.1 ; 20.4]
Widowed/separated/divorced	24.5	[18.1 ; 30.9]	23.3	[14.9 ; 31.6] [E]
Single	22.5	[17.1 ; 27.8]	14.8	[8.1 ; 21.5] [E]
EDUCATION				
< High school diploma	26.5	[22.1 ; 30.8]	21.5	[14.6 ; 28.5]
High school diploma	20.3	[14.5 ; 26.1]	24.7	[12.1 ; 37.2] [E]
Postsecondary or college diploma	22.3	[17.3 ; 27.2]	20.2	[13.9 ; 26.4]
University degree	22.4	[16.2 ; 28.6]	18	[10.4 ; 25.6] [E]

HOUSEHOLD INCOME LEVEL				
Quintile 1 – lowest	ND	...	27.1	[18.6 ; 35.6]
Quintile 2	ND	...	21.3	[12.3 ; 30.3] E
Quintile 3	ND	...	19.6	[9.7 ; 29.6] E
Quintile 4	ND	...	13.4	[5.4 ; 21.3] E
Quintile 5 – highest	ND	...	7.3	[2.2 ; 12.4] F
LIVING ENVIRONMENT				
Urban	20.2	[16.9 ; 23.5]	18.5	[13.7 ; 23.2]
Rural	20.6	[16.2 ; 25]	14.2	[9.3 ; 19]
EMPLOYED [1, 2]				
Yes	ND	...	14.9	[10.3 ; 19.6]
No	ND	...	21.4	[14.9 ; 27.8]
LIVING ALONE				
Yes	19.9	[15.4 ; 24.4]	18.5	[11.9 ; 25.2] E
No	20.4	[17.3 ; 23.4]	16.9	[12.7 ; 21]
Francophone minority (outside QC)	23.6 **	[20.9 ; 26.3]	20.6	[16.9 ; 24.2]
Anglophone majority (outside QC)	16.3	[15.7 ; 17]	16.5	[15.6 ; 17.4]
All of Canada	20.7	[20 ; 21.3]	19.8	[19 ; 20.7]

1. In the week preceding the interview
2. Excluding persons over age 75

ND No data available
... Not applicable
** Significant difference from the Anglophone majority at the 5% threshold
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only, since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

MENTAL AND PHYSICAL HEALTH CHARACTERISTICS

Mental health

Persons in the Francophone minority:

» with a mental disorder,

» taking medication,

are proportionately more likely to score high on the psychological distress scale than persons not in these situations.

Physical health

Persons in the Francophone minority who:

» rate their physical health as fair or poor,

» have pain or discomfort that limit their activity somewhat or a great deal,

» have at least one chronic health problem,

more often score high on the psychological distress scale than those in the other categories for these indicators.

Table 3.15

PERCENTAGE OF PERSONS SCORING HIGH ON THE PSYCHOLOGICAL DISTRESS SCALE, ACCORDING TO CERTAIN HEALTH CHARACTERISTICS, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012		
	HIGH PSYCHOLOGICAL DISTRESS SCALE SCORE	
	%	Confidence interval (95%)
MENTAL HEALTH		
MENTAL DISORDER[1, 2]		
Yes	78.7	[64.6 ; 92.9]
No	13.5	[10.2 ; 16.8]
ALCOHOL ABUSE OR ADDICTION[2]		
Yes	19.7	[0 ; 39.3] [F]
No	17.1	[13.4 ; 20.8]
CANNABIS ABUSE OR ADDICTION[2]		
Yes	32.6	[3.2 ; 61.9] [F]
No	1.9	[13.5 ; 20.8]
MEDICATION USE[2, 3]		
Yes	51.2	[39 ; 63.3]
No	13.4	[10 ; 16.9]
PHYSICAL HEALTH		
PERCEIVED PHYSICAL HEALTH		
Fair or poor	32.1	[21.8 ; 42.3]
Good	19.6	[12.4 ; 26.8] [E]
Very good or excellent	11.5	[6.8 ; 16.2] [E]
EXERCISE[4]		
Yes	17.9	[13.2 ; 22.5]
No	15.6	[9.8 ; 21.4] [E]
PAIN OR DISCOMFORT		
No pain	14.5	[10.6 ; 18.5]
Pain limiting activity little or not at all	23.8	[13.4 ; 34.1] [E]
Pain limiting activity a good deal [5]	36.3	[16.8 ; 55.7] [E]
CHRONIC HEALTH PROBLEM[6]		
Yes	22.9	[17.9 ; 27.9]
No	8	[3.4 ; 12.7] [E]

1. Depressive episode, bipolar disorder or generalized anxiety disorder
2. In the last 12 months
3. Taking prescribed or unprescribed medication for problems related to emotions, mental health or use of drugs or alcohol
4. In the last 7 days
5. This category includes the answer choices "many" and "most" in reference to activities prevented by usually experienced pain or discomfort
6. At least one chronic health problem

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only, since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

3.2.2 Days that are quite a bit or extremely stressful

WHAT IS BEING MEASURED?

Personal assessment of the stress felt in daily life is measured by means of the following question:

> Q. Thinking about the amount of stress in your life, would you say that most days are...?
>
> A. Not at all stressful, not very stressful, a bit stressful, quite a bit stressful or extremely stressful

The figure below breaks down the population according to five answer categories. For the following analysis, the quite a bit stressful and extremely stressful categories are grouped together to document suboptimal mental health.

Comparison with *CCHS — Mental Health, 2002:* Indicator is comparable.

WHAT DO THE RESULTS SAY?

SOCIODEMOGRAPHIC CHARACTERISTICS

For the entire Francophone minority population

In 2012, 20.9% of the Francophone minority population aged 15 and over described most of their days as quite a bit or extremely stressful. This proportion is similar to that of the entire country (20.6%) and in the Anglophone majority outside Quebec (20.2%).

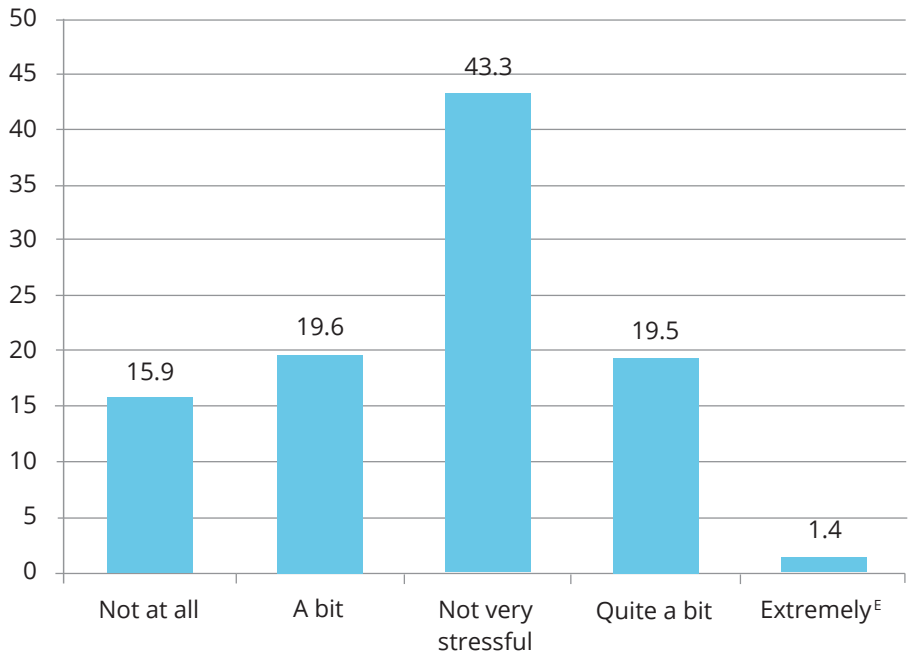
Sex and age

A higher proportion of women than men in the Francophone minority feel that most of their days are quite a bit or extremely stressful (22.2% vs. 19.3%).

A greater proportion of persons aged 30-49 in the Francophone minority consider that most of their days are quite a bit or extremely stressful (33.9%), compared with persons aged 15-29 (18.9%) and 50 and over (13.7%). These differences also held true in 2002.

Figure 3.8

DAILY STRESS, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012



E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

Marital status

Fewer married or common-law persons in the Francophone minority consider that most of their days are quite a bit or extremely stressful (19.8%) compared to persons who are widowed, separated or divorced (23.3%) or persons who are single (22.6%).

Education

In 2012 and 2002, Francophone minority persons with the highest levels of education report that most of their days are quite a bit or extremely stressful (36.2% vs. 32.7%).

Household income level

The greatest proportion of persons in the Francophone minority who feel that most of their days are quite a bit or extremely stressful are situated in the extremes of the income continuum, i.e., in the lowest (28.7%) and highest quintiles (26.1%).

