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Mental Health and Equality Rights:

Mood Disorders

An analysis using the 2012 Canadian Community Health Survey (CCHS) – Mental Health Component

By

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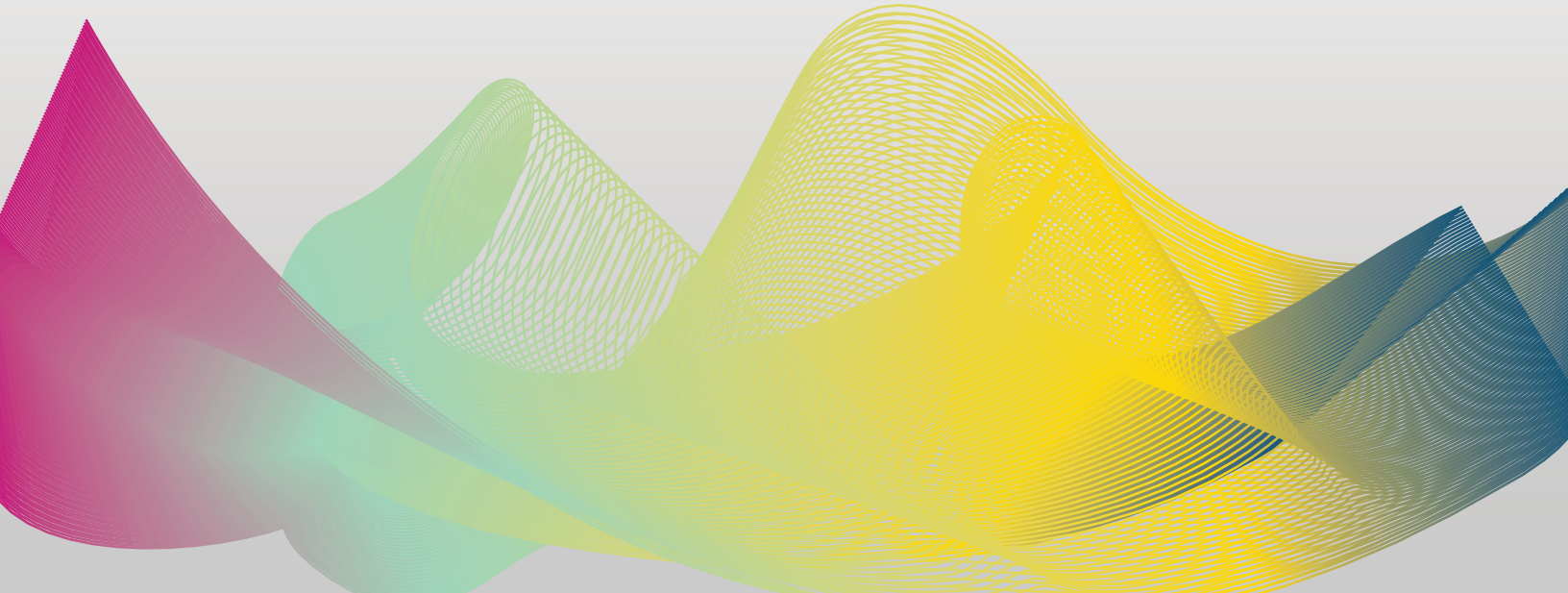

The following symbols are used in this publication:

Symbol	Definition
E	Use with caution, coefficient of variation (CV) between16.5% and 33.3%.
F	Too unreliable to be published.
**	Difference between women and men with mood disorders is not significant at the 0.05 level.

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Introduction

The Canadian Human Rights Commission (CHRC) is producing a new series of research reports entitled, "Mental Health and Equality Rights." The reports will look at how people with various mental health problems and illnesses fare in relation to key dimensions of well-being, outlined in the CHRC's *Framework for Documenting Equality Rights.*

This report, the first in the series, is entitled, *Mental Health and Equality Rights: Mood Disorders.* It presents statistics on how Canadian adults who reported having mood disorders fare in terms of education, employment and economic well-being compared to adults without mood disorders. It also looks at health care needs and experiences with discrimination.

