CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO FALL 2010

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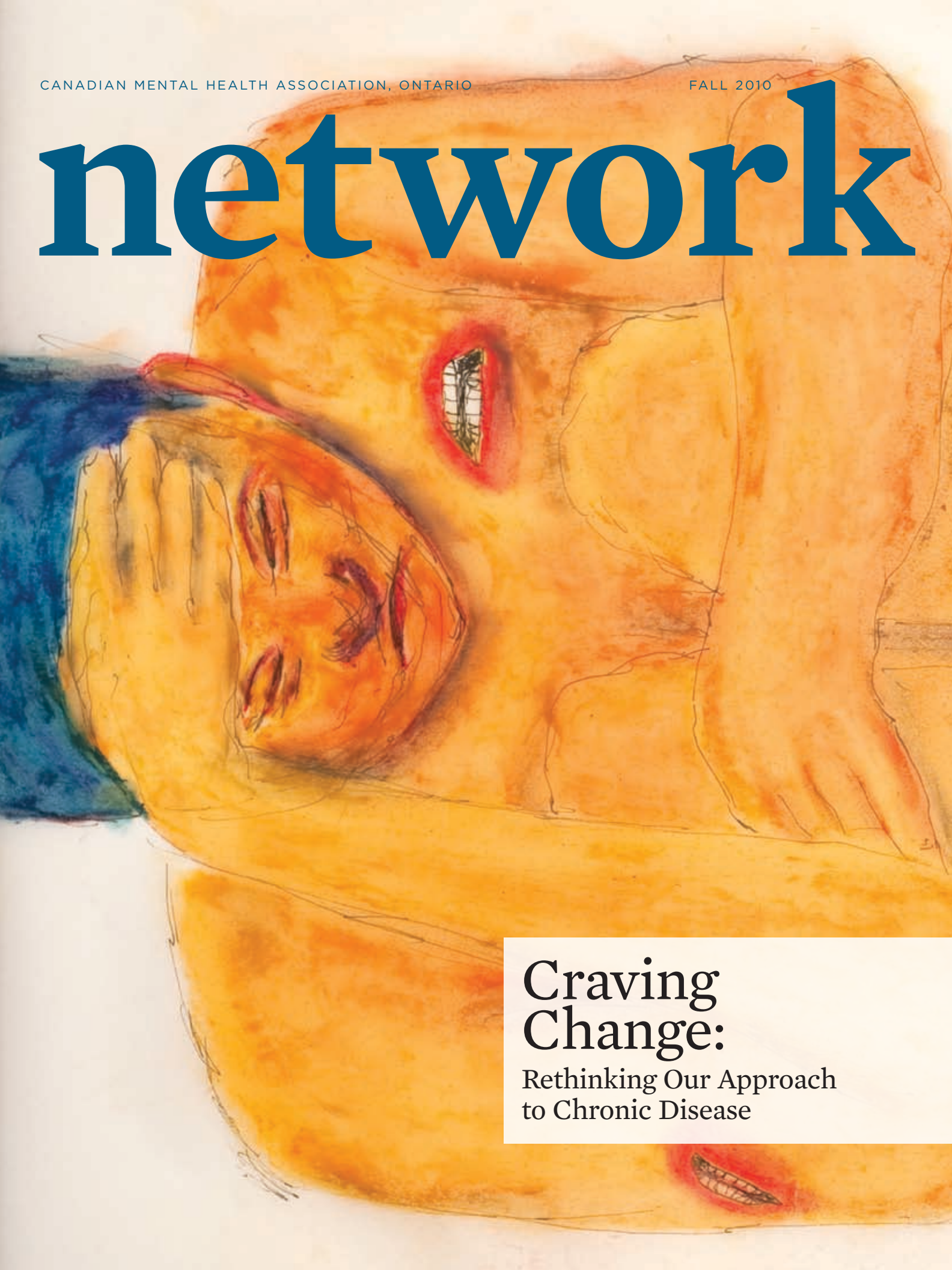

Craving Change:

Rethinking Our Approach to Chronic Disease

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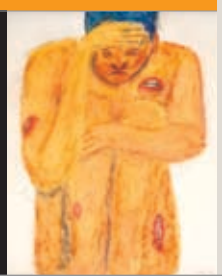
Re: Cover

Lisa Walter, *Untitled* (oil pastel on Mylar), 2009. Reproduced by permission. This work appears in the Being Scene 2010 art exhibit at the Centre for Addiction and Mental Health in Toronto.



MICHAEL MORBACH, *LEMONS* (OIL ON CANVAS)

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EXECUTIVE EDITOR
Scott Mitchell, Director, Knowledge Transfer

DESIGN
Soapbox Design Communications Inc.

