From Sea to Sea
Regional Trends in EAP in Canada

Insights from the Shepell·fgi Research Group

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From Sea to Sea: Regional Trends in EAP in Canada

Executive Summary

Canada is a vast nation of different physical, social, and economic environments. This rich diversity suggests that the health of Canadians is equally diverse. While the health status of Canadians has been profiled by national agencies, Shepell·fgi can add a layer of information by profiling the psychological, social, and physical health problems that Canadians present to their EAPs.

To understand Canada's health picture, we compared provinces and regions on the basis of EAP accesses over a 4-year period (2003-2006). Using multivariate techniques, we identified the health issues and demographic risk groups that are unique to each province.

Key findings:

- Each province accesses EAP at a rate that is roughly proportionate to its population. In other words, all provinces embrace EAP more or less equally.
- There is an clear 'East-West Divide', in that western clients access EAP more for critical, psychological issues, while central clients access more for practical, day-to-day worklife solutions for less serious issues.
- While each province is associated with unique issues, EAP clients in British Columbia, Alberta, and Quebec are presenting some issues with greater frequency.
- British Columbia showed more relationship (26% vs. 24% of issues for Canada), emotional (14% vs. 12% of issues for Canada), and addiction problems (alcohol: 1.4% vs. 1.2%; drug: 1.3% vs. 0.9% of issues for Canada). The latter two problems have also increased over time. EAP access, in general, is also increasing in British Columbia.
- Alberta showed more relationship (27% vs. 24% of issues for Canada) and addiction problems (alcohol: 2.0% vs. 1.2%; drug: 1.4% vs. 0.9% of issues for Canada). EAP access is also increasing in Alberta.
- Quebec showed more emotional (16% vs. 12% of issues for Canada), stress (19% vs. 16% of issues for Canada), and work-related problems (9% vs. 7% of issues for Canada). EAP access is also decreasing in Quebec.
- The maritime provinces, with the exception of New Brunswick, showed more gambling and debt/credit issues (e.g., for gambling, 0.8% for Newfoundland & Labrador vs. 0.3% of issues for Canada).
- There were even greater differences among regions identified by area code. For example, Montreal clients (514 area) reported depression, anxiety, or stress problems 32% of the time, compared to 20% for Greater Toronto Area clients (416 area).
- A significant link was found between EAP access and economic prosperity across provinces. When GDP increases, EAP accesses for emotional and stress problems decrease the following year. When EAP accesses increase for emotional and stress problems, GDP also increases the following year. The results suggest that widespread, general help-seeking and health levels are tied to national prosperity.

Some conclusions and recommendations::

- Our findings are corroborated by external research, suggesting that EAP research is sensitive enough to detect provincial and regional differences in health problems.
- Given the validity of our findings to profile 'real' national health issues, it stands to reason that Canadians are receiving the assistance they need, where and when needed, through EAP as a well-established health support and care system.
- Provincial and regional differences in EAP access are a testament to the strength of local health drivers. Thus, solutions must be crafted that are relevant to local workforces.
- Paradoxically, national EAPs may be one solution for addressing local health issues. National EAPs tend to manage a diverse range of issues, have the capacity to manage a large number of clients, and can arrive at a bigger picture of national health issues to more deeply inform both national and regional interventions.

It is estimated that by 2015, there will not be enough qualified people in Canada to fill available jobs due to the aging workforce and labour shortages. Employers are invited to benchmark their statistics against the current findings to guide their actions in regions where they have operations to attract, retain, and optimize available talent.

INTRODUCTION

Canada is a vast nation of different physical, social and economic environments. Since our health is intimately tied to these environments, the health status of Canadians should be equally diverse.

To understand this picture, we compared Canada's provinces and regions on the basis of EAP access patterns. We first present a national picture with high-level provincial and regional comparisons. We then present individual provincial profiles of presenting problems, trends, and at-risk groups. From this, we draw overarching conclusions and provide recommendations for both national and local employers.

The report also makes a compelling case for employee assistance programs with integrated health solutions as essential participants in health promotion across Canada.

Method

• The study was based on a sample of 149,291 employees in 1,088 organizations who accessed the EAP between 2003 and 2006.

• We excluded organizations from the study that joined or left the EAP during the study period to partially control for changing sample compositions that could affect the prevalence of study variables.

• Provinces and regions were identified from area codes supplied by EAP clients. Due to shared area codes, results are combined for some provinces and territories.

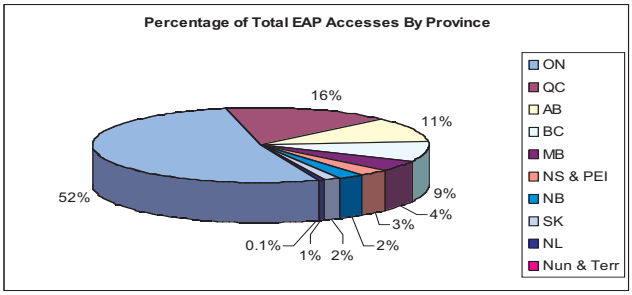
• Some problems were examined as composites. Personal and workplace stress comprise 'stress problems'. Marital/relationship discord, separation, and divorce comprise 'relationship problems'. Depression and anxiety symptoms comprise 'emotional problems'.

• Data analytic methods included Pearson chi-square analysis, classification and regression trees (CRT), and chi-squared automatic interaction detection (CHAID).

THE NATIONAL PICTURE

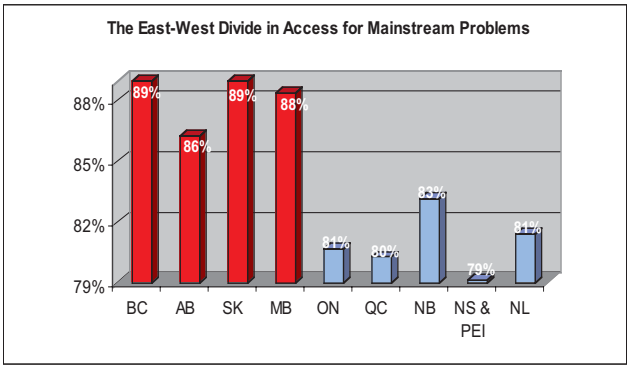
Provincial Differences in EAP Access

The most populous provinces account for the most EAP accesses. Clients in Ontario accounted for 52% of all accesses in the study. Together with Quebec (16%) and Alberta (11%), these three provinces account for over three quarters of all accesses. Provincial rankings for EAP access are more or less in line with rankings based on population size.



