ARTICLE
Kelowna 2011 JEMH Conference: Invited Submission

The Role of Public Health in Mental Health

Bernard M. Dickens, OC PhD LLD FRSC
Professor Emeritus Faculty of Law, Faculty of Medicine and Joint Centre for Bioethics
University of Toronto

Introduction

The Constitution of the World Health Organization (WHO) opens by stating that "Health is a state of complete physical, mental and social well-being..." This acknowledges that social conditions contribute to, or detract from, health, including mental health. Such factors as housing, income, employment and diet influence individuals' health status, and their mental health can be reduced, for instance, by stress or anxiety related to income or employment insecurity, feelings of loneliness and cultural alienation. The Public Health Agency of Canada reflects this wider vision of the social determinants of health in observing that public health is part of every aspect of our lives, from our houses to our work places, and our schools to our communities. Public health is about the way we live.

The disciplines that contribute to public health go far beyond the traditional medical or health sciences. They focus on epidemiology (the study of epidemics), but include sociology, economics, political science and group or mass psychology. A key commitment of public or population health is social justice, recognizing the mental health burden of suffering injustice. The ethical principle of justice requires that like cases be treated alike, which is why following precedents is so important in law, and that different cases be treated in ways that acknowledge the difference. Justice therefore requires comparisons and contrasts with how other cases have been resolved; that is, justice is an institution of society, not just a satisfactory resolution of a conflict between two individuals. It is in drawing social contrasts that we can identify the higher rate of mental illness among disadvantaged populations, measured by higher rates of depression and anxiety. This is not to say that there is necessarily a higher incidence of major psychiatric disorders such as schizophrenia or bipolar disorder, but that the senses of mental and social well-being among disadvantaged populations, part of the WHO description of health, appear lower.[1]

Clinical Health and Public Health

The primary focus of clinical medicine is treatment and care of individuals who suffer from illnesses. That is, the primary good is to serve the best interests of individual patients. In contrast, the primary focus of public health is on prevention of illness and maintenance of population health, rather than on cure of sickness and rehabilitation. The legal origins of the public health service are in the governmental police function. True policing is not in the detection of offences after they are committed or in the arrest and prosecution of suspected offenders, but in control of risk factors for harm, surveillance of community well-being, and upholding of safety and security by prevention of foreseeable injuries.

The public health service discharges policing roles in the detention of infected persons who pose a risk of causing injury to others, such as spreading infection, control of those who may have contracted communicable infections (quarantine) and questioning of those who may have infected others (contact tracing). The public health service is a uniformed service. For instance, the U.S. Uniformed Services University of the Health Sciences in Bethesda, Maryland, is a federal postgraduate academy training medical members of the armed services and of the U.S. Public Health Service Commissioned Corps. The US Surgeon-General usually makes public appearances in uniform, although public health officers elsewhere usually emphasize their medical and health protective role rather than their military credentials. Nevertheless, public health officers possess a range of coercive powers, including involuntary detention of individuals, mandatory reporting of health conditions, closure of dangerous premises, seizure of harmful food and other products and agents of infection, and demolition of dangerous structures.

With regard to mental health, public health activities and strategies may deliberately plan to relieve or reduce mental illness, such as by removing sources of anxiety and insecurity in neighbourhoods, and creating amenities to promote healthy lifestyles and recreational opportunities. As against this, however, public health initiatives may inadvertently cause or aggravate feelings of alienation and exacerbate mental illness, such as by denying individuals' opportunities to live in familiar premises or areas, or close to commercial or cultural outlets they find congenial.