Living environment

More persons in the Francophone minority who live in an urban environment consider most of their days to be quite a bit or extremely stressful; this was observed in both 2012 and 2002.

Employment

Employed persons in the Francophone minority are more likely to state that most of their days are quite a bit or extremely stressful, compared with persons who are unemployed (27.1% vs. 12.8%).

Table 3.16

PERCENTAGE OF PERSONS FOR WHOM MOST DAYS ARE QUITE A BIT OR EXTREMELY STRESSFUL, ACCORDING TO CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE QUEBEC AND CANADA AS A WHOLE, 2002 AND 2012

	MOST DAYS QUITE A BIT OR EXTREMELY STRESSFUL			
	2002		2012	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	22.9	[18.8 ; 27]	19.3	[12.5 ; 26.2] [E]
Female	23.9	[20.7 ; 27]	22.2	[15.7 ; 28.7]
AGE				
15-29 years	19.1	[13 ; 25.2]	18.9	[9.1 ; 28.7] [E]
30-49 years	31	[26.3 ; 35.7]	33.9	[23.9 ; 43.9]
50 and over	17.8	[14.5 ; 21.1]	13.7	[9.7 ; 17.7]
MARITAL STATUS				
Married/common law	23.1	[19.8 ; 26.5]	19.8	[14 ; 25.6]
Widowed/separated/divorced	23.2	[17.7 ; 28.7]	23.3	[15 ; 31.7] [E]
Single	24.8	[19.4 ; 30.2]	22.6	[13.5 ; 31.8] [E]
EDUCATION				
< High school diploma	17.5	[13.7 ; 21.2]	10.3	[5.7 ; 14.8] [E]
High school diploma	21.9	[14.7 ; 29]	27.2	[13.5 ; 40.9] [E]
Postsecondary or college diploma	24.8	[20.1 ; 29.5]	15.4	[9.9 ; 20.9] [E]
University degree	32.7	[25.8 ; 39.6]	36.2	[25.2 ; 47.2]

HOUSEHOLD INCOME LEVEL				
Quintile 1 – lowest	ND	...	28.7	[18.6 ; 38.7] E
Quintile 2	ND	...	10.7	[5.2 ; 16.1] E
Quintile 3	ND	...	19.2	[7.7 ; 30.8] E
Quintile 4	ND	...	19.7	[10.2 ; 29.2] E
Quintile 5 – highest	ND	...	26.1	[16 ; 36.3] E
LIVING ENVIRONMENT				
Urban	24.4	[21.1 ; 27.6]	21.4	[15.4 ; 27.4]
Rural	21.2	[16.9 ; 25.6]	19.6	[13.8 ; 25.4]
EMPLOYED [1, 2]				
Yes	ND	...	27.1	[20.3 ; 33.9]
No	ND	...	12.8	[7.1 ; 18.4] E
LIVING ALONE				
Yes	24.6	[20 ; 29.2]	20.2	[13.8 ; 26.6]
No	23.3	[20.3 ; 26.2]	21.1	[15.7 ; 26.4]
Francophone minority (outside QC)	23.4	[20.8 ; 26]	20.9	[16.2 ; 25.6]
Anglophone majority (outside QC)	22.8	[22.1 ; 23.4]	20.2	[19.1 ; 21.3]
All of Canada	23.1	[22.5 ; 23.7]	20.6	[19.7 ; 21.5]

1. In the week preceding the interview
2. Excluding persons over age 75

ND No data available
... Not applicable
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

MENTAL AND PHYSICAL HEALTH CHARACTERISTICS

Mental health

Persons in the Francophone minority:

» with a mental disorder,

» taking medication,

are more inclined to consider most of their days as quite a bit or extremely stressful, compared with persons who are not in these situations.

Physical health

Persons in the Francophone minority who:

» rate their physical health as fair or poor,

» do not exercise,

» have pain that limits their activity somewhat or a great deal,

» have at least one chronic health problem,

are more likely to assess most of their days as quite a bit or extremely stressful, compared with persons in the other categories for these indicators.

Table 3.17

PERCENTAGE OF PERSONS FOR WHOM MOST DAYS ARE QUITE A BIT OR EXTREMELY STRESSFUL, ACCORDING TO CERTAIN HEALTH CHARACTERISTICS, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 AND OVER, 2012		
	MOST DAYS QUITE A BIT OR EXTREMELY STRESSFUL	
	%	Confidence interval (95%)
MENTAL HEALTH		
MENTAL DISORDER[1, 2]		
Yes	51.2	[31 ; 71.3] [E]
No	19.1	[14.2 ; 24]
ALCOHOL ABUSE OR ADDICTION[2]		
Yes	x	...
No	x	...
CANNABIS ABUSE OR ADDICTION[2]		
Yes	x	...
No	x	...
MEDICATION USE[2, 3]		
Yes	42	[30 ; 53.9]
No	18.5	[13.4 ; 23.6]
PHYSICAL HEALTH		
PERCEIVED PHYSICAL HEALTH		
Fair or poor	28.9	[18.4 ; 39.4] [E]
Good	22.7	[15.6 ; 29.8]
Very good or excellent	17.5	[10.6 ; 24.3] [E]
EXERCISE[4]		
Yes	18.1	[12.4 ; 23.7]
No	29	[20.1 ; 38]
PAIN OR DISCOMFORT		
No pain	19	[13.9 ; 24.1]
Pain limiting activity little or not at all	25.8	[15.8 ; 35.8] [E]
Pain limiting activity a good deal[5]	32	[13.5 ; 50.5] [E]
CHRONIC HEALTH PROBLEM[6]		
Yes	23.3	[17.8 ; 28.7]
No	17	[8.9 ; 25.1] [E]

1. Depressive episode, bipolar disorder or generalized anxiety disorder
2. In the last 12 months
3. Taking prescribed or unprescribed medication for problems related to emotions, mental health or use of drugs or alcohol
4. In the last 7 days
5. This category includes the answer choices "many" and "most" in reference to activities prevented by usually experienced pain or discomfort
6. At least one chronic health problem

x Confidential data
... Not applicable
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

3.2.3 Suicide

3.2.3.1 Suicidal ideation

WHAT IS BEING MEASURED?

The presence of thoughts of suicide over a lifetime and in the 12 months preceding the survey is being measured.

> Q. Over [the reference period], did you seriously think about committing suicide?
>
> A. Yes, no

Comparison with *CCHS — Mental Health, 2002:* Indicator is comparable.

WHAT DO THE RESULTS SAY?

LIFETIME

The proportion of the Francophone minority population aged 15 and over who have had suicidal ideation over their lifetime is 12.7%. In 2002, this percentage was 13.6%. These proportions are slightly higher than for the Anglophone majority outside Quebec and in Canada as a whole.

In 2012, more women than men in the Francophone minority had suicidal ideation (14.5% vs. 10.5%), while in 2002 the proportions were similar for both sexes. A greater proportion of persons in the Francophone minority aged 30 to 49 report having thought about suicide over their lifetime (17%) than persons in the other age groups. In 2002, the 15-to-29 age group had the highest rate. However, because of small numbers, these proportions have to be interpreted with caution due to the high variability in the estimates.

In 2012, nearly twice as many people in the Francophone minority living in urban areas reported having suicidal thoughts compared with people in rural areas (14.6% vs. 7.9%), while in 2002 the difference between the two groups was less significant (14.6% vs. 11.4%).