EDITOR
Jennifer McVittie

CONTRIBUTORS
Diana Ballon
Uppala Chandrasekera
Raymond Cheng
Michelle Gold
Betty Harvey
Jessica Kwik
Jennifer McVittie
Zarsanga Popal
Wayne Roberts
Sheela Subramanian

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180 Dundas Street West, Suite 2301 Toronto, Ontario M5G 1Z8

TELEPHONE 416-977-5580 **FAX** 416-977-2813
E-MAIL network@ontario.cmha.ca
WEBSITE www.ontario.cmha.ca

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guest editorial

by **Betty Harvey, BScN, MScN, RNEC**

Overcoming Disparity

Chronic disease is a global health issue. By the year 2030, according to the World Health Organization, chronic conditions will cause 75 percent of all deaths globally. Here at home, the Ontario Health Quality Council reports that 80 percent of Ontarians over age 45 have a chronic health condition, and 70 percent of these have two or more chronic conditions.

Serious mental illness (SMI) is a significant risk factor for the development of a number of chronic diseases. Compared with the general population, people with SMI have higher rates of chronic obstructive pulmonary disease, breast cancer, colon cancer, lung cancer, stroke and heart disease. Diabetes rates are two to four times higher. People with SMI are twice as likely to die from cardiovascular disease. Overall, their life expectancy is 25 years less than the general population.

Why the disparity?

Chronic physical illnesses in this vulnerable population are underdiagnosed and undertreated. Poor access to primary care is one reason. The barriers are complex and range from the impact of poverty on the ability to afford transportation for medical appointments, to systemic barriers related to the way that primary health care is currently provided in Ontario. Some physicians, for example, may be reluctant to take on new patients with complex needs or psychiatric diagnoses, due to short appointment times or lack of support from mental health specialists.

The stigma associated with mental illness can discourage people from accessing health care services, and negative past encounters can stop people from seeking health care out of fear of discrimination. Physical ailments are often misdiagnosed as psychological issues, and this "diagnostic overshadowing" can result in serious physical symptoms being either ignored or downplayed.

These barriers often contribute to patients not engaging with the system and giving up on improving their health. In the current state, the onus is always on the patient to come and engage with the system to receive services. The system does not engage with patients, and that often leads people who are very vulnerable to fall through the cracks.

Diabetes is the "test case" for chronic disease prevention and management (CDPM) system redesign in Ontario. The number of Ontarians with diabetes has increased by 69 percent over the last 10 years and is projected to reach 1.2 million in 2010. The disproportionate risk of diabetes among people with serious mental illness means that prevention services, health screening and regular access to primary health care should be high on the priority list. More coordination, collaboration and shared care will increase system capacity and improve health outcomes for people with mental illness and chronic diseases.

Family Health Teams may be an effective approach to collaborative care. Team members skilled in mental health care can support prevention and robust treatment of mental health issues. Assertive support and monitoring from the start, when psychiatric medications are prescribed, can help prevent weight gain. Facilitated referrals can help overcome system navigation barriers. Supportive case management can improve an individual's capacity for self-care.

Ontario's CDPM strategy relies heavily on mobilizing the individual's ability to manage his or her own illness — to make daily decisions about food, physical activity, self-monitoring, and medication. Self-management support goes beyond education — it means providing people with the skills, tools and confidence they need to take control of their illness and make positive changes in their lives.

We must also remember that this is a population living with high rates of poverty. Diabetes is disproportionately clustered in neighbourhoods with lower than average household incomes and high proportions of visible minorities and/or recent immigrants. The underlying factors that put these individuals at high risk of chronic conditions and complicate their capacity to manage these illnesses must also be addressed.

Betty Harvey is a nurse practitioner with the Primary Care Diabetes Support Program at St. Joseph's Health Care, London, associate professor at the University of Western Ontario, Faculty of Nursing, and recipient of the 2005 Frederick G. Banting award from the Canadian Diabetes Association.