The East-West Divide

There is a clear east-west divide in the types of problems that Canadians present to EAPs. Clients in western provinces are more likely to present for mainstream services (86% to 89% of the time). Their counterparts in central provinces (i.e., Ontario and Quebec) are more likely to present for worklife programs (79% to 83% of the time; see below).[2]



Mainstream problems include classic psychological issues (e.g., personal, emotional, family, work). Worklife programs are practical resources that support people in various life domains (e.g., legal, financial, nutritional). Thus, western Canadians may be accessing

the EAP for more serious problems that require immediate intervention. Central Canadians may have the 'leisure' of accessing the EAP for worklife programs in the absence of more serious issues. Ironically, the use of worklife services by central Canadians may actually help prevent the kinds of serious problems that are more prevalent in the west.

How might we explain the east-west divide? It may be that Canadians in the west are less likely to live in large, urban centres. The average population density from British Columbia to Manitoba is 3.1 people per square kilometre. The requisite figure for Ontario and Quebec is 9.0 , and rises to11.8 when the Maritime provinces are included. The average percentage of rural citizens from British Columbia to Manitoba is 25%. For Ontario and Quebec, the percentage is 18%. Rural residents tend to report higher stress levels than their urban and suburban counterparts. This may stem, in part, from greater economic dependence on single, seasonal industries (e.g., farming). Resulting financial stressors can lead to depression, poor parenting practices, child-behavior problems, hostility, and marital dissatisfaction. Ironically, mental health services are limited in rural areas. Services that do exist in smaller communities are sometimes complicated by lack of client privacy, accidental meetings between clients and providers, and an increased likelihood of dual relationships among clients and providers.

Provinces vs. Regions

The east-west divide showed that there are clear, provincial differences in EAP presenting problems. However, we found that 'regions', by area code, are even better geographical indicators. While provinces are subject to consistent laws and social programs, each one is a collection of regions with a vast mosaic of different people, cultures, and topography.

Using a method called CHAID, we clustered EAP clients and their area codes on the basis of similar presenting problems. The clustered area codes were then examined for other things that they have in common (e.g., social, economic, geographic).

The findings:

• The combined 'non-metropolitan' regions of British Columbia and Quebec were more likely to report emotional problems than other regions (15% of clients within this cluster vs. 12% for Canada).

• The combined regions most likely to report emotional problems were Montreal, and Nunavut and the Territories (17% of clients within this cluster vs. 12% for Canada).

• The combined regions most likely to report stress problems were Montreal, Northwestern Ontario (e.g., Thunder Bay), Northeastern Quebec (e.g., Chicoutimi, Rimouski), and Nunavut and the Territories (21% of clients within this cluster vs. 16% for Canada).

• The combined regions most likely to report alcohol and drug problems included the Vancouver periphery (i.e., area code 778; 2.6% and 4% vs. 1.2% and 0.9% for Canada) and all of Alberta and Saskatchewan combined (2% and 1.3% vs. 1.2% and 0.9% for Canada).

The findings for 'non-metropolitan' and northern areas suggest a classic urban-rural difference in mental health. People living in less populous and under-developed areas may be more disconnected from social networks and services that are more abundant in urban centres.

Although not noted above, there were also general differences between Montreal and Toronto. Montreal has more in common with the far north, and less in common with the rest of Quebec in terms of negative emotions and higher levels of stress. In contrast, Toronto-area regions showed the fewest problems of any kind. For example, clients in the Toronto/416 area presented depression, anxiety, or stress problems 20% of the time, compared to their counterparts in the Montreal/514 area, who presented these problems 32% of the time.
One explanation of this division between Montreal and Toronto may lie with different municipal

governments and social services. For example, Toronto has the highest per capita spending of Canadian municipalities in this area. Toronto was also recently cited in an international study as the only Canadian city on a list of twelve 'well-rounded global cities'. Government spending and associated services may impact the quality of urban life.

PROVINCIAL PROFILES

The following are individual profiles for each province. Employers are invited to benchmark their own statistics against provinces where they have employees.

British Columbia

More likely to be :
• Part-time (17% vs. 11%).

More likely to report:
• Relationship (26% vs. 24%), emotional (14% vs. 12%), or addiction problems (alcohol: 1.4% vs. 1.2%; drug: 1.3% vs. 0.9%). The latter two have also increased over time.

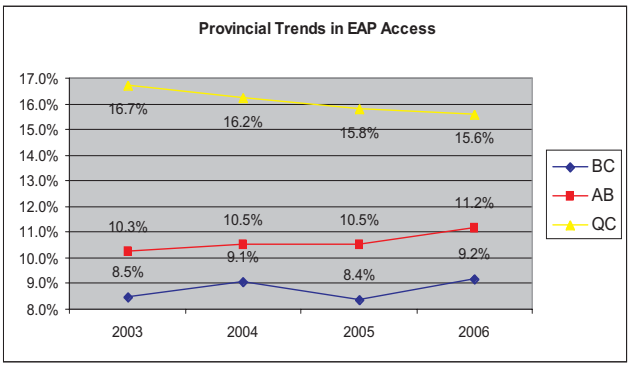
Other:
• Increasing EAP access relative to the national norm (from 8.5% to 9.2% of accesses).
• Increasingly more likely to have less than 1 year of service (from 14% to 18% within BC).
• Emotional Risk Group: < 30 years-old, < 5 years of service, and non-supervisory/professional
• Stress Risk Group: Women, 50+ years-old, and non-supervisory/professional.
• Addiction Risk Group: Men.

Other Research
The above findings are commensurate with community health research. British Columbia is associated with higher rates of alcohol and illicit drug dependence relative to the rest of the country, as well as the highest rate of any measured disorder or substance dependence. British Columbians also report the highest contact with services for emotional, mental health, or addiction problems, the lowest self-rated mental health, and the highest dissatisfaction with life. As an aside, British Columbians also report the highest job dissatisfaction rates in Canada (10.1% vs. 8.6% for Canada).

Overview
British Columbia is showing higher rates of addiction and emotional problems than the rest of Canada. Both are considered critical problems. These rates are also increasing, together with rates of newer employees. A further complication for the province is the higher proportion of part-time employees.