Table 3.19

PERCENTAGE OF PERSONS HAVING HAD SUICIDAL IDEATION IN THEIR LIFETIME, ACCORDING TO CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE QUEBEC AND CANADA AS A WHOLE, 2002 AND 2012

	SUICIDAL IDEATION OVER A LIFETIME			
	2002		2012	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	13.5	[10.5 ; 16.5]	10.5	[6.8 ; 14.1] [E]
Female	13.7	[10.9 ; 16.6]	14.5	[8.7 ; 20.4] [E]
AGE				
15-29 years	19.9	[13.9 ; 25.9]	11.4	[4.2 ; 18.7] [E]
30-49 years	14.2	[10.9 ; 17.5]	17	[8.2 ; 25.8] [E]
50 and over	10.1	[7.5 ; 12.6]	10.4	[6.8 ; 14] [E]
MARITAL STATUS				
Married/common law	11.8	[9.2 ; 14.4]	10.9	[6.1 ; 15.7] [E]
Widowed/separated/divorced	17.6	[13.1 ; 22.1]	14.9	[8.6 ; 21.1] [E]
Single	16.7	[12.5 ; 20.8]	18.6	[10.9 ; 26.4] [E]

EDUCATION				
< High school diploma	13.7	[10.2 ; 17.2]	12.4	[6.1 ; 18.6] E
High school diploma	15.8	[10.2 ; 21.3] E	12.9	[5 ; 20.8] E
Postsecondary or college diploma	14.6	[11.1 ; 18.2]	14.9	[7.4 ; 22.3] E
University degree	9.9	[5.8 ; 14.1] E	9	[3.9 ; 14.1] E
HOUSEHOLD INCOME LEVEL				
Quintile 1 – lowest	ND	...	13.9	[7.9 ; 19.8] E
Quintile 2	ND	...	10.9	[4.5 ; 17.4] E
Quintile 3	ND	...	19.2	[7 ; 31.5] E
Quintile 4	ND	...	11.4	[5.6 ; 17.1] E
Quintile 5 – highest	ND	...	7.6	[2.9 ; 12.3] E
LIVING ENVIRONMENT				
Urban	14.6	[11.8 ; 17.5]	14.6	[9.8 ; 19.3] E
Rural	11.4	[8.4 ; 14.3]	7.9	[4.7 ; 11.2] E
EMPLOYED [1, 2]				
Yes	ND	...	14.3	[8.9 ; 19.8] E
No	ND	...	11.6	[7.3 ; 15.9] E
LIVING ALONE				
Yes	18.5	[14.4 ; 22.7]	18.2	[12.3 ; 24]
No	12.9	[10.4 ; 15.3]	11.6	[7.5 ; 15.7] E
Francophone minority (outside QC)	13.6	[11.5 ; 15.7]	12.7	[9.1 ; 16.2]
Anglophone majority (outside QC)	13	[12.5 ; 13.5]	11.8	[11 ; 12.5]
All of Canada	13.4	[12.9 ; 13.9]	11.9	[11.3 ; 12.5]

1. In the week preceding the interview
2. Excluding persons over age 75

ND No data available
... Not applicable
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

IN THE 12 MONTHS PRECEDING THE SURVEY

The proportion of the Francophone minority population having had suicidal ideation in the 12 months preceding the survey was approximately 3.8% in 2012 and 3.7% in 2002. For Canada as a whole, these proportions were 3.3% and 3.7%, respectively.

A greater proportion of persons in the Francophone minority aged 15 to 29 report having had thoughts of suicide than persons in the other age groups over the 12 months preceding the survey, both in 2012 and in 2002 (5.6% and 7%, respectively).

However, it is important to mention that most of the estimates in Table 3.20 are imprecise due to small numbers, and are provided for information purposes only.

Table 3.20

PERCENTAGE OF PERSONS HAVING HAD SUICIDAL IDEATION IN THE 12 MONTHS PRECEDING THE SURVEY, ACCORDING TO CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITY AND ANGLOPHONE MAJORITY OUTSIDE QUEBEC AND CANADA AS WHOLE, 2002 AND 2012				
	SUICIDAL IDEATION IN THE 12 MONTHS PRECEDING THE SURVEY			
	2002		2012	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	3.5	[1.9 ; 5] [E]	3.8	[1.7 ; 5.9] [E]
Female	3.8	[2.4 ; 5.3] [E]	3.8	[0.8 ; 6.8] [F]
AGE				
15-29 years	7	[3.1 ; 10.8] [E]	5.6	[-1.2 ; 12.3] [F]
30-49 years	3.6	[1.9 ; 5.4] [E]	3.2	[0.9 ; 5.5] [F]
50 and over	2.1	[1.2 ; 3.1] [E]	3.6	[1 ; 6.1] [F]
MARITAL STATUS				
Married/common law	2.5	[1.3 ; 3.6] [E]	2.7	[0.7 ; 4.6] [F]
Widowed/separated/divorced	6.3	[3.1 ; 9.4] [E]	6.5	[1 ; 12] [F]
Single	5.6	[2.8 ; 8.4] [E]	5.2	[0.9 ; 9.5] [F]
EDUCATION				
< High school diploma	ND	...	ND	...
High school diploma	ND	...	ND	...
Postsecondary or college diploma	ND	...	ND	...
University degree	ND	...	ND	...
HOUSEHOLD INCOME LEVEL				
Quintile 1 – lowest	ND	...	3.2	[1.1 ; 5.2] [E]
Quintile 2	ND	...	3.8	[0.6 ; 6.9] [F]
Quintile 3	ND	...	7.3	[0.1 ; 14.4] [F]
Quintile 4	ND	...	2.6	[0.2 ; 5] [F]
Quintile 5 – highest	ND	...	1.7	[-0.6 ; 4] [F]
LIVING ENVIRONMENT				
Urban	4	[2.5 ; 5.4]	4.6	[2.1 ; 7.1]
Rural	3	[1.5 ; 4.4]	1.6	[0.3 ; 3] [F]
EMPLOYED [1, 2]				
Yes	ND	...	3.2	[0.8 ; 5.6] [F]
No	ND	...	5.3	[1.8 ; 8.8] [F]
LIVING ALONE				
Yes	4.7	[2.5 ; 6.9] [E]	6.5	[2.1 ; 10.8] [F]
No	3.5	[2.3 ; 4.8] [E]	3.3	[1.2 ; 5.3] [E]
Francophone minority (outside QC)	3.7	[2.5 ; 4.8]	3.8	[1.9 ; 5.6] [E]
Anglophone majority (outside QC)	3.6	[3.3 ; 3.9]	3.5	[3.1 ; 4]
All of Canada	3.7	[3.4 ; 4]	3.3	[3 ; 3.7]

1. See notes on the following page.

1. In the week preceding the interview
2. Excluding persons over age 75

ND No data available
x Confidential data
... Not applicable
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only, since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

3.2.3.2 Attempted suicide

WHAT IS BEING MEASURED?

The fact of having attempted suicide over a lifetime and in the 12 months preceding the survey is being measured for all survey participants.

> Q. [Over the reference period] have you attempted suicide?
>
> A. Yes, no

Comparison with *CCHS — Mental Health, 2002:* Indicator is comparable.

WHAT DO THE RESULTS SAY?

LIFETIME

The proportion of the Francophone minority population having attempted suicide in their lifetime was about 2.2% in 2012 and 4.6% in 2002. The difference in proportions with the Anglophone majority outside Quebec was statistically significant in 2002 (3%) but dwindled over the years.

Other than the overall prevalence, most of the estimates presented in Table 3.21 are imprecise due to small numbers and are provided for information purposes only.

OVER 12 MONTHS

Due to the imprecision in the estimates of suicide attempts in the 12 months preceding the survey, and due to small numbers, the results for this reference period are not presented.

Tableau 3.21

PERCENTAGE OF PERSONS HAVING ATTEMPTED SUICIDE IN THEIR LIFETIME, ACCORDING TO CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 AND OVER, FRANCOPHONE MINORITIES AND ANGLOPHONE MAJORITY OUTSIDE QUEBEC AND CANADA AS A WHOLE, 2002 AND 2012

	LIFETIME SUICIDE ATTEMPTS			
	2002		2012	
	%	Confidence interval (95%)	%	Confidence interval (95%)
SEX				
Male	4.2	[2.4 ; 6] E	2.2	[0.8 ; 3.6] F
Female	5.1	[3.4 ; 6.7]	2.2	[0.8 ; 3.7] E
AGE				
15-29 years	5.3	[2.1 ; 8.5] E	1.7	[-0.1 ; 3.4] F
30-49 years	6.1	[3.8 ; 8.4] E	4.1	[1.1 ; 7] F
50 and over	2.9	[1.5 ; 4.2] E	1.3	[0.4 ; 2.1] F
MARITAL STATUS				
Married/common law	4.5	[2.8 ; 6.1] E	0.9	[0.3 ; 1.5] F
Widowed/separated/divorced	4.5	[2.4 ; 6.5] E	3.7	[1.1 ; 6.3] F
Single	5.6	[3.3 ; 7.9] E	7	[0.7 ; 13.2] F

EDUCATION				
< High school diploma	ND	...	ND	...
High school diploma	ND	...	ND	...
Postsecondary or college diploma	ND	...	ND	...
University degree	ND	...	ND	...
HOUSEHOLD INCOME LEVEL				
Quintile 1 – lowest	ND	...	ND	...
Quintile 2	ND	...	ND	...
Quintile 3	ND	...	ND	...
Quintile 4	ND	...	ND	...
Quintile 5 – highest	ND	...	ND	...
LIVING ENVIRONMENT				
Urban	4.9	[3.3 ; 6.6] E	2.2	[0 ; 3.4] E
Rural	4	[1.9 ; 6.1] E	2.2	[0.2 ; 4.1] F
EMPLOYED [1, 2]				
Yes	ND	...	2.1	[0.8 ; 3.4] E
No	ND	...	2.8	[1 ; 4.6] E
LIVING ALONE				
Yes	7.1	[4.7 ; 9.6] E	4.7	[1.3 ; 8.1] F
No	4.3	[2.9 ; 5.6]	1.7	[0.7 ; 2.7] E
Francophone minority (outside QC)	4.6 **	[3.4 ; 5.8]	2.2	[1.2 ; 3.2] E
Anglophone majority (outside QC)	3	[2.7 ; 3.2]	3.2	[2.8 ; 3.7]
All of Canada	3.1	[2.9 ; 3.4]	3.1	[2.7 ; 3.4]

1. In the week preceding the interview
2. Excluding persons over age 75

x Confidential data
ND No data available
... Not applicable
** Significant difference from the Anglophone majority at the 5% threshold
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only, since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey – Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

THE TAKEAWAY

STRESS AND PSYCHOLOGICAL DISTRESS

In the Francophone minority population aged 15 and over (all other variables held constant) the survey shows that...