Since 2009, approximately 20% of the total complaints received by the CHRC each year are related to mental health. Based upon the increase in discrimination complaints received by the CHRC, it is clear that people living with mental health problems and illnesses face barriers in employment and access to services.[1]

As that number increases, it becomes more important to have relevant and up-to-date information on the impact of mental health problems and illnesses on the workplace in order to identify future accommodation and discrimination prevention efforts.

The issue is a prevalent one for Canada. According to the Mental Health Commission of Canada (MHCC), one in five Canadians lives with mental health problems and illnesses[2] in any given year.[3]

Moreover, the economic burden from mental health problems and illnesses in Canada is quite significant. A 2013 study published by the MHCC estimates the economic cost to Canada is approximately $50 billion per year. The study found that the largest proportion of these costs is related to health care, social services and income support. In addition, mental health problems and illnesses cost Canadian business more than $6 billion in lost productivity (from absenteeism, presenteeism and turnover).[4]

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[1] The *Canadian Human Rights Act* prohibits discrimination on the basis of race, national or ethnic origin, colour, religion, age, sex (including pregnancy or child-birth), sexual orientation, marital status, family status, disability and conviction for an offence for which a pardon has been granted or in respect of which a record suspension has been ordered.

[2] For the purposes of this report, the term "mental health problems and illnesses" comes from the Mental Health Commission of Canada's report entitled: *Changing Directions Changing Live: The Mental Health Strategy for Canada*. Mental health problems and illnesses "refers to the full range of patterns of behaviour, thinking or emotions that bring some level of distress, suffering or impairment in areas such as school, work, social and family integration or the ability to live independently." It is important to note that Statistics Canada's Canadian Community Health Survey – Mental Health Component uses the general term "disorder(s)" to refer to all mental disorders, episodes, conditions or problems.

[3] Mental Health Commission of Canada. *Making the Case for Investing in Mental Health in Canada*. Calgary: Mental Health Commission of Canada, 2013.

[4] Ibid.

Methodology

Descriptive statistics were produced and analyzed using the 2012 Canadian Community Health Survey (CCHS) – Mental Health Component (total sample size of 25,113).[5] This survey covers adults (age 15 or older) who are living in any of Canada's ten provinces. It provides a comprehensive look at the effect of selected mental health problems and illnesses. It also examines access to, and utilization of formal and informal mental health care services and supports.

This survey assesses several mental health problems and illnesses using the World Health Organization version of the Composite International Diagnostic Interview (WHO-CIDI). The WHO-CIDI assesses mental health problems and illnesses according to the criteria outlined in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).[6]

To be identified as someone with a mood disorder, a respondent must have met the CCHS – Mental Health/WHO-CIDI criteria for any measured mood disorder that includes experiencing at least one of the following in the past 12 months: major depressive episode, bipolar I, bipolar II or hypomania.[7]

In this report, household income[8] was adjusted to the family size by dividing the household income provided by the respondents by the square root of the respondents' household size. Adjusting the family household income takes into account that household needs increase as the number of family members increases.

Proportions are used to compare the situation of women and men with and without mood disorders to give an indication of whether or not inequality exists between these groups. It is important to note that this report provides only a descriptive picture of what people with mood disorders answered on the 2012 CCHS – Mental Health Component. This means that the outcomes in this report are not necessarily linked to mood disorders. More in depth research needs to be conducted in order to better understand the relationships, if any, between mood disorders and the outcomes reported by the respondents.

Statistical tests were run on all comparisons to determine if differences were statistically significant at the 0.05 level. Where differences are not significant, this is noted in the table. In addition, the coefficient of variation (CV) was used to assess the reliability of the estimates.[9]

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[5] www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=5015

[6] Canada. *Canadian Community Health Survey (CCHS) – Mental Health Derived Variable (DV) Specifications*. Ottawa: Statistics Canada, 2013.

[7] For more information in the definitions, refer to supra note 6.

[8] It is important to note that data on household income from the CCHS – Mental Health Component is self-reported by the respondent. It provides an estimate of their household income.

[9] The CV is used to determine the reliability of the data. In this report, we used the following Statistics Canada values:

- When the CV is greater than 33.3%, the results are considered unacceptable.
- When the CV is greater than 16.5% and less than or equal to 33.3%, the results must be used with caution.
- When the CV is 16.5% or less, the results are published without restrictions.