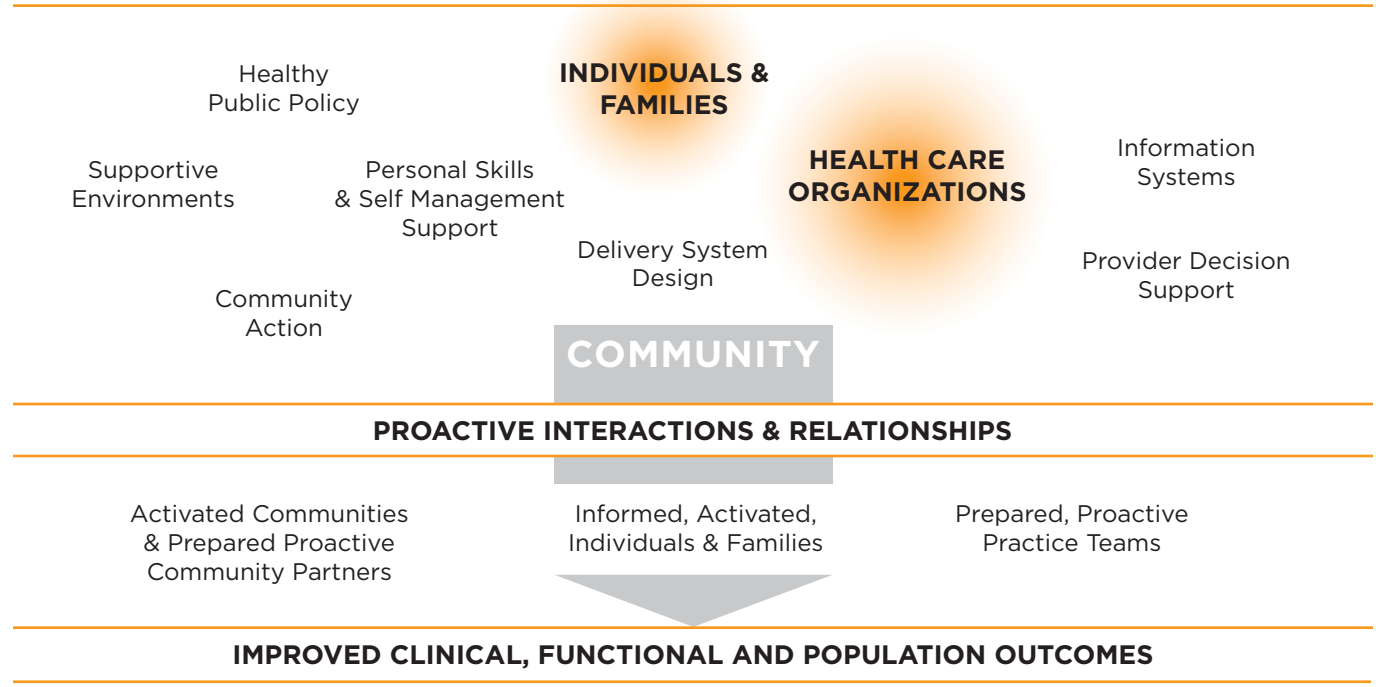
by Zarsanga Popal

Chronic Disease Prevention and Management

THERE IS A STRONG ASSOCIATION BETWEEN CHRONIC DISEASE, MENTAL HEALTH AND MENTAL ILLNESS. PEOPLE WITH CHRONIC PHYSICAL CONDITIONS ARE AT RISK OF POOR MENTAL HEALTH, INCLUDING DEPRESSION AND ANXIETY. AT THE SAME TIME, PEOPLE WITH SERIOUS MENTAL ILLNESSES HAVE A GREATER INCIDENCE OF CHRONIC PHYSICAL DISEASE THAN OTHERS. THEY ARE ALSO AT INCREASED RISK FOR PREMATURE DEATH.

According to one estimate, two-thirds of people with schizophrenia die of cardiovascular disease, compared to only one-third of the general population. As well, mental health consumers often do not get the same level of care for chronic physical health problems as the general public.

The Ontario health care system is currently re-orienting itself to become more focused on both the prevention and management of chronic diseases. In doing so, the Ministry of Health and Long-Term Care and the Ministry of Health Promotion have developed a Chronic Disease Prevention and Management Framework (see diagram). The framework provides directions to guide efforts toward prevention and management of chronic diseases in Ontario; and to facilitate engagement with patients, providers and populations to address chronic diseases. It is intended to reduce the incidence of chronic diseases through fostering healthy behaviours and



addressing the broad determinants of health, such as supportive environments and healthy public policies. The framework is also intended to create an enhanced and comprehensive health care system to improve quality of care for those with chronic conditions.

A chronic disease prevention and management (CDPM) approach can improve the physical health care of people with serious mental illness. The CDPM model also has the potential to improve screening and management of depression in people with chronic physical conditions. Health planners and health care providers across the country are recognizing opportunities to address both mental health and chronic physical conditions within CDPM. They are already working together to develop and deliver programs where mental health and mental illness are being addressed.

CMHA B.C.'s Bounce Back: Reclaim Your Health Program

Initially, the Canadian Mental Health Association, British Columbia Division's Bounce Back: Reclaim Your Health program offered mental health support to people with chronic health conditions who were coping with low mood and mild to moderate depression, although the program no longer requires a diagnosis of any chronic health condition other than low mood. Participants are referred to Bounce Back by a general practitioner (GP) or through a GP-endorsed referral. Through psychoeducation and guided self-help, Bounce Back helps primary health care practitioners improve people's quality of life.

"There is a strong fit between mental health and chronic conditions," says Lynn Spence, associate executive director/director of provincial programs for CMHA B.C. "People who are living with chronic conditions frequently have high levels of anxiety and depression." Bounce Back also recognizes the mental health support needs of family members and caregivers of people with chronic conditions. "We were receiving referral after referral from GPs who said that family members and caregivers needed help," says Spence. The doctors recognized that their patients needed more mental health support in dealing with their chronic conditions and needed tools and resources in order to do that. Indeed, building good relationships with GPs and having their support are key reasons for Bounce Back's success, says Spence. For more information, visit www.cmha.bc.ca/bounceback.