These findings could be problematic for employers who are currently riding a wave of prosperity. British Columbia has the second strongest provincial economy, the third-highest retail sales growth, and its first Triple A credit rating in two decades. Together with Alberta, British Columbia is poised to have the highest GDP for 2007. These current issues could dampen a thriving economy, especially if improvements are not made to BC healthcare.

While British Columbia is pegged as having the highest-quality healthcare system of the provinces, it also has some of the lowest patient satisfaction scores. In particular, British Columbians report the most difficulty accessing mental health services and the highest level of unmet mental health care needs. Perhaps as a result, British Columbia loses more days per worker to illness or disability than any other province (8.5 vs. 7.8 days for Canada). The increase of British Columbians among EAP access, noted above, may be a positive finding in that people are seeking and receiving the help they need. However, BC employers also must be vigilant in their efforts to support employees and prevent the emergence of critical health problems



Alberta

More likely to be:
• Men (48%vs 38%), under 30 years or age (27% vs. 20%for Canada), non-employees (21% vs. 17%), and with less than 1 year of service (25% vs. 14%; also increased from 23% to 27%).

More likely to report:
• Relationship (27% vs. 24% total) or addiction problems (alcohol: 2.0% vs. 1.2%; drug: 1.4% vs. 0.9%).

Other:
• Increasing EAP access relative to the national norm (from 10.3% to 11.2% of accesses).·
• *Emotional Risk Group*: < 30 years-old, < 1 year of service.
• *Stress Risk Group*: 50+ years-old, employee, and non-supervisory/professional.
• *Stress Risk Group*: < 30 years-old, and < 5 years service.
• *Addiction Risk Group*: Men, < 5 years of service.

Other Research

These findings, above, are corroborated elsewhere. The Alberta population has grown considerably – over 10% from 1996 to 2001. Only 51% of Albertans lived at the same address five years prior to 2001. This is striking in comparison with other provinces (e.g., 75% for Newfoundland and Labrador). A significant portion of this growth may be attributable to younger, out-of-province males working in natural resources and related sectors. As of 2001, Alberta had the lowest median age for both sexes. As such, we see more males, younger clients, and newer employees accessing EAP from Alberta. EAP access is also increasing along with provincial growth.

The prevalence of EAP access for addiction problems is understandable. Alberta has one of the highest rates of measured disorder or substance dependence. Twenty-one percent (21%) of total mortality in Alberta is due to addictive substances such as alcohol, tobacco and illicit drugs. Thirty-eight percent (38%) of Albertans have experienced verbal and/or physical abuse as a result of someone else's drinking.

Alberta also had higher rates of EAP access for gambling problems, but not significant enough to record above. External research suggests that 82% of Albertans gamble, with approximately 5% experiencing moderate to severe problems as a result. The average gambling expenditure per capita is highest in Alberta at $604 (vs. $447 for Canada). Gambling is a factor in 2% of suicides in Alberta. [xxiii]

Overview

The combination of strong growth and increasingly younger, male, and/or transient workers suggests significant challenges for Alberta employers. This is especially apparent from the risk groups, described above.

Our internal research shows greater rates of relationship problems in Alberta. External research implicates Alberta with the highest rates of major depressive disorder and reported suicidal thoughts in Canada. These discrepancies might be explained by co-morbidity. For example, interpersonal problems are often associated with depression, and depression is often co-morbid with addiction problems. Depending on when they access EAP, clients may present any one of these three related problems to EAP.

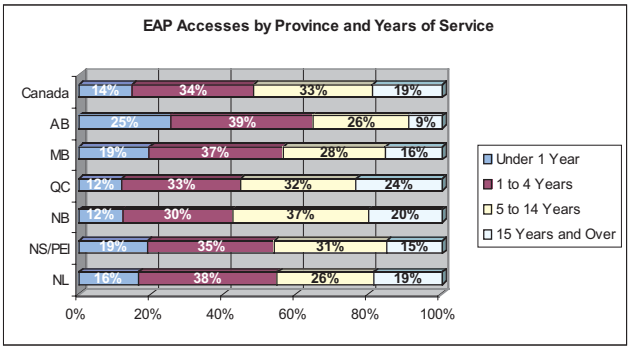
The following employee segments report a **lower** rate of relationship problems relative to the total sample (i.e., lower than 24% of accesses):

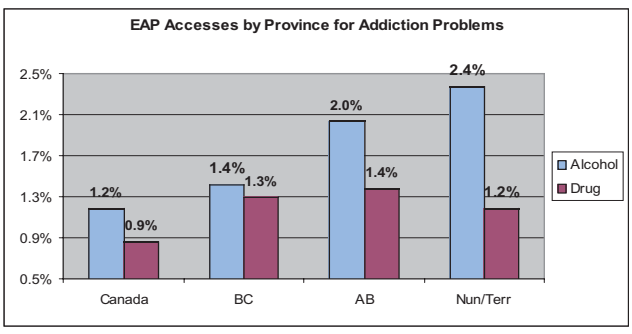
The link between relationship problems and depression cannot be overlooked. Many newer

employees and residents of Alberta may feel displaced and alienated in their new communities. Additionally, while workers can claim some connection to their co-workers, their spouses and dependents may lack similar social support networks. This is suggested by other research. Albertans show a lower sense of belonging to their community than other Canadians. They are also less likely to who know many or most of their neighbours. Overall, Albertans report lower mental health and life satisfaction than other Canadians.

Alberta is at a turning point, both demographically and economically. The province is poised to have the highest provincial GDP for 2007. However, a large part of this growth is resource-based. Labour shortages may hinder this growth. Part of the shortage may be blamed on attraction and retention issues and work stressors that are unique to the oil and gas industry. Relationship and addiction problems may further truncate growth in the province.

Similar to British Columbia, Alberta boasts a top-performing healthcare system. However, according to provincial healthcare rankings, Alberta does not lead the pack in any category. EAPs may be helpful in supporting Alberta employers, especially with wellness solutions that can target expatriates and their families.





Saskatchewan

More likely to be:
• Part-time (24% vs. 11%), and non-employees (21% vs. 17%).

More likely to report:
• Relationship (27% vs. 24%; but decreased from 30% to 25% within SK), gambling (0.7% vs. 0.3%), or others' addiction problems (1.2% vs. 0.7%).