Far more persons in the Francophone minority suffering from one of the mental disorders measured in the survey score high on the psychological distress scale than persons with no such issues (see Table 3.15).

More persons in the Francophone minority living in low-income households (quintile 1) and more of those who are unemployed score high on the psychological distress scale than persons not in these situations. However, more employed persons report that most of their days are quite a bit or extremely stressful compared with unemployed persons (27.1% vs. 12.8%).

More persons in the Francophone minority who perceive their physical health as fair or poor, who usually experience pain or discomfort, and who have at least one chronic health problem score high on the psychological distress scale compared to persons without such issues. Further, a greater proportion of persons in the Francophone minority who perceive their physical health as fair or poor, who usually experience pain or discomfort, and who have at least one chronic health problem, report that most of their days are quite a bit or extremely stressful.

In 2012, as in 2002, higher psychological distress scale scores were observed in Francophone minority women than in men.

IN 2012... IN THE FRANCOPHONE MINORITY POPULATION

20.6% score high on the psychological distress scale

20.9% report that most of their days are quite a bit or extremely stressful

3.8% report having had suicidal ideation in the 12 months preceding the survey

2.2% report having attempted suicide in their lifetime

Chapter 4 – USE OF MENTAL HEALTH RESOURCES

Those wishing to obtain assistance for mental health issues can call upon either professional or non-professional resources. In the CCHS – Mental Health 2012, the questions in the "mental health services" module are aimed at gathering information on the use of both types of resources. In our analyses, professional resources include psychiatrists, family physicians/general practitioners, social workers/counsellors/psychotherapists, psychologists, nursing staff, and hospitalization. Non-professional resources, also called informal resources, include family members, friends, co-workers, supervisors or managers, teachers and school principals, employer-provided services, mutual support groups, telephone help lines and Internet use to find information on symptoms, resources and discussion forums.

While the dividing line between professional and informal resources may not always be clear, we must also bear in mind that the two resource categories do not always make it possible to determine whether services were used under the public or private health and social services system. In Quebec, for example, psychologists and social workers are just as readily available in the private network as in the public system. It is also not inconceivable that professionals are consulted in what could be considered informal resources. As a result, the survey cannot provide much clarity with regard to the location and context under which the various resources were used.

Moreover, a number of other elements must be considered with regard to the limitations of the statistical information in this section. First, the prevalence rates are likely underreported, as only some mental disorders were measured in the CCHS – Mental Health 2012 and institutionalized people were excluded from the population. Second, in an article using data from the CCHS – Mental Health 2012, Statistics Canada analysts highlighted that the data on self-reported use of mental health resources is subject to social desirability bias and recall bias, leading to an underestimation of the studied behaviour (Findlay and Sutherland, 2014). Therefore, if the self-reported data on use of professional services, including hospitalization for mental health reasons, were to be compared with the data from administrative records, a notable difference would likely be observed.

In this chapter, the data on the use of professional or non-professional help in the 12 months prior to the survey interview were cross-tabulated with sociodemographic characteristics, some mental disorders or substance use disorders experienced over the same period, and a few physical health characteristics.

Despite the above-mentioned limitations and the fact that provincial numbers do not allow for more elaborate analyses, this chapter sheds light on the use of professional and non-professional resources. For example, it allows us to estimate the proportion of people who have sought help for emotional, mental health, or alcohol or drug use issues in the entire Francophone population outside of Quebec aged 15 and over and among people affected by the mental disorders measured in the survey. Identifying which professionals and members of their entourage were most called upon is also of interest.

4.1 Health professionals and hospitalization

4.1.1 Consultation of health professionals and hospitalization

WHAT IS BEING MEASURED?

We measured whether a person aged 15 years and over consulted at least one health professional or was hospitalized for problems related to emotions, mental health or drug or alcohol use in the 12 months preceding the survey. The health professionals targeted in the survey were psychiatrists, family physicians or general practitioners, psychologists, nursing staff, social workers, counsellors, and psychotherapists.

No comparison possible with the CCHS — Mental Health 2002: The questions and answer options are different.

WHAT DO THE RESULTS SAY?

SOCIODEMOGRAPHIC CHARACTERISTICS

For the entire minority Francophone population

Within the minority Francophone population aged 15 and over, 12.6% of people were hospitalized or consulted at least one health professional for problems related to emotions, mental health, or alcohol or drug use. This proportion was 11.2% for the Anglophone majority outside of Quebec and 10.8% for Canada as a whole.

Sex and age

Francophone minority women were more likely to be hospitalized or consult a health professional for problems related to emotions, mental health, or alcohol or drug use than Francophone minority men (14.3% vs. 10.7%).

Francophone minority people aged 30-49 were more likely to consult a health professional or to be hospitalized for problems related to emotions, mental health, or alcohol or drug use.

Marital status

Single people in the Francophone minority were more likely to consult a health professional or to be hospitalized for problems related to emotions, mental health, or alcohol or drug use.

Education

Low-educated minority people are the least likely to have seen a health professional or to be hospitalized for emotional, mental health, or substance use problems.

Household income level

People in the Francophone minority in the lowest income quintile are the most likely to have seen a health professional or to be hospitalized for emotional, mental health, or substance use problems.

Living environment

In 2012, Francophone minority persons living in urban areas were more likely than those living in rural areas to consult a health professional or to be hospitalized for problems related to emotions, mental health, or alcohol or drug use (14.3% vs. 8.3%).

Table 4.1

PROPORTION OF PEOPLE HOSPITALIZED OR WHO CONSULTED[1, 2] AT LEAST ONE HEALTH PROFESSIONAL[3] BASED ON CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 YEARS OR OLDER, FRANCOPHONE MINORITY, ANGLOPHONE MAJORITY OUTSIDE OF QUEBEC AND IN CANADA AS A WHOLE, 2012

	%	Confidence interval (95%)
SEX		
Male	10.7	[6.5 ; 14.8] E
Female	14.3	[9.8 ; 18.7]
AGE		
15-29 years	7.5	[3.3 ; 11.6] E
30-49 years	16.7	[10.2 ; 23.2] E
50 and over	11.7	[7.1 ; 16.3] E
MARITAL STATUS		
Married/common law	12.6	[8.5 ; 16.6]
Widowed/separated/divorced	11.9	[6 ; 17.8] E
Single	14.1	[7.5 ; 20.7] E
EDUCATION		
< High school diploma	6.9	[3.1 ; 10.6] E
High school diploma	14.4	[5.1 ; 23.8] E
Postsecondary or college diploma	14.1	[8.5 ; 19.7] E
University degree	14.4	[7.8 ; 21] E
HOUSEHOLD INCOME LEVEL		
Quintile 1 – lowest	18.2	[10.3 ; 26.1] E
Quintile 2	12.5	[5.2 ; 19.8] E
Quintile 3	11.2	[2.3 ; 20.1] F
Quintile 4	15.7	[8.1 ; 23.2] E
Quintile 5 – highest	6.9	[2.9 ; 10.9] E
LIVING ENVIRONMENT		
Urban	14.3	[10.2 ; 18.4]
Rural	8.3	[5 ; 11.7] E
EMPLOYED[4, 5]		
Yes	11.5	[7.5 ; 15.5] E
No	14.4	[8.8 ; 20.1] E
LIVING ALONE		
Yes	13.4	[8.4 ; 18.4] E
No	12.4	[8.9 ; 16]
Francophone minority (outside QC)	12.6	[9.5 ; 15.7]
Anglophone majority (outside QC)	11.2	[10.5 ; 12]
All of Canada	10.8	[10.2 ; 11.5]

1. See notes on the following page.

1. Within the past 12 months
2. For issues related to emotions, mental health, or alcohol or drug use
3. Psychiatrist, family physician/general practitioner, psychologist, nursing staff, social worker/counsellor/psychotherapist
4. In the week preceding the interview
5. Excluding persons over age 75

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

MENTAL DISORDERS AND SUBSTANCE USE DISORDERS

People from the Francophone minority who presented a mental disorder, a substance use disorder, or who experienced both situations were more likely to have consulted at least one health professional or to have been hospitalized than people who did not experience both situations.