It is important to note that differences documented in this report do not necessarily indicate discrimination as defined in human rights law. A number of other factors may account for the differences, including personal choices. However, the differences may point to areas for further study as these may be tied to potential discrimination.

Limitations

There are three important limitations associated with using a population-based survey like the 2012 CCHS – Mental Health Component that should be noted.

First, not all Canadians were sampled in this survey. Excluded from the survey's coverage are: persons living on reserves and other Aboriginal settlements; full-time members of the Canadian Forces; and the institutionalized population. According to Statistics Canada, these exclusions represent about 3% of the total Canadian population. These exclusions may have led to an underestimation of the prevalence of mood disorders in Canada.

Second, as with most other population-based surveys, this survey is cross-sectional and the responses are self-reported by the respondents. This means that the diagnosis of mental health problems and illnesses are based on recall by respondents. This may cause recall biases and can be quite problematic for estimating rates of specific mental health problems and illnesses,[10] such as mood disorders. In addition, respondents may be hesitant to report on their own mood disorder status.

The third limitation relates to the sample sizes. On some occasions, sample sizes were so low that some variables and measures had to be dropped to protect the identity of the respondents, in accordance with Statistics Canada confidentiality requirements. On other occasions, response categories to some questions were aggregated. Other measures were dropped because the value of the CV was too high, meaning too much uncertainty with the accuracy associated with the estimates.

[10] Amy H. Cheung and Carolyn S. Dewa. "Canadian community Health Survey: Major Depressive Disorder and Suicidality in Adolescents," *Health Care Policy*. Vol. 2 No. 2. Toronto: Longwoods Publishing Corp., 2006. P. 76-89.

Adults with mood disorders in the past 12 months

Table 1.1: Rates of mood disorders for adults by personal characteristic – reference year 2012

Personal characteristic	Women	Men	+/-
Age group			
15 to 24	9.7%	6.7%	3.0%
25 to 44	7.6%	5.3%	2.3%
45 to 54	6.9%	4.3%	2.6%
55+	3.5%	2.3%	1.2%
Total adult population (15+)	6.4%	4.4%	2.0%
Marital status			
Married/Common law	4.8%	2.8%	2.0%
Widowed/Divorced	7.4%	5.5%	1.9%
Single	9.7%	7.4%	2.3%
Visible minority	4.7%	4.7%[E]	0.0% [E**]
Aboriginal status	13.5%[E]	5.2%[E]	8.3% [E]

Source: 2012 Canadian Community Health Survey – Mental Health Status
All percentages are rounded to one decimal point.
Missing values are excluded.
[E] Use with caution.
[**] Difference between women and men with mood disorders is not statistically significant at the 0.05 level.

The rates of mood disorders are higher for women than men in all age groups. This is consistent with other findings that demonstrate that the prevalence of mood disorders, such as depressive disorders and psychological distress, is higher for women compared to men.

Research has been done in order to understand the reasons why the rates of mood disorders, and other mental health problems and illnesses, are higher for women. A common hypothesis is that women tend to be in more stressful situations, such as being a lone parent, being solely responsible for child care responsibilities or having unequal opportunities in the workplace.[11] As well, it could be argued that women may be more inclined to disclose their mental health problems and illnesses than men.[12]

The rates of mood disorders decrease for both women and men as their age increases. The rate tends to be higher for adults who are single, especially for women.

[11] Smith, Laura, Lauren M. Appio, and Rosa J. Cho. "The feminization of poverty: Implication for mental health practice." *Women and mental disorders*. Paula K. Lundberg-Love et al. Editors. Santa Barbara: ABC-CLIO, LLC, 2012. 99-117.
[12] Rogers, Anne and Dr. David Pilgrim. *Mental health and inequality*. Palgrave Macmillan, 2003.

Education

Education can be a powerful influence on income levels and economic well-being. It is also a key determinant of human health.[13]

Educational attainment is defined as the highest level of education a person has completed, and is an indicator of a person's knowledge and skill level. It is also a strong predictor of success in the workforce. For example, higher educational attainment, especially post-secondary education, is strongly correlated with finding employment and gaining access to better employment.[14]

This dimension looks at the highest level of education attained.