Other:
• Increasingly more likely to report emotional problems (from 10% to 16% within SK).·
• *Emotional Risk Group:* Non-employee (e.g., spouse, dependent).
• *Addiction Risk Group:* Men and < 1 year of service

Other Research

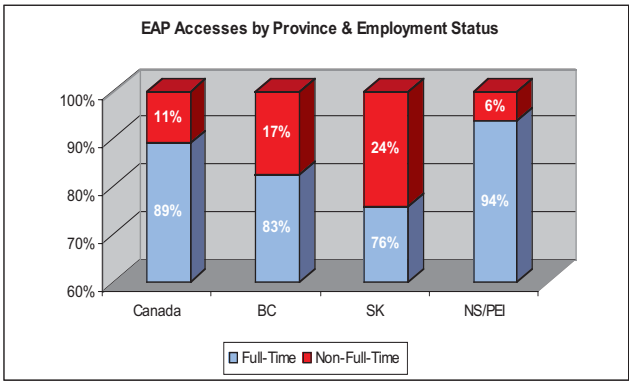
Demographically, Saskatchewan is a unique province. It is one of the youngest of the provinces, but has the most mature labour force in Canada. Similarly, our own research shows the province as having the lowest percentage of EAP accesses by 30-39 years olds and the highest percentage by 40-49 year olds. The prevalence of part-time workers may be explained, in part, by growth in the part-time workforce in Saskatchewan (7.4% between 2006 to 2007 vs. 2.2% for Canada). Saskatchewan also has a higher frequency of accesses by those in the agriculture sector (9.5% vs. 0% to 2.5% for other provinces) and the healthcare industry (15.4% vs. 1.5% to 9.8% for other provinces).

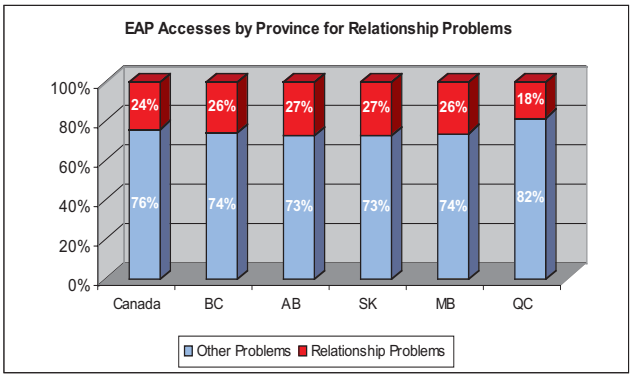
Other findings of ours reflected in external research. Saskatchewan has one of the highest prevalences for any measured disorder or substance dependence. This province, together with other prairie provinces and British Columbia, are associated with the highest levels of alcohol dependence. Saskatchewan and Manitoba also show the highest prevalence of individuals with moderate risk of gambling problems. According to other research, Saskatchewan residents (similar to BC and Alberta) are least satisfied with their personal finances. Financial security is an indicator of health and happiness. However, Saskatchewan residents may have stronger social networks, since they report more

personal contact with friends, and have three or more close relatives than the national average.[xxxvii]

Overview

A confluence of factors may put Saskatchewan employers at risk of higher costs associated with employee and organizational health. Part-time workers often do not receive benefits, even though access to benefits could help prevent more serious health problems. However, the greater proportion of part-time workers in EAP suggests that when programs are available, their issues are being addressed in a cost-effective manner. As well, a higher proportion of EAP clients from this province are non-employees – a group which is also at risk for emotional problems. EAP may be especially valuable in this context since employers cannot directly assist this 'at-home' population. Finally, and perhaps most importantly, reports of emotional problems are increasing relative to other problems in Saskatchewan. This is problematic, given the impact depression and anxiety have on work performance.





Manitoba

More likely to be:
• Under 30 years-old (25% vs. 20%), with less than 1 year of service (19% vs. 14%).

More likely to report:
• Relationship (26% vs. 24% total) or stress problems (18% vs. 16%).

Other:
• Stress Risk Group: Men, < 30 years-old, employee, and < 5 years service.
• Stress Risk Group: 50+ years-old, employee, and < 15 years service.

Other Research

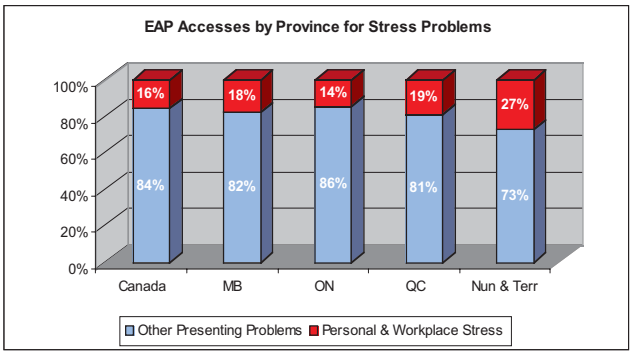
A higher proportion of people accessing EAP from Manitoba are younger than in the rest of Canada. This is understandable given the relative youth of this province. The greater frequency of stress problems is also consistent with community health research, which identifies Manitobans as reporting the highest rates of chronic stress in Canada. They also report lower self-esteem. Although not reflected in our own findings, outside research suggests Manitoba is associated with the highest frequency of individuals with a moderate risk of gambling problems. The average gambling expenditure per person in Manitoba is $538 (vs. $447 for Canada). As an aside, Manitoba is also associated with higher rates of obesity than the rest of Canada (28% vs. 23% for Canada).

Overview

Stress appears to be a concern for Manitobans. Why is this so? Workers across the prairies report longer working hours than other Canadians, so stress may be workload-related. Our own findings, above, may help to pinpoint causes by isolating groups that are at risk. Stress appears more prevalent for younger employees with less tenure, and for older employees with more tenure. Younger people, in general, show lower levels of well-being. Lower tenure can also translate to lower status jobs with less autonomy and job security. Older workers may be faced with greater levels of responsibility. Employers in Manitoba may wish to validate these observations in their own organization.

A greater understanding of this issue may be critical. A recent survey indicated that 75% of businesses in Manitoba are having difficulties finding skilled workers. Over forty percent (40%) of business leaders in the province identified this as their biggest challenge for 2007.

Other research suggests that gambling is a problem in Manitoba. Since this is not corroborated in our own research, clients may be under-reporting this problem. If so, this may be an opportunity for employers to increase awareness among employees of the availability of EAP to address this problem. In fact, greater utilization of EAPs, especially those offering health risk assessments, may benefit all Manitoban employers and employees. Manitoba has the highest proportion of its population: a) waiting more than a month for diagnostic and specialist visits, and b) reporting difficulty obtaining health information or advice any time of day.