WOTCH Community Mental Health Services Clinical Services Program

About seven years ago, in their work supporting clients with serious mental illness in southwestern Ontario, staff at WOTCH Community Mental Health Services started to recognize the high number of clients that were dealing with unmet physical health conditions. In order to better meet the needs of their clients, the WOTCH clinical team was born. Christine Sansom, director of clinical services and a registered nurse, explains that there were other nurses at WOTCH but their main roles were as case managers. "Staff always knew that their clients' chronic health conditions negatively impacted them," explains Sansom. Many WOTCH clients have several of the risk factors associated with diabetes, such as taking certain medications, being overweight, getting little physical activity and having a lack of access to healthy foods. According to Sansom, "when a case manager is trying to encourage a client to get outside and get active because it is good for their mental health but the client doesn't feel good physically or mentally because his blood sugars are high, he is going to the bathroom often and has a headache, it affects the choices he makes." Poor physical health not only affects the body, but also has an impact on the effectiveness of other interventions, like mental health support.

These issues prompted a cultural change at WOTCH, where physical health issues became more integrated with mental health issues. In supporting clients, the clinical team emphasizes health promotion, disease and injury prevention and chronic disease management. The change also gave birth to a two-year research project for screening and management of diabetes that would give WOTCH the data it needed to demonstrate diabetes risk factors and the number of clients who had chronic conditions. Evaluations from the WOTCH diabetes project show impressive outcomes that make a difference in both the mental and physical health of clients. Sansom says that the positive results that came from this initial project helped WOTCH develop a diabetes screening and self-management program. The clinical team also offers other services that promote an individual's overall health and well-being and that improve access to primary health care and psychiatric services in the community, including a medical clinic, foot care clinics, a collective kitchen and a nutrition clinic. Now Sansom says organizations from all over call WOTCH seeking guidance on developing their own programs to address chronic conditions for people with mental health issues. For more information, visit www.wotch.org.

Common Messages to Address Mental Health

The Ontario Chronic Disease Prevention Alliance (OCDPA) has identified poor mental health as one of five chronic disease risk factors, along with high-risk alcohol consumption, physical inactivity, tobacco use/exposure and unhealthy eating. Together with its partners, the OCDPA has developed a set of messages related to mental health that will focus attention and promote collective action at the individual and system level on chronic disease prevention issues. The messages encourage creating the conditions that are necessary for good mental health, such as social inclusion, freedom from discrimination and stigma, access to economic resources, understanding mental health and how to get support, and access to mental health screening. For more information, visit www.ocdpa.on.ca.

For more information about CDPM and CMHA Ontario initiatives, visit www.ontario.cmha.ca/cdpm.

Zarsanga Popal is a health systems analyst at CMHA Ontario.

One More Thing on Their Plates

by Sheela Subramanian

FOR MYA VIJENDRAN, a Toronto-based diabetes outreach worker, two things would enable her South Asian program participants to better manage their diabetes: "A stable job and being more settled in Canada." Vijendran explains, "The only thing I want to do is to help participants keep their stress levels down so that they can focus on their diabetes. Chronic stress leads to poor mental health, which impacts on their diabetes."

A growing body of research tells us that the mental and physical health of Ontarians is not only shaped by medicine and lifestyle, but is significantly altered by the social and economic conditions in which we live. These conditions, known as the social determinants of health and mental health, such as income, racialization, social exclusion and disability (see sidebar), must play a key role in how we approach chronic disease prevention and management. In Ontario, this story is best told by type 2 diabetes, where rates of the illness and complications are highest among low-income, ethno-racial and Aboriginal communities. In these and other disadvantaged communities, the traditional self-management approach to diabetes — teaching individuals about healthy lifestyle and self-care skills such as blood sugar monitoring and proper nutrition — does not go far enough. The impact of the social determinants of health on the prevention and management of diabetes must also be addressed.

The importance of the social determinants of health is recognized by Canadian and international health authorities, including the Public Health Agency of Canada and the World Health Organization. Health inequities, or significant gaps between the health and well-being of advantaged and disadvantaged communities, are largely shaped by social determinants. The result is higher rates of preventable or treatable chronic conditions, such as heart disease, diabetes or asthma, poorer health and mental health overall, poorer access to health care and even greater risk of death for disadvantaged communities.

Mya Vijendran works with the Diabetes Education Community Network of East Toronto (DECNET), a partnership of South Riverdale Community Health Centre, East End Community Health Centre and Toronto East General Hospital. Since 2002, DECNET has been supported by the Ministry of Health and Long-Term Care's diabetes complications prevention program, part of the 1997 diabetes strategy that saw the establishment of new and expanded diabetes education programs across southern Ontario. The diabetes education programs reflect a focus on self-management, or the teaching of self-care skills through a team of educators that primarily includes a registered nurse and registered dietitian, and may also include other health care providers who complement existing service provision and best support the needs of the community, such as a social worker, outreach worker or foot care specialist. In 2008, a new Ontario Diabetes Strategy was launched, including a $6 million investment for prevention programs targeted at "high risk" groups, including Aboriginal, Hispanic, South Asian, Asian and African-Canadian communities, lower-income families and people over age 50. These initiatives use education to raise awareness about the role of physical inactivity, poor nutrition and obesity in type 2 diabetes.