While nearly two thirds (63.7%) of people from the Francophone minority who presented a mental disorder sought help from a health professional, only around a quarter (24.6%) of people affected by substance abuse or addiction sought this kind of help.

Table 4.2

PROPORTION OF PEOPLE HOSPITALIZED OR WHO CONSULTED[1, 2] AT LEAST ONE HEALTH PROFESSIONAL[3] BASED ON CERTAIN MENTAL DISORDERS[4] AND SUBSTANCE USE DISORDERS,[5] FRANCOPHONE POPULATION OUTSIDE OF QUEBEC AGED 15 YEARS OR OLDER, 2012

		%	Confidence interval (95%)
MENTAL HEALTH DISORDER[4]			
Yes		63.7	[45.7 ; 81.6]
No		9.5	[6.5 ; 12.5]
	DEPRESSION		
	Yes	71.6	[52.3 ; 90.9]
	No	9.5	[6.6 ; 12.4]
	BIPOLAR DISORDER		
	Yes	x	...
	No	x	...
	GENERALIZED ANXIETY DISORDER		
	Yes	86.4	[72 ; 100.8]
	No	10.9	[7.9 ; 13.9]
SUBSTANCE USE DISORDER[5]			
Yes		24.6	[7.2 ; 42] F
No		12.3	[9 ; 15.5]
MENTAL DISORDER OR SUBSTANCE USE DISORDER[4, 5]			
Yes		50.6	[34.4 ; 66.7]
No		9.1	[6.1 ; 12.2] E

1. See notes on the following page.

1. Within the past 12 months
2. For issues related to emotions, mental health, or alcohol or drug use
3. Psychiatrist, family physician/general practitioner, psychologist, nursing staff, social worker/counsellor/psychotherapist
4. Depressive episode, bipolar disorder or generalized anxiety disorder
5. Alcohol, cannabis or other drug abuse or addiction

x Confidential data
... Not applicable
E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

PHYSICAL HEALTH CHARACTERISTICS

People from the Francophone minority who:

» assessed their physical health as being fair or poor;

» engaged in moderate or high-intensity exercise within the past seven days;

» had at least one chronic health condition;

» experienced activity-limiting pain or discomfort;

were more likely to have consulted at least one health professional or to have been hospitalized than people in the other categories for these indicators.

Table 4.3

PROPORTION OF PEOPLE HOSPITALIZED OR WHO CONSULTED[1,2] AT LEAST ONE HEALTH PROFESSIONAL[3] BASED ON CERTAIN PHYSICAL HEALTH CHARACTERISTICS, FOR THE FRANCOPHONE POPULATION OUTSIDE OF QUEBEC AGED 15 YEARS OR OLDER, 2012

	%	Confidence interval (95%)
PERCEIVED PHYSICAL HEALTH		
Poor or fair	20.7	[11.9 ; 29.4] E
Good	12.7	[6.4 ; 18.9] E
Very good or excellent	10.3	[6.2 ; 14.4] E
PHYSICAL ACTIVITY		
Yes	13.4	[9.5 ; 17.2]
No	10.5	[6.1 ; 15] E
CHRONIC HEALTH CONDITION[4]		
Yes	18.8	[14.2 ; 23.4]
No	2.5	[0.8 ; 4.2] F
PAIN OR DISCOMFORT		
No pain	10	[6.8 ; 13.1]
Pain does not restrict or hardly restricts activities	20.1	[10.5 ; 29.6] E
Pain greatly restricts activities[5]	26.4	[9.3 ; 43.5] E

1. Within the past 12 months
2. For issues related to emotions, mental health, or alcohol or drug use
3. Psychiatrist, family physician/general practitioner, psychologist, nursing staff, social worker/counsellor/psychotherapist
4. At least one chronic health problem
5. This category includes the answer choices "many" and "most" in reference to activities prevented by usually experienced pain or discomfort

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

4.1.2 Which resources were consulted?

WHAT IS BEING MEASURED?

Among the entire Francophone population outside of Quebec aged 15 years or older who consulted at least one professional resource for problems relating to emotions, mental health, or alcohol or drug use, we measured the proportion of people who consulted a psychiatrist, family physician or general practitioner, psychologist, nursing staff member, or social worker/counsellor/psychotherapist, as well as the proportion of people hospitalized in the 12 months preceding the survey.

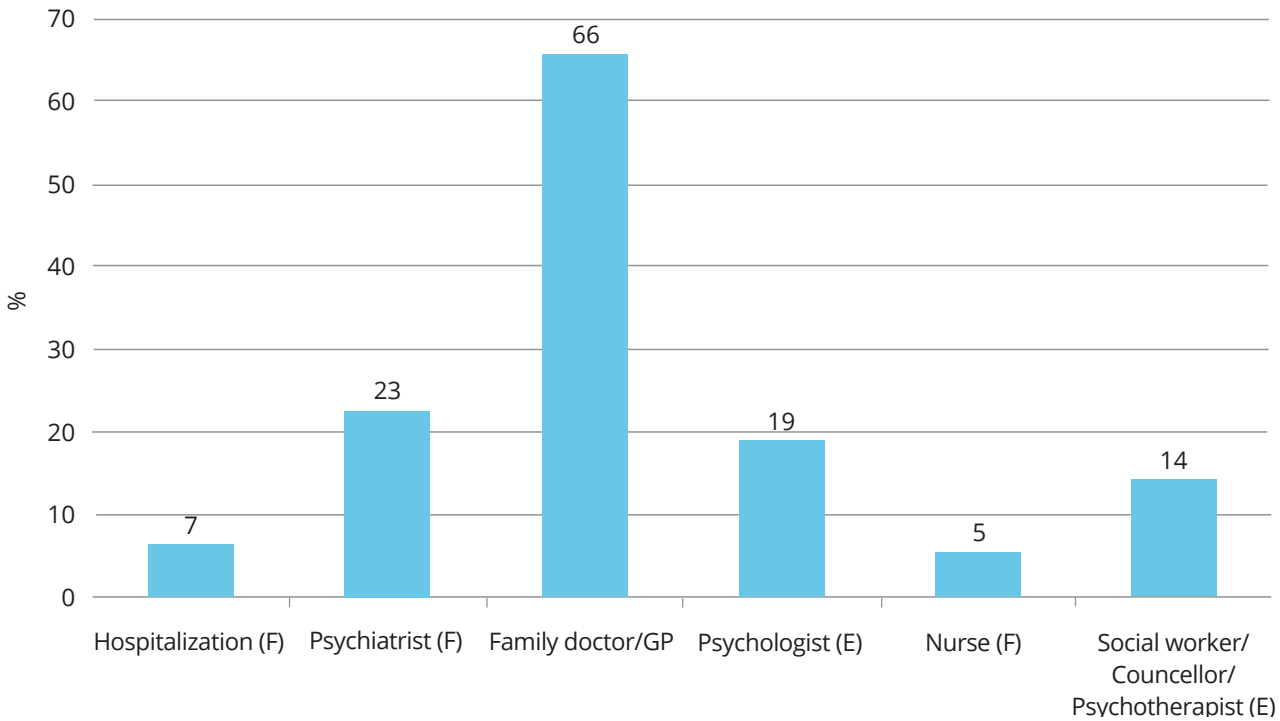
No comparison possible with the CCHS – Mental Health 2002: The questions and answer options are different.

WHAT DO THE RESULTS SAY?

When we look at consultation of at least one health professional for mental health-related problems in the minority Francophone population aged 15 years or older, family physicians/general practitioners (66%) are consulted the most often, followed by psychiatrists (23%) and psychologists (19%).

Figure 4.1

PROPORTION OF PEOPLE HOSPITALIZED OR WHO CONSULTED[1,2,3] A HEALTH PROFESSIONAL BASED ON RESOURCE TYPE, FRANCOPHONE POPULATION OUTSIDE OF QUEBEC AGED 15 YEARS OR OLDER AND WHO CONSULTED AT LEAST ONE RESOURCE, 2012



1. Within the past 12 months
2. For issues related to emotions, mental health, or alcohol or drug use
3. A person may use more than one resource

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

4.2. Assistance from a member of their entourage or an informal resource

4.2.1 Seeking assistance from a member of their entourage or an informal resource

WHAT IS BEING MEASURED?

Within the Francophone population outside of Quebec aged 15 and over, we measured whether an individual sought assistance from at least one member of their entourage or from an informal resource for problems related to emotions, mental health, or alcohol or drug use in the 12 months preceding the survey.