Ontario

More likely to be:
• Women (66% vs. 62%), 40 or more years-old (45% vs. 43%), and 50 or more years-old (13% vs. 10% for Canada; also increased from 12% to 15%).

More likely to report:
• Fewer stress problems (14% vs. 16%).

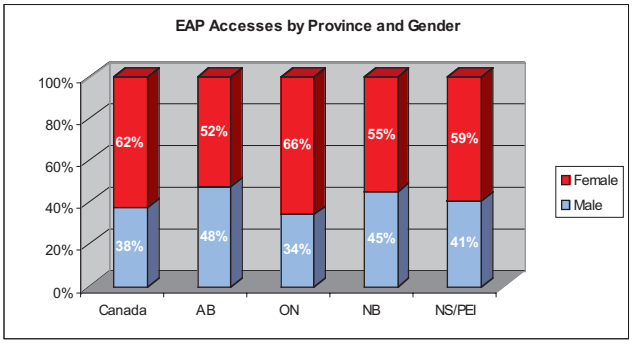
Other Research

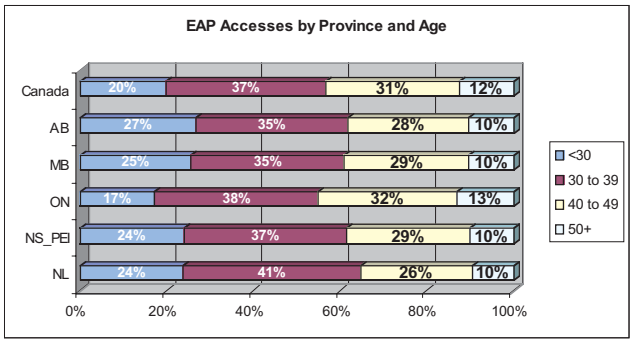
More women are accessing EAP in Ontario. There are likely several reasons for this. For example, Ontario women report low levels of satisfaction with community-based care. EAP may be a desirable alternative to other available services. Additionally, more mature workers are accessing EAP in Ontario. This is interesting, since the workforce in Ontario is not aging as fast as other Canadians (e.g., Maritimers). This suggests that older Ontarians are accessing EAP in greater numbers for reasons unrelated to changing demographics.

While our findings show fewer stress problems in Ontario, community health sources identify Ontario and Quebec workers as reporting the highest levels of work stress. While it is possible that work stress is under-reported to EAPs in Ontario, it is interesting to note that out of the Fifty Best Employers in Canada for 2007, more than half of them hail from Ontario – more than any other province. This would seem more commensurate with our results. Ontario workers also lose fewer work days than workers in other provinces (8.8 days vs. 9.7 days for Canada). [xlix]

Overview

The overview for Ontario is generally positive compared to other provinces. Another way of stating this is that it departs minimally from the national picture of EAP access. However, Ontario employers are advised to consider when, and for whom additional support may be needed. For example, and in line with our results, employers could enhance workplace health for women and older workers. Additionally, other research shows that when Ontario workers report high levels of workplace problems, work stress, and life dissatisfaction, they are amongst the least likely Canadian workers to have received help from others. Similarly, Ontarians report the lowest level of patient satisfaction with hospital care in Canada. These findings suggest that there are opportunities for employers and EAPs to further enhance the quality of life among Ontario residents.





Quebec

More likely to be:
• Employees (87% vs. 83%), with 5 or more years of service (56% vs. 52%), with 15 or more years of service (24% vs. 19%).

More likely to report:
• Emotional (16% vs. 12%), stress (19% vs. 16%), or work-related problems (9% vs. 7%).
• *Fewer* relationship problems (18% vs. 24%)

Other:
• Decreasing access relative to the national norm (from 16.7% to 15.6% of accesses)..
• *Emotional Risk Group*: Men, and < 30 years-old.
• *Stress Risk Group*: < 30 years-old, < 5 years service, and non-supervisory/professional.
• *Stress Risk Group*: Women, and 50+ years-old.

Other Research:
Our findings in Quebec are corroborated elsewhere. According to the Canadian Institute for Health Information (CIHI), Quebeckers spend more days in hospitals for mental health issues than other Canadians. Working women in Quebec (and British Columbia) have the highest incidence of anxiety and depression symptoms in Canada (both 23%). Life Mastery Scores are also below the national average for Quebec residents. Finally, Quebec's suicide rate is exceeded only by Yukon and the territories. [lvii]

Our research also shows a greater prevalence of work-related stressors in Quebec. Consistent with this, external research suggests that fewer Quebeckers are very satisfied with their jobs. Of the Fifty Best Employers in Canada in 2007, only seven employers hail from Quebec. Overall, community health research identifies Quebeckers as having some of the highest levels of self-reported life and work stress.

Quebeckers report fewer relationship problems to EAP. In other research, Quebec is associated with the highest percentage of separated or divorced individuals in Canada (12%). These findings may appear inconsistent. However, it is possible that relationship problems are less likely to be reported when relationships have ended or in the absence of marriage.[v]

Overview
The profile of well-being in Quebec appears troubling. Since younger people occupy two of the three Quebec risk groups, it may be speculated that this merely reflects a younger province. However, Quebec has a higher median age than the rest of Canada (40.4 vs. 40 years). This indicates that the causes likely lie elsewhere.

On the whole, community health research depicts the average Quebecker as socially alienated. Relative to other Canadians, Quebec residents are most likely to report having few or no close relatives, least likely to report having three or more friends, and report less personal contact with friends than the national average. Quebec also has a lower percentage of adults reporting to know many or most of their neighbours. While it may be construed from this body of work that the average Quebecker is more independent than alienated, the emotional and stress findings suggest otherwise.