Since 2002, DECNET's staff of 15, including registered dietitians, registered nurses and an outreach worker, has provided diabetes education support to the general public and underserved communities including consumer/survivors, ethno-racial communities, and low-income or under-housed individuals. DECNET's unique approach goes beyond self-management to incorporate mental health promotion and an understanding of the social determinants of health. This dual focus stems from founding members' experiences in the community mental health sector, where consumer/survivors have high rates of type 2 diabetes. "In many cases, [it was] noted that it was due to the overlapping effects of medication side-effects and the impacts of the social determinants on physical and mental health," manager Stephanie MacLaren explains. "Diabetes often lands on someone's plate, so to speak, as one more barrier to wellness and feeling good." Clients living with a mental health condition often also struggle with many of the social determinants of health, including social exclusion, poverty, homelessness, food insecurity and lack of access to health services; these factors both contribute to and are deepened by mental health issues or conditions. The same can be said for diabetes.

The Social Determinants of Health and Mental Health in Canada

In the Canadian context, the following social determinants of health have been identified:

- Aboriginal status or background
- Access to health services
- Disability
- Early life
- Education
- Employment and working conditions
- Food insecurity
- Gender
- Housing
- Income and income distribution
- Racialization or race
- Social exclusion
- Social supports
- Unemployment and job security

From "Social Determinants of Health: The Canadian Facts," 2010, available at www.thecanadianfacts.org.

Connecting the Dots: Social Determinants, Health Inequities and Diabetes

When filmmaker Lalita Krishna learned that Aboriginal and ethno-racial communities face a higher risk for type 2 diabetes, her curiosity was piqued. "There was growing discussion about the risk for diabetes among certain communities," she explains. "I wondered why that was and whether people are predisposed to diabetes because of genetics.

Then I came across research that made connections between type 2 diabetes, poverty, racism and chronic stress, suggesting that there are bigger issues that need to be addressed." The resulting film, *I Have a Little Sugar*, asks whether the social determinants of health contribute to the development of type 2 diabetes, suggesting that communities in Ontario may experience higher risk for the disease because of chronic stress connected to poverty, racism and social exclusion. The film takes viewers into the lives of four people diagnosed with diabetes, each from a different Aboriginal or ethnoracial community at high risk.

Growing evidence supports this line of questioning. A team led by Dennis Raphael, a key researcher in this area and professor at York University's School of Health Policy and Management, recently completed a study with support from DECNET that reveals that poverty is a major factor in the development of type 2 diabetes. The authors of the study, published in the journal *Health Policy*, found that poverty has a big impact on diabetes even when compared to traditional factors such as body mass index, diet, physical activity and education. For Dr. Kwame McKenzie, Senior Scientist at the Centre for Addiction and Mental Health (CAMH) and Professor of Psychiatry at the University of Toronto, mental health is part of the physiological dimension of this dynamic. The hormones adrenaline and cortisol, produced by our adrenal glands in response to stress, lead to a number of changes in the body, and raise the risk of increased glucose levels in the blood. This response allows us to react rapidly to threats by bringing energy quickly to our muscles. McKenzie continues, "When you experience fear due to a threat, you release glucose, which gives your body energy to run away. Unfortunately, the challenges of today's world are often things from which you cannot run. Racism, for example, is an everyday thing. This can result in increased sugar in your blood, day in, day out."

The social determinants of mental and physical health have a cyclical impact on chronic disease in the context of marginalized communities. Effective self-management requires access to resources such as food, medical equipment, safe locations to exercise, housing and health care. Factors such as poverty, food insecurity and lack of access to health services make it difficult or impossible to carry out the self-care or self-management practices that may promote positive mental and physical health. At the same time, poor mental or physical health make it difficult to challenge disadvantage related to poverty, racism, social exclusion or other factors.

Mental health plays an important but often unrecognized role in this dynamic. The Ontario Chronic Disease Prevention Alliance emphasizes the importance of promoting positive mental health for chronic disease prevention and management (see page 5). They argue that prevention and management must address the socioeconomic conditions that promote mental health, including social isolation, freedom from discrimination and violence, and access to economic resources.

DECNET's experience offers evidence of these dynamics. Initially, few South Asians participated in programming although many lived in the catchment area and high rates of diabetes had been recorded provincially for the population. When Vijendran was brought on as an outreach worker, a welcome addition to the team, she began with a series of focus groups in Urdu, Bangla, Gujarati and Tamil. The groups revealed two things: securing stable employment and income were much higher priorities than diabetes management; and participants were living with high levels of stress, and ongoing feelings of sadness and isolation. Both factors impacted on diabetes management: while many individuals knew how to better manage diabetes, they faced challenges related to access to affordable healthy food, access to regular medical care, the cost of diabetes medication and equipment, in addition to language barriers, social exclusion, isolation, poverty and unemployment. Concerns and issues varied by community and individual, with many people of Sri Lankan Tamil background experiencing trauma, stress and fear due to their own

THE URDU/HINDI COMMUNITY KITCHEN AT THE EAST END COMMUNITY HEALTH CENTRE, TORONTO. PHOTO: SCOTT CHALMERS

or family members' experiences of the country's civil war. "There is no health without mental health," McKenzie explains. "If you don't think there's much of a future or if today is not that wonderful, you might not prick your finger to test your blood sugar. And if you have to choose between controlling diabetes and putting bread on the table, you may want to put bread on the table."