For the purpose of the study, members of a person's entourage were considered to be family members, friends, co-workers, supervisors or bosses, teachers and school principals. Informal resources were identified as support groups, telephone help lines, employee assistance programs, and using the Internet to find information on symptoms and resources as well as to post in discussion forums[1].

No comparison possible with the CCHS – Mental Health 2002: The questions and answer options are different.

WHAT DO THE RESULTS SAY?

SOCIODEMOGRAPHIC CHARACTERISTICS

For the entire minority Francophone population

In 2012, 14.9% of the minority Francophone population aged 15 years or older sought assistance from at least one member of their entourage or from an informal resource for problems related to emotions, mental health, or alcohol or drug use. The proportion was 16% for all Canadians aged 15 and over and 17.2% for the Anglophone majority outside of Quebec.

Sex and age

Women from the Francophone minority were more likely to involve people from their social environment or informal resources than men (17.7% vs. 11.6%).

The Francophone minorities 15-29 age group was the most likely to seek assistance from someone in their entourage or from an informal resource (23.6%). This proportion decreased as age increased; thus, the proportions are 20.9% for the 30-49 age group and 8.7% for the 50-plus age group.

Marital status

Widows/separated/divorced from the Francophone minority are more likely to seek assistance in their entourage or from an informal resource (21.3%) than couples (13.6% and single 10.8%)

Living environment

It is urban people who are more likely to consult someone close to them or an informal resource (17.2%) than people in rural areas (9.3%)

Table 4.4

PROPORTION OF PEOPLE WHO SOUGHT ASSISTANCE FROM AT LEAST ONE PERSON IN THEIR ENTOURAGE OR FROM AN INFORMAL RESOURCE[1,2] BASED ON CERTAIN SOCIODEMOGRAPHIC CHARACTERISTICS, POPULATION AGED 15 YEARS OR OLDER, FRANCOPHONE MINORITIES, ANGLOPHONE MAJORITY OUTSIDE OF QUEBEC AND IN CANADA AS A WHOLE, 2012

	%	Confidence interval (95%)
SEX		
Male	11.6	[7.2 ; 16] E
Female	17.7	[12.9 ; 22.5]
AGE		
15-29 years	23.6	[14.7 ; 32.4] E
30-49 years	20.9	[13.9 ; 27.8] E
50 and over	8.7	[4.6 ; 12.8] E

1. Employee assistance programs were considered as informal resources by Statistics Canada.

MARITAL STATUS		
Married/common law	13.6	[9.2 ; 18]
Widowed/separated/divorced	21.3	[13.8 ; 28.8] E
Single	10.8	[4 ; 17.6] E
EDUCATION		
< High school diploma	10.6	[5.2 ; 16.1] E
High school diploma	16	[5.5 ; 26.4] F
Postsecondary or college diploma	15.1	[9.4 ; 20.7] E
University degree	18	[10.6 ; 25.5] E
HOUSEHOLD INCOME LEVEL		
Quintile 1 – lowest	17.1	[9.5 ; 24.6] E
Quintile 2	13.4	[5.2 ; 21.6] E
Quintile 3	19.7	[9.4 ; 30] E
Quintile 4	14	[7.3 ; 20.7] E
Quintile 5 – highest	10.3	[5 ; 15.7] E
LIVING ENVIRONMENT		
Urban	17.2	[12.9 ; 21.5]
Rural	9.3	[5.2 ; 13.3] E
EMPLOYED[3, 4]		
Yes	15.3	[10.9 ; 19.7]
No	16.3	[10.3 ; 22.2] E
LIVING ALONE		
Yes	10.6	[5.4 ; 15.7] E
No	15.8	[11.9 ; 19.8]
Francophone minority (outside QC)	14.9	[11.6 ; 18.2]
Anglophone majority (outside QC)	17.2	[16.3. 18.2]
All of Canada	16	[15.3 ; 16.8]

1. Within the past 12 months
2. For issues related to emotions, mental health, or alcohol or drug use
3. In the week preceding the interview
4. Excluding persons over age 75

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

MENTAL DISORDERS AND SUBSTANCE USE DISORDERS

Francophone minority persons suffering from a mental disorder, a substance use disorder, or both were more likely to seek assistance from a member of their entourage or an informal resource than were people unaffected by these issues.

Table 4.5

PROPORTION OF PEOPLE WHO SOUGHT ASSISTANCE FROM AT LEAST ONE PERSON IN THEIR ENTOURAGE OR FROM ONE INFORMAL RESOURCE[1,2] BASED ON CERTAIN MENTAL DISORDERS [3] OR SUBSTANCE USE DISORDERS,[4] FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 YEARS OR OLDER, 2012

		%	Confidence interval (95%)
MENTAL DISORDER			
Yes		67.9	[51.6 ; 84.2]
No		11.6	[8.5 ; 14.7]
	DEPRESSION		
	Yes	79.2	[64.3 ; 94.1]
	No	11.4	[8.4 ; 14.5]
	BIPOLAR DISORDER (12 MONTHS)		
	Yes	x	...
	No	x	...
	GENERALIZED ANXIETY DISORDER (12 MONTHS)		
	Yes	83	[65.6 ; 100.4]
	No	13.3	[10.1 ; 16.5]
SUBSTANCE USE DISORDER			
Yes		31.9	[9.7 ; 54] F
No		14.3	[11 ; 17.6]
MENTAL DISORDER OR SUBSTANCE USE DISORDER			
Yes		55.9	[40.7 ; 71.2]
No		10.9	[7.9 ; 13.9]

1. Within the past 12 months
2. For issues related to emotions, mental health, or alcohol or drug use
3. Depressive episode, bipolar disorder or generalized anxiety disorder
4. Alcohol, cannabis or other drug abuse or addiction

x Confidential data
... Not applicable
F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

PHYSICAL HEALTH CHARACTERISTICS

Francophone minority persons who:

- rated their physical health as good;
- engaged in moderate or high-intensity exercise within the past seven days;
- had at least one chronic health condition;
- typically experienced pain or discomfort;

were more likely to seek assistance from a person in their entourage or from an informal resource than people who rated their physical health as excellent or very good and those with no chronic health conditions.

However, due to small numbers, these estimates must be interpreted with caution owing to the high variability in the estimates.

Table 4.6

PROPORTION OF PEOPLE WHO SOUGHT ASSISTANCE FROM AT LEAST ONE PERSON IN THEIR ENTOURAGE OR FROM AN INFORMAL RESOURCE[1, 2] BASED ON CERTAIN PHYSICAL HEALTH CHARACTERISTICS, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 YEARS OR OLDER, 2012

	%	Confidence interval (95%)
PERCEIVED PHYSICAL HEALTH		
Poor or fair	15	[7.4 ; 22.6] E
Good	18.5	[11.6 ; 25.3] E
Very good or excellent	12.7	[8.3 ; 17.1] E
PHYSICAL ACTIVITY		
Yes	16.7	[12.5 ; 20.9]
No	9.9	[4.6 ; 15.2] E
CHRONIC HEALTH CONDITION[3]		
Yes	18.4	[13.7 ; 23.1]
No	9.3	[5 ; 13.6] E
PAIN OR DISCONFORT		
No pain	13.8	[10.3 ; 17.3]
Pain does not restrict or hardly restricts activities	18.2	[8.4 ; 28] E
Pain greatly restricts activities[4]	20.1	[3.9 ; 36.4] F

1. Within the past 12 months
2. For issues related to emotions, mental health, or alcohol or drug use
3. At least one chronic health problem
4. This category includes the answer choices "many" and "most" in reference to activities prevented by usually experienced pain or discomfort

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

4.2.2 Where is assistance being sought?

WHAT IS BEING MEASURED?

Among the Francophone population outside of Quebec aged 15 years or older who, in the 12 months preceding the survey, sought assistance from at least one person in their entourage or from an informal resource for problems related to emotions, mental health, or alcohol or drug use, we measured the proportion of people who sought out the following resources: family members, friends, the Internet, support groups, help lines, co-workers, supervisors, teachers, school principals, or employee assistance programs.

