A note about the sponsors
- Canada's largest mental health and addiction teaching hospital.
- Combines clinical care, research, education, policy development and health promotion.
- Aims to help transform the lives of people affected by mental health and addiction issues.
Mental Health Commission of Canada (MHCC)

- Non-profit organization created to focus national attention on mental health issues and to improve the lives of people living with mental illness.
- It is a national body, funded by the Health Canada, endorsed by all levels of government but operates at arm's length.
- The Commission is working on five key initiatives:
  - Mental health strategy
  - Opening Minds (Anti-stigma/anti-discrimination) initiative
  - At Home/Chez Soi demonstration project
  - A knowledge exchange centre
  - Partners for mental health program
Mental Health Strategy: Step 1
What is a transformed system = 7 Goals

- Actively engaged and supported in their journey of recovery and well-being.
- Mental health promotion and prevention.
- System responds to the diverse needs of all people.
- Families and care circle included and supported.
- Equitable, timely, effective and integrated around client needs.
- Built on best evidence and multiple sources of knowledge, outcomes are measured, and research is advanced.
- Social inclusion
Mental Health Strategy Step 2: How to achieve a transformed systems

- A series of Roundtables March and September 2010.
- 25 people reflecting a cross-section of stakeholders
- One round table on diverse needs and strengths
- This paper one document that informs round table:
Outline: three parts

- How the report came into being
- Issues
  - (census, literature review, focus groups)
- Options
  - (model, recommendations)
How the report came into being

Kwame McKenzie
Stage set by international demographics
immigration common to big cities

This map was made for the MPI Data Hub by Nuala Cowan, Department of Geography, George Washington University (March 2007). The data are from the Globalization, Urbanization and Migration web site (www.gstudynet.org/gum) developed by Marie Price and Lisa Benton-Short.
Language and culture play an important role in mental health service delivery. For example, if I go to a service provider who doesn’t know my language and is not familiar with my culture, first of all I will not be able to explain my problem to him/her as I want to say it, secondly, even if he/she gets me, will still not be able to provide me with culturally appropriate treatment which is very important. – Focus Group Participant
“Developing mental health care for multi-cultural society common challenge”

Inattention to mental health needs of ethnic minorities leads to:

- Poorer access to care
- Increased use of crisis and emergency care
- Increased use of police and prison justice system
- Increased hospitalisation (involuntary)
- Poorer outcomes
- Increased community burden of mental illness
- Increased deaths due to suicide
Attempts at policy in Canada but not clearly led to service improvement

- After the door has been opened - *National Mental Health Task Force 1988*
  - 27 recommendations – 6 taken up
This issues and options paper for MHCC = academic synthesis & lots of consultation

- census
- literature
- synthesis
  - Task group
  - Issues and options
  - Policy makers
  - Focus groups
  - website
  - forums
  - roundtable
Data for issues from 3 sources

- Census
- Literature review
- Focus groups
- Population of Canada  
  • 31,241,030
- Immigrant population  
  • 5,420,540
- Visible minority population  
  • 5,068,090
- Population with non official mother tongue  
  • 6,138,395
Immigrant, refugee, ethno-cultural and racialised groups (IRER)

- Diverse groups with different realities and needs
- Does not include Aboriginal, first Nations or Inuit groups
- Diversity between and within provinces and communities
- All provinces have changing demographics
- 64% belong to three Statistics Canada groupings: “South Asian”, “Chinese”, and “Black”
Percentage of population that IRER in provinces and territories

- Yukon Territory
- Saskatchewan
- Quebec
- Prince Edward Island
- Ontario
- Nunavut
- Nova Scotia
- Northwest Territory
- Newfoundland & Labrador
- New Brunswick
- Manitoba
- British Columbia
- Alberta

Canada
Percentage change in IRER 2001 to 2006

Canadian Average
Increase 27.2%
Highest change in IRER populations in some central metropolitan areas

% IRER population

% IRER population growth

- Abbotsford (B.C.)
- Calgary (Alta.)
- Kelowna (B.C.)
- Kitchener (Ont.)
- Moncton (N.B.)
- Oshawa (Ont.)
- Sherbrooke (Que.)
Main driver of population growth
• Responsible for more than two-thirds of growth between 2001 and 2006
• Nearly 20% of Canadian population foreign-born
Region of birth of people who have immigrated to Canada in last 5 years

Percent of Immigrants by Region of Birth

- U.S. Oceania and Other
- Caribbean, South and Central America
- Africa
- Asia and the Middle East
- Europe

Before 1961
1961-1970
1971-1980
1981-1990
1991-2000
2001-2006
% immigrant population by electoral ward
In Toronto and Vancouver moving from city centre to suburbs
Social determinants of mental health

- Not much data in census to date
- Main information on education and literacy and employment
Highly educated immigrant populations in Canada
  - Education becoming more important
Underemployment a problem for some groups
Ratio of earnings of recent immigrants to Canadian people is decreasing over time
Main messages

- Growing and changing population in all provinces
- Most populous cities Toronto, Montreal, Vancouver
- Greatest percentage changes in smaller CMAs
- Links between IRER groups and social determinants of health
Canadian literature 3 main issues

- social determinants of health
- rates of mental illness
- barriers and facilitators to care,
Social determinants

- Social factors linked to mental health problems for all
- IRER groups more exposed to social determinants
- IRER groups also exposed to novel social determinants
  - migration, discrimination and language difficulties.
- Impacts of social determinants complex
- Social forces that increase risk increased in some IRER populations
- Social forces that decrease risk in some IRER groups because of their social status in Canada
Rates of mental illness