There is a strong link to mental health: "Stress management is a big part of diabetes management," Vijendran explains. "Many of our participants experience high levels of stress and don't know what to do because the sources of their stress are always there. To get at the diabetes, we need to address the other issues."

Seeing the Bigger Picture: Getting at Diabetes through the Social Determinants

So "to get at the diabetes," DECNET adapted the self-management model to work with communities impacted by the social determinants of health. While a focus on individual choices and behaviour was effective with the general public, a community-engagement approach was needed for marginalized communities. DECNET created working groups to identify needs of specific underserved populations, including mental health consumer/survivors and ethno-racial communities, and to focus on issues related to the social determinants of health, like food security. Community-specific programming is offered, including drop-in sessions at shelters, information and referrals about community and social services and community-based support groups. Efforts are made to address immediate barriers. For example, the South Asian support group is located at a community space near the subsidized housing area where participants live. Childcare, tokens, language interpretation and refreshments are provided and discussion goes beyond diabetes to include settlement, employment and other issues. The team also takes a strengths-based approach to service delivery, focusing on what individuals are already doing. "We take a distinctly non-shaming approach. It's not about being the Diabetes Police," MacLaren says. "Previously, diabetes education was about 'you should do this.' Now it's about recognizing that the money might not stretch far enough and you will eat a peanut butter sandwich or Kraft Dinner."

DECNET also worked with Community Resource Connections of Toronto, North York General Participant Council and a Recovery Educator to develop a recovery-based peer support program for consumer/survivors with diabetes. In addition to a diabetes education course, nutrition education and monitoring by the nurse educator, the five-month pilot project also featured a Wellness Recovery Action Planning (WRAP) group that was designed to help participants develop an action plan for supporting physical and mental health issues, alongside a peer support and leadership development discussion group and weekly walking sessions. The pilot, part of the Minding Our Bodies project (see "Active Recovery," page 18), was very successful and DECNET is currently running a second session.

DIABETES PREVALENCE RATES IN ONTARIO

Over nine percent of adults aged 20 and older had diabetes in Ontario from 2006 to 2007.

However, rates of diabetes increase as neighbourhood income decreases. Almost 11 percent of women and over 12 percent of men in Ontario's lowest income neighbourhoods had diabetes, compared to over six percent of women and over eight percent of men in the highest income neighbourhoods.

For Black, Arab, South and West Asian adults, rates of self-reported diabetes were almost twice as high as those for non-racialized or White adults.

Rates of diabetes among Aboriginal communities in Ontario have been estimated at three to five times the rates of the general population.

Source: The Canadian Diabetes Association and the Project for an Ontario Women's Health Evidence-Based Report: Volume 2: Toronto, 2010.

DECNET's experience suggests the value of complementing clinical work with community-based supports that consider the individual and the bigger picture. MacLaren suggests that changes are needed in program delivery to move away from an education focus: "The challenge is that we are given a nurse and a dietitian when we really need outreach workers, a social worker or health promoter, and resources for peer support." For Dr. McKenzie, it is clear that diabetes prevention and management efforts promote positive mental health in a way that addresses the social determinants. More research is needed to identify what social and economic factors determine the mental and physical health of different communities and what strategies are effective in promoting positive mental health.

Program-level change may not be enough. At the first screening of *I Have a Little Sugar*, a diabetes nurse cautioned that we cannot just blame poverty and stress, but need to encourage people to take care of themselves through diet and exercise. Krishna counters that this is not always possible. "For example, one of the people profiled in the film, Williana, cannot afford to purchase healthy foods that are recommended to her. People are not always in a position to take care of themselves," Krishna explains. "To more effectively prevent and manage diabetes, we need to look at the overall conditions of people's lives and consider those conditions from a larger perspective. We need support at the policy level to make this possible." To do this, all stakeholders — communities, service providers, researchers, policy-makers and others — need to develop a comprehensive approach to chronic disease prevention and management that cuts across all policy areas and reflects the range of socioeconomic factors that determine mental and physical health.

Sheela Subramanian is a policy analyst at CMHA Ontario.

by Jennifer McVittie

GOING TO THE EXPERTS

PEER SUPPORT AND CHRONIC DISEASE SELF-MANAGEMENT

Barbara Neuwelt, a member of the mental health strategy team at the Mental Health Commission of Canada and a former policy analyst at CMHA Ontario where she took the lead on developing the Diabetes and Mental Health Peer Support project (see sidebar), talks about how mental health peer supporters can contribute to chronic disease self-management support.