Reduction of Mental Illness

Public health sciences and understanding have developed with the growth of urbanization, which has congregated masses of people within relatively confined areas and facilitated the spread of contagious and air-borne diseases. Town planning laws and land-use zoning regulations shape the urban built environment. Wealthy families can escape congested towns to reside on landed estates, but poorer people are concentrated in low-rental housing districts, often close to their industrial workplaces. Health disparities

 (ISSN: 1916-2405)

between more affluent and impoverished communities, including mental health disparities, may be related to their living conditions. It has been observed that:

> Research on the connections between health and the environment, specifically the built environment, has shown that the burden of illness is greater on minority and vulnerable populations, and on those of low socio-economic status. The high prevalence of noxious land uses and ready availability of tobacco products and inexpensive, unhealthy foods in communities where low-income families...are more likely to live, work, and play provide salient examples of how the built environment can impact health and exacerbate health disparities. [2]

To mitigate effects of residing within overcrowded communities, which create risks of interpersonal violence, public health laws limit urban population densities, and aim to provide safe, sanitary residential accommodation at some distance from sites of industrial production and waste, including toxic effluents and smoke emission. Healthy domestic environments are enhanced by easy access to recreational space such as parks, playgrounds and cycle and jogging paths.

Related to convenient residential accommodation is convenient public transportation. Workplaces, commercial facilities and shopping areas must be accessible, as must health centres. The stress of congested traffic and delayed access to schools and, for instance, emergency services, should ideally be minimal. Accordingly, an important component of healthy living that reduces stress and anxiety is town planning, road traffic management, and the assurance of individuals' means of access to services. Responsibility for public transportation does not lie directly with public health authorities, but they must take account of individual mobility considerations, and if necessary liaise with more directly responsible transportation agencies, in both the public and private sectors, as part of their underwriting of population health.

Without means of transportation, people even in urban areas may feel isolated, but cultural isolation and feelings of alienation are also factors affecting mental health. This is especially so in Canada, where sizeable numbers of immigrants have settled, often but not always within urban immigrant communities, and various aboriginal communities exist whose members may leave their traditional settlements to live in urban areas. A society's respect for and accommodation of the cultural beliefs and values, including spiritual beliefs of its different members, contributes to their mental health and feelings of social well-being.

Promotion of the mental health of members of indigenous or aboriginal communities can pose major challenges where concepts of health have a biomedical, western orientation. The holistic way in which aboriginal communities may conceive of health [3] has much in common with the WHO concept of health, but in westernized societies "health" care is often focussed on care of those affected by medically diagnosed sickness, and promotion of mental or psychological wellness may be considered outside the medical healer's immediate skill or responsibility.

Legal systems differ on their recognition of traditional aboriginal healers, and approval of use of their herbal or other medications. In Ontario, for instance, the lawful practise of medicine is generally reserved to those who are medically qualified and licensed, but traditional aboriginal healers are exempted from this requirement when treating members of their own communities. Their legal status in other Canadian jurisdictions is not so clear, but it is widely considered that their practices, and use of their methods, would be tolerated even if not explicitly accommodated. Traditional healers are of particular value regarding several forms of mental illness, because they can communicate with their community members in culturally sympathetic ways, situate their mental disorders in relevant contexts, and explain therapeutic strategies in comprehensible language. [4]

Prevention of Injury and Mental Illness

Strategies to reduce the incidence of brain damage include motor cycle helmet laws, provision of reserved cycle lanes on major roads and encouragement of cyclists to wear helmets. Similarly, laws often require wearing of helmets on construction sites and elsewhere where objects may fall from above. Prevention or reduction of brain damage is also approached by more medical interventions, such as to prevent and reduce the damage due to cerebral hemorrhage or stroke, birth traumas causing brain damage and prenatal injuries, such as by discouragement of multiple pregnancies in in vitro fertilization (IVF).[5] Beyond physical protection of the brain, however, are public health measures to address risks of emotional or psychological injuries, many of which are stress- or anxiety-related.

Workplaces often present causes of stress. Anger and frustration due to discriminatory practices, are the concern of human rights and employment equity agencies, but public health authorities may regulate such issues as work-breaks, access to seating for employees in jobs based on walking and standing, and to adequate toilet facilities. The Canadian Mental Health Association's educational and training programme on Emotional Distress in the Workplace, for instance, addresses both reduction of employment-related stress and anxiety, and how workplace managers can address employees' mental health affected, for instance, by life events, depression, trauma, substance abuse and anxiety, whether arising within or outside the workplace.