- IRER often considered as single population which can create inaccurate picture
- Low rates of mental illness in immigrant groups when they arrive in Canada but these may increase over time
- Local studies in Canada report high rates of mental health problems and illnesses in some IRER groups
- Rates vary in IRER groups in Canada
- Less likely to get care and poorer care received
- Numerous barriers eg:
  - Awareness and stigma
  - Pathways unclear
  - Models of care and personnel not acceptable
  - Lack of cultural competence and sensitivity
  - Financial barriers
  - Language
Literature results: Facilitators of care

- length of stay in Canada / acculturation
- knowledge and education
- ethno-specific health promotion
- trust in the system
- cultural competency
- co-operation between service providers
- diversity of services including alternative approaches
Focus groups
Kwame McKenzie

Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale
“I would like to receive long term mental health services. I do not wish to be discharged if you think I am feeling better. I want to decide when it is time for me to go. I like receiving the additional support, it helps me to live a fulfilling life.”
“I have the ability to speak with an individual in Tamil and English, which is nice. I definitely think the language barrier is a key component in many people in our community not being able to take advantage of the services that are offered. I had switched from having a doctor at (Hospital A) to (a Tamil doctor at Hospital B) because I felt there was a spiritual/cultural component/link to understanding my health problems. I did not receive this respect for culture in using the services at (Hospital A).”
“If youth are not targeted, there is a big risk of addiction to drugs and joining the gangs.”

“If our children are healthy and fine, we are happy and relieved, but if they are suffering from mental health problems then the whole family are affected and our symptoms are worsened.”

“Youths are suffering from the cultural conflict, from one side they are forced by parents to stick to their culture and traditions while from the other side, they are exposed to different cultural norms, therefore it is important focus on youth and adolescents groups.”
Focus groups: main messages
General agreement with literature

- Work on social determinants including pre-migration stress
- Anti-stigma work needed
- Better awareness and information about services
- Better access to services
- IRER specific services could help
- More diverse services would help – one stop shops services at places of worship
- Value services but think they could be improved
- Target intersections (eg young, old, new comers)
Back to basics: Multilevel aetiology of mental health problems

- Each level different scientific rules
- Each level may contain sub-levels
- Impact at any level confined by higher level
- An intervention may have impact at more than one level
- Studying interaction vitally important
Need interacts with community to change service needs and effectiveness

Pathway through care for someone in psychological distress
Options based on theory of health equity

- Different groups may have different needs.
- The issue not just different needs but service response.
- Health inequities = differences in access, use or outcome because of an interaction between community need and service response
### Who can offer interventions for what type of need

<table>
<thead>
<tr>
<th></th>
<th>Differential need</th>
<th>Inequitable service response</th>
<th>Context in which need &amp; service response occur</th>
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</thead>
<tbody>
<tr>
<td>Clinicians and teams</td>
<td></td>
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<tr>
<td>Organisation</td>
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<td>Service system</td>
<td>Xx</td>
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<tr>
<td>Societal / legislative</td>
<td>Xx</td>
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</tbody>
</table>
Rules for successful interventions:

• need to be purposeful and targeted at a specific level
• need to understand the science and rules at that level for their impact to be predictable
• may have impacts at different levels but this will not be efficient unless they are purposeful
Options recognise MHCC position and the responsibility of Provinces, Territories and Regions.

Shape of the response –
- Issues and options paper

Content of the response -
- Defined locally
- Need to promote strong and healthy communities and build resiliency
- Need to improve services

So...

- Need
  - Traditional health services
  - Government
  - Public organisations
  - Private and voluntary sectors
- Population-based, flexible services that use the involvement of IRER communities to understand and meet their needs.
- Provinces, territories and regions tailor service development to their demographic imperatives.
- Experience of local communities and people with lived experience employed to help develop more appropriate services
Co-ordination of policy, knowledge and accountability

The involvement of communities, families and consumers

More appropriate and improved services
Co-ordination of policy, knowledge and accountability

- Policy and plans needed: coordinated and aligned at all levels
  - Promotion
  - Prevention
  - Improved services
- Plans built on local data with wide view of evidence
- Leadership
Involving communities useful as it helps to:

- Understand needs
- Understand resources
- Build partnerships
- Decrease duplication
- Improve awareness
- Build on multiple voices and strengths
- Build democracy
Better service response

- Changed focus towards prevention and promotion
- Improvement within services
- Improved diversity of treatment
- Linguistic competence
- Needs linked to expertise
MHCC Diversity Task Group

- Adriana Reina
- Robert Wright, Child Youth Strategy, Nova Scotia
- Dr. Miriam Stewart, University of Alberta
- Dr. Ted Lo, Centre for Addiction and Mental Health
- Dr. Laurence Kirmayer, McGill University
- Aseefa Sarang, Across Boundaries, Toronto
- Sri Pendakur, Vancouver Coastal Health
- Dr. Kwame McKenzie, Centre for Addiction and Mental Health
- Kwasi Kafele, Centre for Addiction and Mental Health
- Steve Lurie, Canadian Mental Health Association and Chair of the Service Systems Advisory Group to the Mental Health Commission of Canada
- Dr. Howard Chodos, Mental Health Commission of Canada
- Dr. Gillian Mulvale, Mental Health Commission of Canada
- Brenda Leung, Mental Health Commission of Canada
- Emily Hansson, Centre for Addiction and Mental Health
- Andrew Tuck, Centre for Addiction and Mental Health
thanks