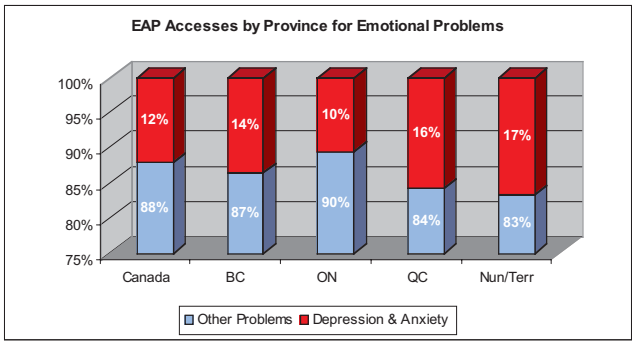
The physical health profile of Quebeckers is equally alarming. A recent Conference Board paper associated the following with Quebec:

• Highest male incidence rate for lung cancer (highest female rate, tied with Manitoba);
• Highest incidence rate for female breast cancer;
• Highest male mortality rate for heart attacks (third highest female rate);
• Highest male mortality rate for lung cancer (second highest female rate);

• Highest female mortality rate for colorectal cancer (second highest male rate);
• Lowest proportion of the population with a regular family doctor. [lxii]

Residents in Quebec (and British Columbia) also report the longest times since their last blood pressure measurement (2 or more years ago). As may be expected, Quebec spends more money per capita, per year, on prescription drugs than the rest of Canada ($674.39 vs. $640.49).

On a positive note, the profile of EAP access for Quebec suggests that many residents are receiving help for the psychological issues that have come to be associated with the province. However, EAP access may be decreasing in Quebec (see below). Action may be warranted to boost EAP awareness among Quebec



employees. The risk groups identified above suggest a starting place for employers and EAPs to fast-track responses to these issues. Urgency is also needed, since workers in Quebec (and New Brunswick) lose more days than other Canadian workers (11.5 vs. 9.7 for Canada). Quebec has also registered the smallest gains in provincial labour productivity from 1997 to 2005.

New Brunswick

More likely to be:
• Men (45% vs. 38%), non-employees (20% vs. 17%), and with 5 or more years of service (57% vs. 52%).

Other Research

New Brunswick differs little from the national profile of EAP access. There are few salient risks that define the province as tracked by EAP. How does this compare to external research? In general, findings from community health research depict New Brunswick as lying close to the national average for most mental health indices (e.g., disorders, addictions, hospital stays for mental health problems).

Overview

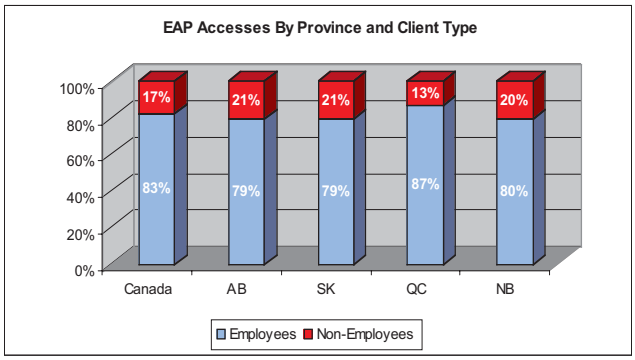
New Brunswick residents appear to be no better nor worse adjusted than other Canadians. At best, they seem to be more protected from serious mental health issues. The reasons for this may be partly social as New Brunswick residents report having larger social networks than other Canadians. They are also most likely (along with residents from Saskatchewan and other Atlantic provinces) to report three or more close relatives, as well as more personal contact with friends than the national average.

While levels of social and psychological health appear stable for many residents of New Brunswick, physical health may be another matter. The Conference Board of Canada recently cited the following statistics for the province:

• Second highest incidence rate for male lung cancer;
• Lowest proportion of both sexes with self-reported health as good, very good or excellent;
• Second lowest proportion of both sexes reporting being active or moderately active;
• Second highest female mortality rate for stroke.

New Brunswick is also associated with higher rates of obesity (29% vs. 23% for Canada). More adults in the province report high blood pressure (16.5% vs. 14.4% for Canada), and diabetes (5.8% vs. 4.7% for Canada) than Canadians in other provinces. Given this physical health profile, it is not surprising that the province spends more money per capita, per year, on prescription drugs than Canada as a whole ($701.58 vs. $640.49). Additionally, employees in New Brunswick (and Quebec) lose the most work days per year compared to the rest of the country (11.5 vs. 9.7 for Canada). With maritime provinces aging more quickly than the rest of Canada, these combined problems and costs may escalate.[lxviii]

Economically, New Brunswick appears poised for growth. Moody's recently upgraded the province's credit rating from Aa3 to Aa1, giving it the highest rating east of Ontario. It may be ventured that New Brunswick would be better positioned to take advantage of economic opportunities with a healthier workforce



Newfoundland & Labrador

More likely to be:
• Under 40 years-old (65%vs. 57%), employees (85% vs. 83%).

More likely to report:
• Gambling problems (0.8% vs. 0.3%), or debt/credit issues (3.3% vs. 1.5%).

Other:
• Self-reported stress at intake decreasing more rapidly than the national norm (from 49% to 27%)

Other Research

EAP clients in Newfoundland and Labrador are more likely to be under 40 years of age than other clients. However, Newfoundland and Labrador have a higher median age than other provinces (41.3 vs. 40 years for Canada). Thus, the presence of younger clients is not likely a demographic byproduct.[lxxvi]

Newfoundlanders do not differ markedly from other Canadians on the basis of presenting problems. This is consistent with community health research, which depicts the province as lying close to the national average for most mental health indices. This includes self-reported stress, which is decreasing in our own data for the province.

Our data does suggest that gambling problems are more prevalent in Newfoundland and Labrador. This is at odds with Statistics Canada, which reports the average gambling expenditure per person, per year in the province as below average ($438 vs. $447 for Canada). However, this statistic hails from 2001. Net gambling revenue for the province has doubled from $54 million to $108 million between 1994 to 2004. To date, Newfoundland and Labrador is the only regions to not conduct a provincial gambling prevalence study. Our data may provide an early warning sign for the province in this area.

An additional and positive external finding is that Newfoundlanders report liking their jobs – registering the lowest levels of job dissatisfaction in Canada (4.8% vs. 8.6% for Canada).