Safety and anxiety in the home are also public health concerns. Statistics of home injuries, workplace injuries and road traffic injuries may be complex to compare and contrast, but there are enough sources and causes of injuries in the home, not only to more vulnerable occupants such as children and elderly or disabled occupants, to justify realistic, non-alarmist anxiety. Consumer protection requirements for electronic and other home-use devices, and licensure standards for instance for electrical engineers, home construction and repair contractors, and home construction inspectors, can go some way to relieve some consumers' anxieties, but on-going public health education programmes are justified to maintain alertness to anxiety-inducing sources of health threatening domestic injuries.[6]

Related public health concerns that tend to attract greater attention of newsmedia are safety of domestic drinking water and food sources. Contaminated drinking water has been a long-

standing concern on First Nations' reserves in Canada,[7] where jurisdictional accountability conflicts among federal, provincial and municipal governmental authorities have obstructed effective resolution. However, public enquiries such as concerning the Walkerton, Ontario contaminated water supply in 2000 and in North Battleford, Saskatchewan in 2001,[8] illustrate the attention public health authorities must give to reduce this source of anxiety. Similarly, the Canadian Food Inspection Agency (CFIA) is mandated to ensure access to a continuous and secure supply of safe foodstuffs by assessing their quality and inspecting commercial food products and manufacturers, including where necessary introduction of quarantine measures. The CFIA also sets policy on and monitors plant and animal product imports, and provides guidance to provincial and municipal public health agencies.

Public health authorities have less power to regulate country foods that particularly aboriginal communities acquire by hunting, trapping and fishing. For instance, the high mercury content of lake fish in areas of Northern Ontario, due both to the natural environment and to industrial (e.g., paper mill) pollution, has been found to cause neurological damage particularly to children. The risk is aggravated by local communities' heavy dependency on lake fishing, including several meals of fish daily during the spring, summer and fall seasons. Advice by public health authorities against excessive reliance on a fish diet may be of limited effect when communities' lack resources to buy alternative goods in commercial markets. A similar concern arises in Northern Canada and its Pacific Coast, where local communities consume the meat and other body materials of whales that feed in heavily polluted waters.[9]

Public health management of addictive disorders contrasts the pragmatic nature of public health disciplines with the moralistic motivation and rhetoric of many politicians. In June 2011, a high-level international panel, including former presidents of Mexico, Colombia and Brazil and the former UN Secretary-General, Kofi Annan, condemned the "War on Drugs" as a failure. It recommended experiments to decriminalize the use of drugs, particularly marijuana, to undermine the power, expressed in sponsorship of corruption and violence, of organized criminal cartels. Compiled by the Global Commission on Drug Policy, the panel's report observed how criminalization and repressive measures have failed in their purpose but have caused devastating consequences for individuals and societies around the world. The panel's conclusions were immediately rejected by governments, for instance in the US and, by implication, in Canada, where the government in May, 2011 argued in the Supreme Court against judicial findings that maintaining a supervised injection facility for drug users in Vancouver is a legitimate harm reduction strategy.[10]

Provision of sterile equipment to injection drug users has long been a public health approach to reduce the spread of HIV and hepatitis infection, and comparable initiatives have been taken to reduce the burden of mortality and morbidity from drug overdoses. In 2003, the Canadian federal health minister approved the creation of the agency named Insite, in Vancouver, as North America's first safe injection facility for drug users. The facility provides sterile needles and syringes, advises drug users on safe dosages, and provides means of escape from the bonds of drug addiction. When, with a change of national government, the federal health ministry ended its support in 2008, and the site's associated exemption from the Controlled Drugs and Substances Act (CDSA), a British Columbia provincial health authority, Vancouver Coastal Health, maintained Insite. It obtained a British Columbia Supreme Court ruling, subsequently upheld by the provincial Court of Appeal, that criminal laws restraining conduct of the facility are unconstitutional. The site has achieved an overall 35% reduction in drug overdose fatalities since it opened, whereas during the same period the fatal overdose rate in other parts of the city decreased by 9.3%.[11]