Q&A

Q: What is self-management support?
A: Self-management support is one aspect of the chronic disease prevention and management (CDPM) model. It simply means supporting people to effectively manage their own health. Traditionally, people were given a lot of information about their diet, exercise, and how to monitor their blood glucose. But now it's recognized that self-management support goes beyond giving people

information and must include providing people with the skills, tools and confidence they need to take control of their illness and make positive changes in their lives.

Q: How does mental health peer support fit with self-management support?

A: Peer support is one way to provide these skills, tools and confidence. And it's an evidence-based way — randomized controlled trials and "real-life" evaluations have shown that peer support contributes to improved diabetes self-management, helping with things like medication adherence, diet, exercise and blood glucose monitoring.

Basically, we have the evidence that peer support works to support people with mental illness in their recovery, and we have evidence that peer support works as a form of self-management support for people living with chronic diseases, so let's put the two together.

Q: It's a matter of doing both at the same time because each is going to impact the other.

A: Right. And the key thing is that for many years in the mental health field in Ontario both case managers and peer support workers have been supporting people in achieving their own goals and quality of life. So I think the mental health field has a lot of expertise to lend to the chronic disease field in this area because health management support is a less explored area of the chronic disease prevention model than some of the other aspects of it. I think that people looking to figure out how to best support people living with diabetes and other illnesses — to manage and to live with their own illness — could learn something from the mental health field; both from peer supporters and also from service delivery.

There's also the fact that it's known in the chronic disease community that one aspect of CDPM is the whole issue of the social determinants of health. So that supporting people to manage their illness has to take into account their life situations. I think that the mental health field, particularly the more innovative edges of the mental health field, have been trying to do that for many years and have a lot of experience doing that. In the mental health field, it is a part of community services and peer support services working with individuals around those issues.

Q: So what models of peer support are effective?

A: There are basically four types that have been looked at: formal structured programs, such as the Chronic Disease Self-Management Program developed by Stanford University, peer mentoring, cultural community health workers and telephone and web-based peer support.* The first is highly structured: it could be a weekly meeting with a certain number of weeks and there's particular material that gets covered and discussion topics that happen. The Stanford model is by far the most well evaluated and well researched model and has been shown to be effective in improving health outcomes and reducing emergency room visits. The program focuses on problem-solving, decision-making and confidence-building. The peer support leaders are trained and follow a curriculum, but there is a participatory discussion group led by peers so it can certainly be seen as a peer support program.

The Stanford is excellent but it's not going to meet everybody's needs. Not everybody is comfortable in a structured program where you have to come every week or every month and participate in a group. Some people are more comfortable with an informal setting.

So the second type of peer support — peer mentoring — is informal one-to-one support. But the peers are trained so it's very similar to some of the consumer/survivor initiatives that have drop-ins where the peer support workers are trained and they're official peer supporters. This is especially effective with people who have a distrust of the health care system. Peer mentors have experienced the same challenges as the people they are supporting, just like mental health peer support workers. They

Diabetes and Mental Health Peer Support Project

The Canadian Mental Health Association, Ontario, the Ontario Peer Development Initiative (OPDI) and the Provincial Consumer/Survivor LHIN Leads Network (PCSLL) have launched a two-year project to provide diabetes competency training for mental health peer support workers.

The training will increase the skills of peer support workers in helping others prevent and self-manage diabetes while living with mental illness. The project will also increase awareness in the diabetes community of the role mental health workers can play in support of prevention and self-management.

A diabetes peer support training module will be developed and pilot-tested across Ontario. The module will be one of a series of specialty modules that will build on a core skills training program for mental health peer support workers that is being developed by OPDI. An evaluation of the diabetes training module and its application in the field will be carried out by Cheryl Forchuk, a scientist at the Lawson Health Research Institute. The diabetes module will then be revised and distributed provincially as a stand-alone resource for training mental health workers delivering peer support in any setting.

The project will be guided by an advisory committee that includes representatives from the Ministry of Health and Long-Term Care, Local Health Integration Networks, Family Health Teams, Community Health Centres, the Canadian Diabetes Association, community mental health service providers and other stakeholders.

For more information about the project, see the backgrounder "Diabetes and Mental Health Peer Support Training," May 2010, at www.ontario.cmha.ca/dmhps.

"Strategies to support people to prevent and manage their diabetes must be accessible, affordable and practical. Mental health peer support workers know and understand this reality and have experience supporting people to improve their health and quality of life under difficult circumstances."

Barbara Neuwelt

can help their peers learn and practice prevention strategies for diabetes, and help them stay as healthy as possible.

The third type is the community health worker model and it's a bit more structured. Cultural community health workers come from the same culture as their peers but they don't necessarily have the same health problem. They offer support but the peer aspect of it is that they come from the same culture. They understand the issues that people are facing and they support them to access resources to deal with the reality of the limits of their daily lives as well as helping them get to appointments and helping them understand how to stay healthy. Consumer/survivor initiatives are ideally situated to offer this type of peer support.