Table 1.2: Highest educational attainment of adults aged 15+ by educational level, sex and mood disorder status – reference year 2012

Educational Level	Women with mood disorders	Women without mood disorders	+/-	Men with mood disorders	Men without mood disorders	+/-
Below high school	8.0%[E**]	7.8%	0.2%	8.0%[E**]	6.6%	1.4% [E]
High school	10.4%	10.2%	0.2%	12.5%[E]	10.4%	2.1% [E]
Post-secondary education below Bachelor's[1]	50.5%	46.0%	4.5%	46.0%[E]	47.9%	-1.9% [E]
Bachelor's and above[2]	31.1%[E]	36.0%	-4.9% [E]	33.5%[E]	35.0%	-1.5% [E]

Source: 2012 Canadian Community Health Survey – Mental Health Status
All percentages are rounded to one decimal point.
Missing values are excluded.
[E] Use with caution.
[**]Difference between women and men with mood disorders is not statistically significant at the 0.05 level.
[1] Includes some post-secondary education; trades certificate or diploma; college/CEGEP certificate or diploma; and university certificate below Bachelor's level.
[2] Includes Bachelor's Degree; university degree or certificate above Bachelor's level such as Masters and PhD.

More than 45% of women and men with mood disorders have a post-secondary education below a Bachelor's Degree as their highest educational attainment. In addition, women with mood disorders are proportionally more likely to have this level of education as their highest educational attainment than men with mood disorders (50.6% v. 46.0%).

Both women and men with mood disorders are less likely to have a post-secondary education at the Bachelor's level or above as their highest educational attainment compared to women and men without mood disorders.

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[13] Frank, J.W. and J.F. Mustard. The Determinants of Health from a Historical Perspective. *Daedalus*, 1994. Vol. 123. No. 4. 1-17.
[14]Canada. *The human face of mental health and mental illness in Canada*. Public Health Agency of Canada: Ottawa , 2006.

Employment

The type of work that an individual does is often linked to their social identity and used by others as a way to evaluate the contribution that person makes to society. Having a job can promote good mental health in that it offers one a place to socialize, develop interpersonal contacts, use their skills, and gain a sense of personal accomplishment and esteem.[15]

However, impacts of mental health problems and illnesses on job performance have been estimated to be greater than that of chronic physical conditions such as arthritis, hypertension, back problems and diabetes.[16] Mental health problems and illnesses are often associated with difficulty in finding and keeping a job and with both absenteeism and presenteeism.[17] According to a 2007 report,[18] 79% of employed individuals who reported depression in the last year said that their symptoms had interfered with their ability to work to at least some degree. In addition, one in five (19%) had experienced very severe interference.

Once employed, it can be quite challenging for people with mental health problems and illnesses to stay employed. Challenges include loss of confidence, feeling isolated, lack of understanding from colleagues, fear of disclosing the diagnosis and poor prospects of promotion.[19] These factors may increase the level of stress that people with mental health disorders and illnesses have to manage in the workplace. That may lead to other problems such as decreased personal satisfaction towards their employment and higher work-related stress.

This dimension looks at four employment-related indicators:

- labour force status;
- job satisfaction;
- work-related stress; and
- help received from employer.

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[15] Thornicroft, Graham. *Shunned: Discrimination Against People with Mental Illness*. Oxford: Oxford University Press, 2006.

[16] Lerner, Debra. "Work Performance of Employees With Depression: The Impact of Work Stressors." *American Journal of Health Promotion*, 2010. Vol. 24, No.3. 205-213.

[17] *Ibid*.

[18] Gilmour, Heather, and Scott B Patten. "Depression and work Impairment." *Health Reports*, 2007. Vol. 18, No 1. Ottawa: Statistics Canada. 9-22.

[19] Bird, Lisa. "Poverty, social exclusion and mental health: A survey of people's personal experiences." *A Life in the Day*, 2001. Vol. 5 No. 3, MCB UP Ltd. 4-8.

See also:

- Huxley, P. and G. Thornicroft. "Social inclusion, social quality and mental illness." *The British Journal of Psychiatry,* 2003. Vol. 182. No. 4. 289-290.
- Supra note 15.