At the end of September 2011, the Supreme Court of Canada unanimously ruled that provisions of the CDSA are constitutionally valid criminal law, and in principle generally applicable. However, the Court ordered the federal Minister of Health to renew Insite's exemption from liability under the Act, so that it could continue to operate. The Court saw Insite as an effective harm reduction facility that served a legitimate public health purpose, promoting the well-being of addicted individuals and the wider community. This raises the question of whether the Minister will have to grant similar exemptions to comparable facilities in other centres.

Particular Work-Related Stress

It has been noted above that mental disorder due to general employment-related stress and anxiety has been the focus of public health initiatives. Evidence has shown, however, that particular forms of employment are unusually prone to cause mental disorder among those engaged in them, and that training is required for development of individual and institutional protective and recuperative techniques. Disaster response management is studied for events that can be anticipated to occur in principle, but the timing of which cannot be predicted.

Public health, firefighting, ambulance and, for instance police personnel, collectively described as First Responders, are often first to witness the effects of the devastating injuries and deaths suffered by victims of a wide range of natural or man-made disasters, sometimes working for weeks or months with affected communities. It has been observed that, while they may be faced with risks of physical injuries:

> Harms to first responders' mental health...are equally important to consider. Although mental health conditions may be overlooked because they can be difficult to visibly identify and diagnose, their presence may significantly affect first responders' ability to function.
>
> Studies have demonstrated that...first responders experience elevated rates of depression, stress disorders, and post-traumatic stress disorder (PTSD) for months and sometimes years. Those without disaster response training face greater risk of receiving a PTSD diagnosis after the response concludes.[12]

The terrorist attack on the twin towers of the World Trade Center in New York City on September 11, 2001, left an aftermath of traumatic responses suffered by rescue personnel. In 2002, the US National Institute for Occupational Safety and Health (NIOSH) funded the World Trade Center Medical Monitoring and Treatment Program, with clinics in New York and New Jersey,

for long-term health screening and care for 9/11 first responders' physical and mental health conditions, including PTSD, depression and substance abuse.

Following the Second World War, soldiers and others directly exposed to combat, were often described as suffering from "shell shock". This is now known as PTSD, and its incidence is now commonly recognized among veterans of subsequent conflicts, and among directly affected civilian populations, including refugees. The former are often eligible to receive care from governmental health services dedicated to military veterans, but care of civilian residents and refugees may become the responsibility of less experienced and equipped personnel and facilities. As a further disadvantage, potential immigrants from war-torn areas may be denied entry to some countries, including Canada, if their suffering from PTSD is liable to burden local health care services.

Providing care for the caring professionals raises concern for public health as well as clinical health services. For instance:

> US researchers have known for several decades that physicians have worryingly high rates of suicide and depression when compared with the general population... Male doctors are 1.4 times more likely to commit suicide than other men, and female doctors are 2.3 times more likely to do so than other women, according to a 2004 analysis in the American Journal of Psychiatry.[13]

Exact causes remain unknown, but the problem has been traced back to competitiveness in medical school, the quest for perfection, and fear of showing weakness or vulnerability. Stress and burnout among physicians is increasingly identified as a public health concern, associated with rates of self-medication, alcoholism and use of accessible drugs, and fear of loss and medical licences if mental stress is reported. Despite public health publicity to destigmatize receipt of mental health care, seeking care apparently remains stigmatizing within the medical community itself. Concerns and measures to improve doctors' professional coping skills are not specific to North America but have been addressed, among other countries, in Australia.[14]