Overview

The relative lack of stress or emotional problems as defining issues may reflect strong social networks in the province. Newfoundlanders are among the most likely Canadians to report three or more close relatives. They also report more personal contact with friends than the national average, and fewer separations and divorces. Although frequencies of gambling and debt/credit issues appear only marginally higher in Newfoundland and Labrador, both rates are twice the national average. Additionally, since both issues appear together in more than one provincial grouping (see Nova Scotia and Prince Edward Island), their co-occurrence may point to a 'real' co-morbid problem. While levels of social and psychological health generally appear to be 'average' for Newfoundlanders, physical health may be another matter. The Conference Board of Canada recently cited the following statistics for the province:

• Lowest female and second lowest male life expectancy;
• Lowest proportion of females and third lowest proportion of males reporting being active or moderately active;
• Highest female mortality rate for heart attacks (second highest for males);
• Highest mortality rate for prostate cancer;
• Highest male mortality rate for colorectal cancer (second highest female rate);
• Highest male mortality rate for colorectal cancer (second highest female rate)
Newfoundland and Labrador is also associated with the highest rates of obesity (34% vs. 23% for Canada). Additionally, more adults in the province report high blood pressure (17.7% vs. 14.4% for Canada), and diabetes (6.7% vs. 4.7% for Canada).[lxxxiv]

The physical health picture, above, may get more complicated as the province ages. Newfoundland and Labrador is already the oldest province, and getting older. The median age in the province rose 3.2 years between 2001 and 2006 – the fastest increase in the country. The population size is also decreasing as a result of interprovincial migration, with a significant proportion likely accounted for by younger workers

Economically, Newfoundland and Labrador is enjoying the highest average provincial productivity growth from 1997 and 2005. The province will need to successfully manage the health issues noted above in order to achieve and maintain a 'have' status among provinces.

Nova Scotia & Prince Edward Island

More likely to be:
• Men (41% vs. 38%), under 40 years-old (61% vs. 57%), with less than 1 year of service (19% vs. 14%; also increased from 15% to 21%), with less than 5 years of service (54% vs. 48%).

More likely to report:
• Gambling problems (0.7% vs. 0.3%), or debt/credit issues (2.8% vs. 1.5%).

Other:
• Emotional Risk Group: 50+ years-old, full-time, and < 5 years service.
• Stress Risk Group: 50+ years-old, and 5+ years service.
• Addiction Risk Group: Male, and < 30 years-old

Other Research

EAP clients in Nova Scotia and Prince Edward Island are more likely to be under 40 years of age than other clients. However, these provinces have older populations, so this is not likely a byproduct of demographics (median ages 41 and 39.8 vs. 40 years for Canada). The greater frequency of gambling problems is corroborated by other information. The average gambling expenditure per person, per year is above median for Nova Scotia ($473 vs. $447 for Canada). In other, unrelated findings, Nova Scotians report slightly higher job dissatisfaction than other Canadians (9.1% vs. 8.6% for Canada). In Prince Edward Island, only 5% report job dissatisfaction.

Overview

The growing prevalence of newer hires accessing EAP from Nova Scotia and Prince Edward suggests that, while this group of employees is receiving the help they need, employers may also need to fast-track this group for human resource initiatives with company orientations or better placements. The growing prevalence of this group may also reflect recent hiring growth in the provinces.

The relative lack of stress or emotional problems as defining issues may reflect strong social networks in the province. Along with other Atlantic provinces, Nova Scotia and PEI residents are among the most likely Canadians to report three or more close relatives, and more personal contact with friends. Although

reports of gambling and debt/credit issues appear only marginally higher in Nova Scotia and Prince Edward Island, both rates are nearly twice the national average. Additionally, since both issues appear together in more than one provincial grouping (see Newfoundland and Labrador), their co-occurrence may point to a "real" co-morbid issue.

It is interesting to note that while younger people are accessing EAP from these provinces (under 40 years), the groups most at risk for emotional and stress problems are older (over 50 years). This serves as a reminder that not all people accessing EAP experience critical problems. EAP is also used to manage day-to-day worklife problems and prevent more serious mental illness. The presence of an older group at risk for emotional problems is also interesting, given that psychological adjustment tends to improve with age. It is possible that some older residents in these provinces face extraordinary stressors that cannot be countered with resilience factors associated with aging, such as conscientiousness and relationship stability.

While levels of social and psychological health appear stable for many residents of Nova Scotia and Prince Edward Island, physical health may be another matter. The Conference Board of Canada recently cited the following statistics for Nova Scotia:

- Lowest male and second lowest female health-adjusted life expectancy
- Highest male prevalence rate of diabetes (tied with Manitoba), second highest female rate;
- High male and female incidence rate for lung cancer.
- Highest female mortality rate for lung cancer, fourth highest male rate;
- Lowest share of women aged 50 to 69 who have had a mammogram in the past two years.[xciii]

Additionally, Nova Scotia logs the highest proportion of adults in Canada reporting high blood pressure (18.6% vs. 14.4% for Canada). Reports of diabetes are also more frequent (5.8% vs. 4.7% for Canada). [xcv]

For Prince Edward Island:
- Lowest male life expectancy;
- Highest female infant mortality rate, second highest male rate;
- High male and female incidence rate for lung cancer;
- Highest incidence rate for prostate cancer, second highest mortality rate;
- Lowest rate of males reporting being active or moderately active, third lowest female rate;
- Highest mortality rate for female breast cancer;
- Highest male and female mortality rate for stroke;
- Highest male and female hospitalization rate for ambulatory care sensitive conditions;
- Second lowest male patient satisfaction rate with community-based care;
- Highest proportion of the population reporting difficulty obtaining immediate care for a minor health problem any time of day.

Despite these issues, full-time employees in Prince Edward Island still report the fewest lost work days in Canada (8.5 vs. 9.7 for Canada). Absenteeism may not necessarily be linked to the problems listed above as many of these areend state or terminal. It is also possible that many employees in the province are subject to presenteeism, where these and other health problems are eroding their performance.

Nova Scotia and Prince Edward Island are facing demographic changes that may impact health and productivity. Similar to other Atlantic provinces, their populations are aging faster than the rest of Canada. Additionally, the Nova Scotian population is decreasing due to lower generational replacement and interprovincial migration. All of this may create more frequent age-related health issues and rising claims costs for employers. Prince Edward Island already has one of the smallest labour productivity gains of any province, so the aging population may be an additional

challenge.

Nunavut, Northwest & Yukon Territories

More likely to be:
• Emotional (17% vs. 12%; also increased from 17% to 22%), stress (27% vs. 16%), addiction (alcohol: 2.4% vs. 1.2%; drug: 1.2% vs. 0.9%), other's addiction (2.3% vs. 0.7%), or work-related problems (13% vs. 7%).

Other Research

The picture of Nunavut and the territories is a complicated one. First, it is difficult to compare our findings with external indicators due to a small sample. Our findings may not reflect the regional population at large. The small sample is, perhaps, one reason why we could not identify risk groups for these regions.