Labour force status

Table 1.3: Labour force status of adults aged 15+ by sex and mood disorder status – reference year 2012

Labour force status	Women with mood disorders	Women without mood disorders	+/-	Men with mood disorders	Men without mood disorders	+/-
Employed	59.5%	64.1%	- 4.6%	60.8%[E]	74.1%	-13.3% [E]
Unemployed	31.7%	33.6%	-1.9%	28.2%	23.7%	4.5%
Permanently unable to work	8.8%	2.3%	6.5%	11.0%[E]	2.2%	8.8% [E]
Employed part-time	30.6%	24.2%	6.4%	14.6%[E]	10.9%	3.7% [E]

Source: 2012 Canadian Community Health Survey – Mental Health Status
All percentages are rounded to one decimal point.
Missing values are excluded.
[E] Use with caution.

The proportion of unemployed men with mood disorders is 4.5% higher than that of men without mood disorders. Both women and men with mood disorders are proportionally more likely to be "permanently unable to work" and to work part-time compared to women and men without mood disorders.

More than one in five women—both with and without mood disorders—work part-time. However, women with mood disorders are proportionally more than twice as likely to work part-time compared to men with mood disorders.

Job satisfaction

Table 1.4: Proportion of adults aged 15+ who report being unsatisfied[20] at work by sex and by mood disorder status – reference year 2012

Sex	With mood disorders	Without mood disorders	+/-
Women	24.5%	7.6%	16.9%
Men	30.1%	7.0%	23.1%

Source: 2012 Canadian Community Health Survey – Mental Health Status
All percentages are rounded to one decimal point.
Missing values are excluded.

The proportions of women and men with mood disorders who report being unsatisfied at work is more than three times higher than those of women and men without mood disorders. In addition, men with mood disorders are proportionally more likely to report being unsatisfied at work than women with mood disorders.

[20] Includes people who reported being either "not too satisfied" or "not at all satisfied."

Work-related stress

Table 1.5: Proportion of adults aged 15+ who report being stressed at work[21] by sex and mood disorder status – reference year 2012

Sex	With mood disorders	Without mood disorders	+/-
Women	41.7%	28.9%	12.8%
Men	43.8%	24.1%	19.7%

Source: 2012 Canadian Community Health Survey – Mental Health Status
All percentages are rounded to one decimal point.
Missing values are excluded.

Women and men with mood disorders are proportionally more likely to report being stressed at work than women and men without mood disorders.

Help received by employer

Table 1.6: Proportion of adults aged 15+ with mood disorders who receive help or services from their employer for their condition by sex – reference year 2012

Women	Men	+/-
15.4%[E]	10.5%[E]	4.9% [E]

Source: 2012 Canadian Community Health Survey – Mental Health Status
All percentages are rounded to one decimal point.
Missing values are excluded.
[E] Use with caution.

A higher proportion of women with mood disorders report receiving help or services from their employer for their condition than men with mood disorders. A possible explanation could be that women might be more inclined to ask for help than men.

[21] Includes people who reported that their work was "quite a bit stressful" or "extremely stressful."

Income

This dimension provides a portrait of the economic well-being of people with mood disorders through the use of three indicators:

- household income;
- difficulty affording basic expenses with current household income; and
- government transfers.

Household income

This indicator looks at the two following measures: adjusted average household income and household income distribution by quintile.

Table 1.7: Adjusted average household income for adults aged 15+ by sex and mood disorder status – reference year 2012

Sex	With mood disorders	Without mood disorders	+/-
Women	$37,053	$48,048	-$10,995
Men	$35,914	$52,492	-$16,578

Source: 2012 Canadian Community Health Survey – Mental Health Status
Amounts are in dollars.
All numbers are rounded to the nearest whole number.
Missing values are excluded.

Adults with mood disorders have a lower adjusted average household income than adults without mood disorders. The largest difference is seen between men with and without mood disorders ($16,578).