Like soldiers and civilian populations caught in combat zones, disaster rescue teams and those they rescue may suffer mental health effects. For instance, a year after the Deepwater Horizon oil spill disaster in the Gulf of Mexico in April 2010, it was observed that:

> Mental health symptoms are commonly reported by response workers and community members after oil disasters. Calls to mental health and domestic violence hotlines in the Gulf area have increased since the oil spill, in keeping with reports of increased domestic violence, mental illness, and substance abuse after other disasters.[15]

However, the lack of pre-disaster baseline data and variations in the rigor of assessments of stressors and post-disaster mental health symptoms, have raised questions about the reliability of this observation.

Public Health Dysfunctions

It has been seen that public health initiatives may inadvertently cause or aggravate mental health disorders, such as by triggering anxiety or distress. Actions by public health authorities that jeopardize mental health are often the unintended consequences of well-intended acts. For instance, measures to assist residents' comfort in rooming accommodation may result in individuals becoming homeless. International experience confirms that homelessness is associated with increased rates of psychiatric morbidity.[16] As against this, an initiative to ensure accommodation may cause poor residential distribution and overcrowding, resulting in loss of privacy and inter-personal conflict ending in violence. Provision of single sex shelters, usually to safeguard women and their young children against abusive male partners, may divide families and hinder reconciliation, but mixed sex accommodation lacking supervision may expose women to risks of sexual assault and violence, with attendant mental health effects.[17]

Residential overcrowding and its harmful effects on loss of privacy and the potential for domestic conflict is a particular concern in Canada on many First Nations reserves. Historical law denied Aboriginal women who married non-Aboriginal husbands Indian status, and their right to live with their children on reserves. The UN Human Rights Committee ruled in 1981, however, that this unlawfully denied them the right to practice their culture, which they could do only on the reserves on which they had grown up. Legal change in 1985 entitled such Aboriginal women and their families to return to and live on their reserves, but no additional funds were available to accommodate them. This resulted in domestic overcrowding with its harmful effects, among others, on mental health.

A related concern, affecting Aboriginals both on reserves and off, arises with lack of access to Aboriginal healers, and continuing uncertainty about healers' legal right to practice and to employ traditional therapies. Legal concerns have been resolved in some jurisdictions, but continuing uncertainties about the provision, funding and legality of Aboriginal health services, for both somatic and psychiatric care, leave the care of some of the Aboriginal population in the care of providers whose techniques members of the population find alien and alienating.[18]

This effect on members of Aboriginal populations is amplified in the culturally alienating experience of members of immigrant communities.[19] They may be dependent on health service providers who do not speak their languages, and whose choice of words based on a biomedical model of health care, and whose techniques, they do not understand. Providers may find their patients' attitudes, explanations, rationalizations and responses similarly incomprehensible, and perhaps to evidence mental disorder, such as when shaped by occult spiritual beliefs.

Public health officers may have little influence over a health system's recruitment and distribution of professional health personnel, although they can helpfully indicate what needs exist and are unmet. They may be more influential, however, to guide municipal and other land use zoning committees regarding how decisions might bear upon health in general, and particularly mental health. Their lack of guidance initiatives may contribute to poorly planned urbanization, with a special impact on the health of impoverished

communities, such as in ghettos, barrios or favelas.[20] Decisions that separate communities' residential accommodation from their workplaces and healthcare centres, for instance, may aggravate anxiety and frustration in achieving transportation between home and work, and to health care services.

A feeling of helplessness, discrimination and depression may affect disadvantaged communities in whose areas environmental or comparable hazards are located. The sociological term "environmental racism" describes the practice of using low-income or racial minority disadvantaged communities' residential areas as sites, for instance, for waste-disposal facilities such as garbage or hospital waste incinerators and for outlets of industrial or other sources of pollution. Blame for causation may arise because health hazards are placed within politically powerless victim communities, or because low-income populations are allowed to be attracted to hazardous locations by the related cheap land prices and rents. Positive planning decisions are involved, however, in, for instance, locating prison-release halfway houses or detention centres for delinquent adolescents in less advantaged urban area. This is not just an urban concern, however, since in Canada, for instance, Aboriginal communities have protested against land adjacent to their reserves being targeted as landfill sites for industrial waste products, thereby affecting fishing streams, access to medicinal herbs and areas for spiritual cleansing ceremonies.