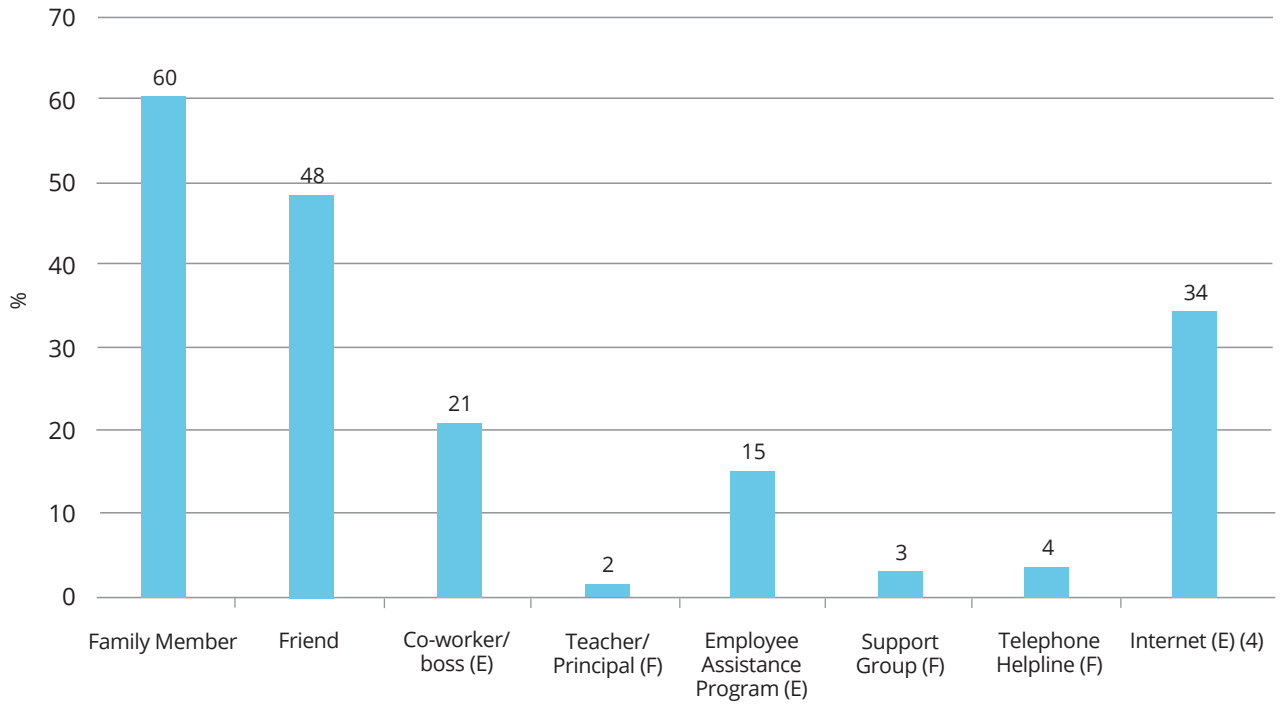
No comparison possible with the CCHS – Mental Health 2002: The questions and answer options are different.

WHAT DO THE RESULTS SAY?

Among the non-professional resources from whom Francophone minority persons sought assistance with mental health-related problems, the most commonly consulted resources were family members, friends, and the Internet, at 60%, 48%, and 34%, respectively.

Figure 4.2

PROPORTION OF PERSONS SEEKING ASSISTANCE FROM AT LEAST ONE PERSON IN THEIR ENTOURAGE OR FROM ONE INFORMAL RESOURCE[1,2,3] BASED ON THE PERSON OR RESOURCE CONSULTED, FRANCOPHONE POPULATION OUTSIDE QUEBEC AGED 15 YEARS OR OLDER WHO INVOLVED AT LEAST ONE RESOURCE, 2012



1. Within the past 12 months
2. For issues related to emotions, mental health, or alcohol or drug use
3. A person may use more than one resource
4. Use of the Internet to find information on symptoms and resources or to post in discussion forums

E Coefficient of variation between 16.6% and 33.3%; interpret with caution due to high variability of estimates.

F Coefficient of variation above 33.3%; imprecise estimate provided for information purposes only since the data do not meet Statistics Canada's quality standards for this statistical program.

Source: Statistics Canada, *Canadian Community Health Survey on Mental Health*, 2012, microdata file. Adapted by Bouchard et al., 2019

THE TAKEAWAY

REGARDING THE USE OF MENTAL HEALTH RESOURCES

In 2012, the survey revealed that...

Francophone minority persons suffering from one of the mental or substance use disorders measured in the survey are more likely than those not experiencing such issues, to consult a professional resource, person from their entourage or informal resource for problems related to emotions, mental health, or alcohol or drug use.

People who typically experienced pain or discomfort and those with at least one chronic health condition were more likely than those without such issues to have consulted a professional mental health resource.

People who consulted health professionals most often turned to family physicians/general practitioners, psychiatrists, and psychologists.

People who consulted non-professional resources were more inclined to seek out friends or family members. Furthermore, in comparison to men, women were more likely to use both types of resources.

IN 2012, IN THE MINORITY FRANCOPHONE POPULATION...

12.6% of people consulted a health professional or were hospitalized for mental health or substance use-related problems

14.9% of people sought assistance from at least one person in their entourage or from an informal resource

8.2% of people used both professional and non-professional resources

CONCLUSION

This secondary analysis of the CCHS – Mental Health provides an overview of mental health in the Francophone official language minority population, a population that is rarely studied in itself, and also gauges the influence of some key social determinants. However, given the small size of the Francophone sample and the large amount of data that was kept confidential or involved high coefficients of variation, the findings must be interpreted with caution owing to the high variability in the estimates. Nevertheless, this report provides a snapshot of mental health in 2002 and 2012, which will allow us to broaden certain analyses to better understand the impact of minority community status on health and quality of services in the minority official language.

Over a lifetime, depression was the most prevalent mental disorder in both 2002 and 2012 (14%) in the Francophone minority and in comparison to the Anglophone majority outside of Quebec (11%). In terms of social determinants in the Francophone minority, the results indicate that, in line with national and international trends, women are more affected by depression and proportion rose slightly in 2012. Further, the 30-49 age group was the most affected in 2002, and that the 50-plus age group and people living in urban areas were most affected in 2012.

Among the substance use-related disorders over a lifetime, alcohol abuse or addiction was the most common condition, with a prevalence of approximately 19% in both the Francophone minority and the Anglophone majority. Men were more affected than women.

Overall, mental and substance use disorders are slightly more common among minority Francophones (38%) than among their Anglophone counterparts (33%); however, a statistically significant relationship could not be demonstrated.

The proportion of people perceiving their mental health as excellent or very good was similar for both populations in 2002 (65%), but slightly lower in 2012. In terms of social determinants in the Francophone minority, women, single people, those with the lowest education levels, low income earners, and those living alone were less likely to report having very good or excellent mental health. Similarly, people who reported chronic conditions did not feel that they had very good or excellent mental health.

The Francophone minority and Anglophone majority were also comparable in terms of the proportion who felt their ability to deal with the day-to-day demands of life was excellent or very good; in both 2002 and 2012, the proportion was approximately 67%. In terms of social determinants in the Francophone minority, women, people aged 50 and over, single people, those with the lowest education levels, people living alone, and those who were less well off and those living in rural areas were less likely to rate their ability to deal with day-to-day demands as excellent or very good. People who reported having a mental disorder, poor health, pain that greatly curtailed their activities, and chronic illnesses were less likely to rate their ability to deal with day-to-day demands was good.

In 2002, the sense of belonging to a community was significantly lower in the Francophone minority (55%) than in the Anglophone majority (61%); however, it rose for both groups in 2012 and the difference was no longer statistically significant. In terms of social determinants in the Francophone minority, in 2012, women, people aged 50 and up, single people, and people living in rural areas stated that they had a stronger sense of belonging to their community. People with a mental disorder, those dealing with cannabis abuse or addiction, or who were taking medication were less likely to express a strong or somewhat strong sense of belonging to their local community, as compared to persons not in those situations. However, people who reported alcohol abuse or addiction felt more strongly attached to their community.

In 2002, the proportion of Francophones outside of Quebec who scored high on the psychological distress scale was significantly higher (24%) than that in the Anglophone majority (16%). However, in 2012, the situation for the Francophone minority improved slightly (21%), while that of the Anglophone majority remained stable. In terms of social determinants in the Francophone minority in 2012, women, the 30-49 age group, people who were widowed, separated or divorced, those with the lowest levels of education, low income earners, and those living in urban areas were more likely to score high on the psychological distress scale. Unsurprisingly, people affected by mental disorders, people taking medication, and those with chronic illnesses were more likely to score high on the psychological distress scale.

In 2002, both the Francophone minority and the Anglophone majority stated that most of their days were quite a bit or extremely stressful at 23%. This figure dropped by a few points in 2012 (20%). In terms of social determinants in the Francophone minority, women, the 30-49 age group, people with the highest education levels, those at both extremes of the income scale, the employed, and those living in urban areas reported the highest levels of stress. This also held true for people who reported having a mental disorder and chronic health problems.