Table 1.8: Household income distribution of adults aged 15+ by quintile, sex and mood disorder status – reference year 2012

Quintile	Women with mood disorders	Women without mood disorders	+/-	Men with mood disorders	Men without mood disorders	+/-
Lowest 20%	33.0%	22.0%	11.0%	31.8%	16.4%	15.4%
Second 20%	20.2%	20.8%	-0.6%	29.1%	18.6%	10.5%
Third 20%	18.5%	20.7%	-2.2%	17.2%	19.9%	-2.7%
Fourth 20%	16.3%	18.5%	-2.2%	12.3%[E]	22.1%	-9.8%[E]
Highest 20%	11.9%	18.1%	-6.2%	9.6%[E]	23.0%	-13.4%[E]

Source: 2012 Canadian Community Health Survey – Mental Health Status
Amounts are in dollars.
All numbers are rounded to the nearest whole number.
Missing values are excluded.
[E] Use with caution.

More than 30% of both women and men with mood disorders have a household income that falls in the lowest quintile, compared to 22.0% of women without mood disorders and 16.4% of men without mood disorders. Conversely, approximately 10% of women

and men with mood disorders have a household income that falls in the highest quintile compared to approximately 20% of women and men without mood disorders.

Difficulty affording basic household expenses with current household income

This indicator look at individuals with mood disorders who report having difficulty affording basic household expenses, such as housing, food and clothing, with their current household income.

Table 1.9: Proportion of adults aged 15+ who report difficulty affording basic household expenses with current household income by sex and mood disorder status – reference year 2012

Sex	With mood disorders	Without mood disorders	+/-
Women	31.0%	11.8%	19.2%
Men	35.2%	9.2%	26.0%

Source: 2012 Canadian Community Health Survey – Mental Health Status
All percentages are rounded to one decimal point.
Missing values are excluded.

More than 30% of women and men with mood disorders report difficulty affording basic household expenses with current household income. The proportion of women with mood disorders who report difficulty affording basic household expenses with their current household income is close to three times higher than that of women without mood disorders. Meanwhile, the proportion of men with mood disorders who report the same difficulty is close to four times higher than men without mood disorders.

These differences may be partly explained by the fact that women and men with mood disorders are more likely to be in low-income status.[22] Low-income analysis using the 2012 CCHS - Mental Health Component shows that the proportion of women with mood disorders in low-income status is more than10% higher than that of women without mood disorders, while it is more than 20% higher for men with mood disorders compared men without mood disorders.

[22] Given that data on household income from the CCHS – Mental Health Component is self-reported by the respondent and it does not have annual income for a common calendar year, it only provides an estimate of the respondents' household income. Therefore, the low income estimates in this report are 'non-standard' and are not necessarily in line with other Low-Income Measure (LIM) concepts or estimates. They only provide a rough approximation of the household's income that would allow the determination of lower income families and individuals. Low-income estimations were calculated using the following steps, as proposed by Statistics Canada:

1. Household income was adjusted by family size;
2. The median adjusted income of the population was then calculated and divided by 2 to obtain a standard low-income threshold ($20,000.00 for this report); and
3. The standard low-income threshold was then multiplied by the square root of the household size.

Government transfers

This indicator looks at people with mood disorders who depend on government transfers[23] as their major source of income.

Table 1.10: Proportion of adults aged 15+ who receive government transfers as their major source of income by sex and mood disorder status – reference year 2012

Sex	With mood disorders	Without mood disorders	+/-
Women	17.7%	12.7%	5.0%
Men	18.7%	8.1%	10.6%

Source: 2012 Canadian Community Health Survey – Mental Health Status
All percentages are rounded to one decimal point.
Missing values are excluded.

Women and men with mood disorders are proportionally more likely to depend on government transfers as their major source of income compared to women and men without mood disorders. It is interesting to note that men with mood disorders are more than twice as likely to receive governmental transfers compared to men without mood disorders.

[23] Government transfers include all federal and provincial government transfers such as Employment Insurance, social assistance, Old Age Security, Canada child tax benefit, etc.

Mental health experiences

This dimension looks only at the mental health experiences reported by people with mood disorders. Their experiences are measured through:

- access to health care services for mental health problems and illnesses; and
- discrimination due to mental health problems and illnesses.