The interaction of psychiatric disorders and employment, including long-term employability, remains insufficiently studied. It has been observed that psychiatric disorders are now the most common reason for long-term sickness absence from the workforce. The associated loss of productivity and the payment of disability benefits, place a substantial burden on the economies of many developed countries. The occupational dysfunction associated with psychiatric disorders can also lead to poverty and social isolation. As a result, the area of work and psychiatric disorders is a high priority for policy makers.[21] Accordingly:

> [t]here are two main agendas: for many researchers and clinicians the focus is on the need to overcome stigma and ensure people with severe psychiatric disorders have meaningful work; however the public health agenda predominantly relates to the more common disorders such as depression and anxiety, which contributes a greater burden of disability benefits and pensions.[22]

Nevertheless, workplaces remain sources of common forms of psychiatric distress, due, for instance to "job strain." Strain or stress responses occur when workers perceive that their effort at work is not matched by rewards such as pay, timely promotion, self-esteem and sense of achievement. The public health service, among others in the public and private sectors, has scope to address this concern since:

> [t]he public health impact of psychiatric symptoms on occupational outcomes is substantial but it is unclear how governments, insurers, employers, and health services should respond and there is a paucity of high quality studies to guide them.[23]

Another aspect of social functioning where the public health service might improve community mental health is the interchangeability of members of the prison and mental health populations. Some members are imprisoned for offences due to their mental illnesses, while others suffer mental illness due to conditions of their imprisonment. In September 2010, the Canadian federal prison ombudsman wrote that Corrections Canada, the federal agency responsible for prisons, was warehousing people with mental health disabilities, and that federal penitentiaries are becoming the largest psychiatric facilities in the country. Worldwide, it is estimated that more than 10 million people are currently incarcerated, including 2.3 million in the US alone, which in 2009 had 743 prisoners per 100,000 of population, the international mean being 145 prisoners per 100,000.[24] In Canada in 2009, there were 117 per 100,000 population.

Mental disorders and infectious diseases are considerably more common in prisoners than in general populations, with comparatively high rates of suicide. The public health service cannot remedy the current need for adequate mental health care within prisons, affected by overcrowding and vulnerability to sexual and other violence but:

> [m]ost prisoners with mental health problems return to their home communities, and treatment of their illness is therefore an important public health opportunity because treatment seems to decrease rates of repeat offending. However, many patients have difficulty accessing appropriate medical care in the community, and prognosis is associated with the duration of untreated illness.[25]

Such measures as prolonged solitary confinement in prison, condemned by a Canadian court as cruel and inhumane treatment, persist in Canada and elsewhere.

Public health leaders could speak out against this practice, on mental health and humanitarian grounds. It would be appropriate for the public health service to advocate on behalf of societies' least favoured members, consistently with its professed commitment to social justice and equality for all. This advocacy requires commitment and courage, not least in countries, such as Canada, where governments are committed to expansion of the prison population, with longer terms of detention, and legislation of minimum sentences that denies judges the power to calibrate terms of detention to the factors in individual cases, in order that punishment fits not the abstraction of "the crime", but the reality of the convicted offender as an individual social and human being.

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Acknowledgements: *None*

Competing Interests: *I am a member of the JEMH Editorial Committee/Board of Directors.*

Address for Correspondence:
Bernard Dickens, Professor Emeritus
Faculty of Law, Faculty of Medicine and Joint Centre for Bioethics
University of Toronto
84 Queen's Park Crescent
Toronto Canada M5S 2C5

Published: *November 30, 2011*