The picture is also complicated by a schism in the north along lines of culture and well-being. While many social and health indicators are positive for the general population, there is no question that the quality of life among First Nation citizens is less positive. Compared to other groups, for example, the Inuit population faces the worst conditions for employment, income, cost of living, housing, communicable diseases, and life expectancy. Our findings, above, may disproportionately reflect difficulties faced by these citizens. In general, Yukon and the territories are associated with the highest suicide rate in Canada, a problem correlated with the emotional and addiction problems we reported, above. The northern regions are also 'younger' than the rest of Canada, especially Nunavut (23.2 years) and the Northwest Territories (30.9 years; compared to a median of 40 years for Canada). Youth is often implicated in emotional problems. Additionally, the percentage of criminal charges in Nunavut that are attributable to alcohol is 45% (vs. 36% for Canada). In general, combined life expectancies for these regions are only 72 and 77 years for males and females (compared to 77 and 82 for Canada).

Overview

The north has experienced significant growing pains as a region. It now appears poised to excel in a number of areas. Employment rates for Yukon and the Northwest Territories rival the national average. Over the past five years, Nunavut experienced the strongest growth in working hours (equalling Alberta) while the Northwest Territories recorded the largest gains in labour productivity (equalling Newfoundland and Labrador).

The above findings, however, suggest that future growth may be limited by psychological problems within these regions. The presence of work-related problems may also curb productivity. One factor that may compound these problems is a lack of social services in more remote communities. The Government of Nunavut recognizes this problem, and recently launched the IIU Network Telehealth Project to provide tele-counselling to isolated citizens in need. EAPs typically provide similar services. Together, both governments and EAPs can address the critical needs of isolated workers and their families in the north.

CONCLUSIONS & RECOMMENDATIONS

EAP research is sensitive enough to detect provincial and regional differences in health problems.

The following are some conclusions that can be drawn from our study.
Our findings are commensurate with external research. Thus, it is fair to say that EAP data represents a real and accurate picture of health issues across Canada.

EAP data may even be sensitive enough to detect relationships between provincial economies and mental health. For example, we also found:

•As provincial GDP increases, provincial EAP

accesses for emotional and stress problems decrease in the following year (r = -.42 for emotional problems; r = -.33 for stress problems).
• As provincial EAP accesses increase for emotional and stress problems, provincial GDP also *increases* in the following year (both problems, r = .39).

There are many ways to interpret these results. The first point suggests that economic prosperity may lead to fewer psychological problems. However, with regard to the second point, it is not likely that EAP accesses lead to economic prosperity. A small proportion of the general population uses EAP. We do know that individual performance (and hence, national productivity) is impacted by mental health. It may be that millions of people are finding some way to resolve their problems each year and becoming more productive. EAP may be one of those solutions. It may be ventured that, if there is a causal link between receiving assistance and future prosperity, and assistance was more structured for a greater proportion of the population (e.g., EAP), then the impact of such assistance on economic prosperity could be even larger.

Canadians are receiving the assistance they need, where and when needed, through EAP as a well-established health support and care system.

Given the validity of EAP data as a reflection of provincial and regional health differences, it stands to reason that many Canadians are receiving they help they need through EAPs. This is important to note, since many Canadians may be falling through the cracks of public mental healthcare. Canada is the only G8 country without a national mental health strategy. As such, provinces and territories are individually responsible for delivering mental health services. This fragmentation led Roy Romanow to comment that mental health is the "orphan of Medicare"

Additionally, many provinces have begun to regionalize their health services. This may adversely affect Community Health Centres (CHCs), which have traditionally delivered mental health services. Some CHCs have retained their local governance structure. CHCs in Quebec, however, have not. Regional health centres in Quebec are now more remote, deliver a wider range of services, and are responsible for much larger populations. Health planning in Ontario, on the other hand, is still driven partly by local CHCs. Ontario is the only province that has expanded its community-governed CHCs (i.e., Local Health Integration Network – Bill 36). These trends may explain some of our divergent findings for Ontario and Quebec.

EAPs are emerging as an essential partner in national mental healthcare, as many Canadians may be stymied in their ability to address their problems through overburdened, provincial healthcare systems. Many of these problems could be prevented through access to an employee assistance program with an integrated health solutions focus.

Interestingly, citizens in British Columbia, Alberta, and Quebec (the provinces showing the most problems in this report) report on community health surveys that that they 'feel some action is needed' and 'intend to take needed action' to improve their health. Thus, an opportunity clearly exists for prevention-based EAPs. They can provide a supplementary solution by picking up the slack and addressing health problems long before they translate into illness and disability costs borne by employers.

Provincial and regional differences in EAP access are a testament to the strength of local health drivers. Solutions must be crafted that are relevant to local workforces.

Many of Shepell·fgi's organizational clients employ people in a national corporation with employees across Canada. Thus, observed problems are not necessarily 'corporate' in origin, and solutions cannot be easily dictated from head offices. EAP research adds a layer of information to the understanding of local health problems and, as a result, may inform local or 'homegrown' responses on the part of employers and their EAPs.

Paradoxically, retaining a national EAP is one way of addressing local health problems. Although some national employers may be tempted to secure a patchwork of local EAP providers, the provincial and regional differences observed in this report suggest that national EAPs are broad and capacious enough to handle the diversity of issues faced by Canadians from coast to coast. The data collected by national EAPs also provide a bigger picture, through provincial comparisons, that enable them to entertain local explanations and interventions. This perspective is lost in the retention of multiple local providers. As a final note, national EAPs boast an economy of scale that is not enjoyed by employers using a patchwork of local providers.

The Shepell·fgi Research Group

The Shepell·fgi Research Group, a subsidiary of Shepell·fgi, has a mandate to educate employers and business leaders on the physical, mental and social health issues that impact clients, their employees and families, and workplaces. The Research Group analyzes and provides commentary on key health trends, partnering with some of the industry's highest profile research institutes and scholars, and drawing from 25 years of expertise in the EAP industry. The findings contained in this report are based on Shepell·fgi proprietary data and are supported by information from a variety of academic, government, and private research sources. References have been omitted for space considerations and are available upon request. This study was conducted by Paul Fairlie, Director of Research of the Shepell·fgi Research Group. The Shepell·fgi Research Group is overseen by Paula Allen, VP Health Solutions and Shepell·fgi Research Group. Questions or comments may be directed to Paula Allen at 1-800-461-9722.