In 2002, the proportion of people who had suicidal thoughts over their lifetimes was comparable in the Francophone minority (13.6%) and Anglophone majority (13%). In 2012, the figure dropped by one point for both groups. In terms of social determinants in the Francophone minority, the people most likely to have suicidal thoughts over their lifetimes were women, the 15-29 age group in 2002 and the 30-49 age group in 2012, people with the lowest education levels as compared to the university educated, and people with the lowest income as compared to the higher income quintile and people living alone.

In 2002, suicide attempts were proportionately and significantly more common in the Francophone minority (5%) than in the Anglophone majority (3%). They decreased for the Francophone minority in 2012 (2%) but remained stable for the Anglophone majority. In 2012, in terms of social determinants in the Francophone minority, the 30-49 age group, single people and those living alone were more likely to have attempted suicide.

In 2012, use of formal resources (hospitals and health professionals) was fairly comparable between the Francophone minority (13%) and the Anglophone majority (11%). In terms of social determinants in the Francophone minority in 2012, women, the 30-49 age group, single people, those living in urban areas and the employed made more frequent use of these resources, as did those reporting a mental or substance use disorder. Family physicians were by far the formal resource consulted most often, followed by psychiatrists, psychologists, and social workers.

Use of informal resources (in the person's entourage) was also fairly comparable between the Francophone minority (15%) and the Anglophone majority (17%). In terms of social determinants in the Francophone minority, women, people who were widowed, separated or divorced, and those living in urban areas more often sought informal help, as did those reporting a mental or substance use disorder. Family members were the most frequently sought informal resource, followed by friends and the Internet.

A few studies demonstrated the difficulty minority Francophones experience in obtaining health and social services in their language (Drolet, Bouchard and Savard, 2017). The numerous reforms that have restructured health systems in recent decades were all aimed at better meeting the needs of populations and communities. At the bottom of the list was "making sure the right patient receives the right care at the right time." The response continues to be inadequate when it comes to minority Francophone communities, who grapple not only with the absence of health resources but also the lack of access to services in their language, which can impede or delay care and lead to misdiagnosis.

A number of experts feel that mental health and illnesses are unfortunately not deemed a priority in most health systems (McDaid et al., 2017; Vigo et al., 2016). Rigorous consideration of mental health would make it possible to place the emphasis on prevention models, timely care, improved access to proven treatments, eliminating inequalities, and incorporating social determinants into mental health care transformation, all in the official language of the individual's choice. It is a matter of equity and service quality.

REFERENCES

BARALDI, Rosanna, Katrina JOUBERT, and Monique BORDELEAU. *Portrait statistique de la santé mentale des Québécois : résultats de l'Enquête sur la santé dans les collectivités canadiennes – Santé mentale 2012*. Québec City : Institut de la statistique du Québec, 2015.

BOUCHARD Louise and Anne LEIS. "La santé en français." In Joseph-Yvon Thériault, Anne Gilbert and Linda Cardinal. *L'espace francophone en milieu minoritaire au Canada : nouveaux enjeux, nouvelles mobilisations*. Fides, 2008. Pp. 351-381

BOUCHARD, Louise, Isabelle GABOURY, Jean-Marie BERTHELOT, Marie-Hélène CHOMIENNE, Lise DUBOIS and Anne GILBERT. "La santé en situation linguistique minoritaire," Health Care Policy/Politiques de Santé, Vol. 4, No. 4, 2009. p. 37-42.

BOUCHARD, Louise and Martin DESMEULES. "Minorités de langue officielle du Canada : égales devant la santé ?", Québec City: Presses de l'Université du Québec, 2011.

CAMIRAND, H., and V. NANHOU. "La détresse psychologique chez les Québécois en 2005, Série Enquête sur la santé dans les collectivités canadiennes." *Zoom santé*. Institut de la statistique du Québec, 2008. 4 p.

CANADIAN INSTITUTE FOR HEALTH INFORMATION. *Exploring Positive Mental Health*. Ottawa, 95 p.

CARON, J. "Une validation de la forme abrégée de l'Échelle de provisions sociales : l'ÉPS-10 items." *Santé mentale au Québec*, vol. 38, nº. 1, 2013. p. 297-318.

COMMISSAIRE À LA SANTÉ ET AU BIEN-ÊTRE. *État de situation sur la santé mentale au Québec et réponse du système de santé et de services sociaux.* Québec City: Gouvernement du Québec, 2012. 232 p.

DIETRICH, Sandra, Stephanie DECKER, Martib CEYNOWA, Ulrich HEGRTL and Katarina STENGLER. "Depression in the workplace: a systematic review of evidence-based prevention strategies", *International Archives of Occupational and Environmental Health*. Vol. 85, Nº. 1, 2012. p. 1–11.

DROLET, Marie, Pier BOUCHARD and Jacinthe SAVARD (dir.). *Accessibilité et offre active : Santé et services sociaux en contexte linguistique minoritaire*. Presses de l'Université d'Ottawa.

FINDLAY, L. C., and A. SUNDERLAND. "Professional and informal mental health support reported by Canadians aged 15 to 24". *Health Reports*, vol. 25, nº. 12, nº. 82-003-X, p. 3-13, 2014.

JOUBERT, N. *Improving the Health of Canadians: Exploring Positive Mental Health. Additional article on the report from the Canadian Institute for Health Information*, CIHI, 2009. 33 p.

KESSLER R.C., ANDREWS G., COLPE L.J., HIRIPI E., MROCZEK D.K., NORMAND S.L., WALTERS E.E., and ZASLAVSKY A.M. "Short screening scales to monitor population prevalences and trends in non-specific psychological distress", *Psychological Medicine*, vol. 32, nº 6, 2002. p. 959–976.

KEYES, C. L. M. (2002). "The Mental Health Continuum: from languishing to flourishing in life", *Journal of Health and Social Behavior*, vol. 43, nº 2, p. 207–222.

LESAGE, A., F. BERNÈCHE, and M. BORDELEAU. *Étude sur la santé mentale et le bien-être des adultes québécois : une synthèse pour soutenir l'action*. Canadian Community Health Survey (Cycle 1.2). Québec City: Institut de la statistique du Québec, 2010. 104 p.

McDAID, David, Emily HEWLETT, and A-La PARK. "Understanding effective approaches to promoting mental health and preventing mental illness." *OECD Health Working Papers*, No. 97, 2017. Website: **http://dx.doi.org/10.1787/bc364fb2-en**. Accessed on February 7, 2018.

MENTAL HEALTH COMMISSION OF CANADA (MHCC). *Making the Case for Investing in Mental Health in Canada*. n.p.: The Commission, 2012.

MENTAL HEALTH COMMISSION OF CANADA (MHCC). *Strengthening the Case for Investing in Canada's Mental Health System*.

PEARSON, C., T. JANZ, and J. ALI. "Mental and substance use disorders in Canada." *Health at a Glance*. Statistics Canada, 2013. 8 p.

ROBERT, Glen, and Kelly GRIMES. "Return on Investment: Mental Health Promotion and Mental Illness Prevention." Canadian Policy Network at the University of Western Ontario and the Canadian Institute of Health Information, 2011.

RUST, Keith F., and Jon N.K. RAO. "Variance estimation for complex surveys using replication techniques", *Statistical Methods in Medical Research*, Vol. 5, Nº. 3, 1996. pp. 283-310.

SMETANIN, Paul, David STIFF, Carla BRIANTE, Carol E ADAIR, Sheeba AHMAD, and Minhal KHAN. The life and economic impact of major mental illness in Canada: 2011 to 2041. RiskAnalytica, 2011, for the Mental Health Commission of Canada.

STATISTICS CANADA (2017). *English, French and official language minorities in Canada*. 2016 Census of Population. Product catalog no. 98-200-X2016011.

STATISTICS CANADA (2013a). *CCHS – Mental Health: Data Dictionary Public Use Microdata File*, 2012. 338 p.

STATISTICS CANADA (2013b). *CCHS– Mental Health User Guide*. 206 p.

STATISTICS CANADA (2013c). *CCHS – Mental Health: Public Use Microdata File Derived Variable (DV) Specifications* 2012. 195 p.

VIGO, Daniel, Graham THORNICROFT, and Rifat ATUN. "Estimating the true burden of mental illness." Lancet Psychiatry, Vol.3, 2016. p.171-78.

WORLD HEALTH ORGANIZATION. *International Classification of Diseases (ICD)*. 1994. Website: **http://www.who.int/classifications/icd/en/**. Accessed on October 1, 2014.

WORLD HEALTH ORGANIZATION. *Mental health: a state of well-being*. 2014. Website: **https://www.who.int/features/factfiles/mental_health/en/.** Accessed on October 9, 2014.

WORLD HEALTH ORGANIZATION (WHO). *Mental health: a state of well-being*. 2014. Ref. from November 6, 2017. Website: **http://www.who.int/features/factfiles/mental_health/en/**