Access to health care services for mental health problems and illnesses

Having a mental health problem and illness is a significant predictor of using the health care system.[24] For people with mental health problems and illnesses, accessing first-line services is often seen as reducing the severity and prevalence of mental health problems and illnesses.[25] Barriers to utilizing and accessing health care for people with mental health problems and illnesses include lack of social support, acceptability, accessibility and availability of health care services.[26]

This indicator looks at adults with mood disorders who report not getting the help they need.

Table 1.11: Proportion of adults with mood disorders aged 15+ who report needing help but not receiving it by sex – reference year 2012

Women	Men	+/-
34.2%	37.7%	-3.5%

Source: 2012 Canadian Community Health Survey – Mental Health Status
All percentages are rounded to one decimal point.
Missing values are excluded.

Over one third of women and men with mood disorders report not receiving needed help, with slightly more men reporting so than women.

[24] Schultz, Izabela Z., and Sally E. Rogers, ed. *Work Accommodation and Retention in Mental Health*. New York: Springer Science+Business Media, 2011.
[25] Rogers, Anne, and Dr. David Pilgrim. *Mental health and inequality*. United Kingdom: Palgrave Macmillan, 2003.
[26] I Lesage A., et al. *Prevalence of Mental Health Illnesses and Related Service Utilization in Canada: An Analysis of the Canadian Community Health Survey.* Mississauga: Canada Collaborative Mental Health Initiative, 2006.

Table 1.12: Proportion of adults with mood disorders aged 15+ who report that their needs are only partially met or not met at all by type of help needed and sex – reference year 2012

Type of help needed	Women	Men	+/-
Counseling	27.9%	26.7%	1.2%
Health information	12.5%	11.3%[E]	1.2%

Source: 2012 Canadian Community Health Survey – Mental Health Status
All percentages are rounded to one decimal point.
Missing values are excluded.
[E] Use with caution.

The proportion of women with mood disorders who report that their needs for counselling and for health information are only partially met or not met at all is slightly higher than those of men with mood disorders.

Discrimination due to mental health problems and illnesses

Table 1.13: Proportion of adults with mood disorders aged 15+ who report being discriminated[27] against because of their mental health problem and illness by sex – reference year 2012

Women	Men	+/-
43.0%	31.5%	11.5%

Source: 2012 Canadian Community Health Survey – Mental Health Status
All percentages are rounded to one decimal point.
Missing values are excluded.

A high proportion of both women and men with mood disorders report being discriminated against because of their condition. The proportion is especially high for women with mood disorders.

[27] Question MHE_Q06 "(During the past 12 months, did you feel that anyone held negative opinions about you or treated you unfairly because of your past or current emotional or mental health problem?" was used to determine if the respondent perceived being discriminated against.

Conclusion

This report shows that in terms of socioeconomic well-being, adults with mood disorders do not fare nearly as well as adults without mood disorders.

Adults with mood disorders are more likely to:

- have lower household income;
- rely on government transfers as their major source of income;
- report difficulty affording basic household expenses such as housing, food, clothing, etc.

The adjusted household income of women and men with mood disorders is more than $10,000 lower compared to women and men without mood disorders. In addition, more than 30% of women and men with mood disorders report experiencing difficulty affording basic household expenses with their current household income.

Mood disorders seem to have a negative impact on education level, job satisfaction and work-related stress. It is important to note however that other reasons (such as family-related reasons, physical health reasons, etc.) may have an impact on job satisfaction and work-related stress. Adults with mood disorders report being discriminated against because of mental health problems and illnesses. And more than 25% of adults with mood disorders report their counseling needs are met only partially or not met at all.

Compared to men with mood disorders, women with mood disorders seem to be:

- less likely to have post-secondary education at the university level as their highest educational attainment;
- more likely to report working part-time and experiencing discrimination;
- more likely to report being satisfied and less stressed at work; and
- less likely to report experiencing difficulty affording basic household expenses with their current household income.

Additional research is necessary to better understand the impact of mood disorders on equality rights, especially in the workplace. For example, we need to better understand the relationship between discrimination in the workplace and the prevalence of mood disorders. In other words, is discrimination in the workplace a contributing factor to mood disorders? Other research could look at:

- the protective factors that may reduce the impact of mood disorders in the workplace;
- the reasons why individuals with mood disorders do not disclose their condition to their employer; and/or
- the employment conditions of people with mood disorders by industry.

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