Q: And so the "culture" for our purposes would be "people with mental illness."

A: Yes. Or it could be people with mental illness who've experienced stigma and discrimination and the limits of having a low income and poor housing. There could be many joint factors.

I think that we have growing expertise in the mental health peer support field of people who have lived with those experiences and are really good at supporting others to live a better life given the limits that they have to live with and the challenges of stigma or low income. Those peer support workers would not only be helpful with other people with mental illness, but also with other marginalized populations that may not be experiencing mental illness but still have to deal with low income, discrimination, that kind of thing. I think that's an area that could be explored as well.

Q: What about non-face-to-face support?

A: Right — telephone and web-based peer support have also been evaluated and found to be promising for people not willing or able to be involved in face-to-face peer support. As someone pointed out recently to me, we shouldn't dismiss the web-based stuff because a lot of people are getting a lot of support through the web already, particularly young people who are using all kinds of alternative media. I think there's some exciting work that needs to be done around peer support and alternative media. But it'll be younger people that do that research.

Q: So how do you decide which is the best model to use?

A: It's not about which is the best model. The main point is that it's important to have a number of models to choose from depending on who you are working with because no one model is going to be one size fits all. In terms of face-to-face peer support, the three models that I've spoken of are just three different alternatives. It's not so much about contrasting them but saying here are three models that could work depending on what you have the resources to do and what you feel is appropriate in your situation.

We have talked in the project that we're doing around diabetes and training mental health peer supporters (see sidebar) that people should be trained in basic information and basic support to be able to offer whatever they feel is appropriate in their circumstances. So if you're working in a drop-in centre and do informal one-to-one peer support, how can you apply that to support people who live with diabetes? Similarly, if you tend to offer a very structured program, how can that be adapted to support people around diabetes? And if people are doing recreational programs, how can you incorporate support for people with diabetes?

Q: So where do we start?

A: We need to apply existing mental health consumer/survivor expertise in peer support for people living with mental illness to support self-management and prevention of diabetes. They're already in an ideal position to support their peers to understand their risk of diabetes. People with mental illnesses face barriers related to fundamental things needed to live a healthy life like adequate income and housing, and challenges related to stigma and discrimination and the side-effects of medication. Strategies to support people to prevent and manage their diabetes must be accessible, affordable and practical. Mental health peer support workers know and understand this reality and have experience supporting people to improve their health and quality of life under difficult circumstances.

Jennifer McVittie is e-content developer at CMHA Ontario.

*M. Heisler (2007). "Overview of Peer Support Models to Improve Diabetes Self-Management and Clinical Outcomes." *Diabetes Spectrum*, 20 (4): 214-221.

by Raymond Cheng

Why Peer Support Is Like a

BOX OF CHOCOLATES

FOR ME, IT BEGAN WITH A VOICE THAT MUST BE OBEYED THAT I STARTED TO HEAR IN THE HOSPITAL. IT TOLD ME THAT I HAD AN INCURABLE ILLNESS (ONE DAY IT WAS SCHIZOPHRENIA, THE FOLLOWING WEEK IT WAS BIPOLAR DISORDER). I WOULD BE ON MEDICATION FOR THE REST OF MY LIFE. I NEEDED TO HAVE A QUIET LIFE ONCE I LEFT THE HOSPITAL. I "MIGHT" BE ABLE TO RETURN TO WORK.

In my first weeks as an in-patient, I tried to integrate these new facts with my world view. It didn't make sense. I argued with the Voice — constantly. It didn't seem like I would ever be free.

My first introduction to peer support came after two months, in the floor lounge with another patient — someone with whom I had shared furtive conversations. "I'm crazy," she said. "But you're not. But you need to tell them you're crazy or you will never get out." I accepted her advice and was discharged two weeks later. I now realize this was my first experience with peer support. **Lesson learned: Peers are experts in getting others out of hospitals.**

Once stabilized, thanks to the formal healthcare system and community mental health services, I began to reclaim and reconstruct a new self-identity. Spurred by participation in committees, social-recreational activities and a constant stream of volunteer opportunities in mental health reform, fast friendships developed. The sharing from discussions and sidebar conversations after meetings gave me insights beyond the complimentary coffee and sandwiches. It dawned on me that these conversations and peer groups were focused on coping strategies, either with the direct consequences of treatment (medication side-effects such as weight gain, sleepiness, and lethargy) or the indirect (the inability to earn a "life-worth-living" wage). I learned from some, and shared with others. **Lesson learned: Peers are experts in teaching each other about harm reduction and the mental health system.**

Eventually, I ended up sitting on an agency board that received a grant to start up a consumer/survivor self-help centre. I moved from volunteer to advisor to paid employee as the project developed. It was possible to earn money doing something I loved and to help others by introducing the concept of self-help to diverse cultures. **Lesson learned: Peers can work and be acknowledged for the skills derived from lived experience.**

The organization I now work for, Ontario Peer Development Initiative (OPDI), has become a strong stakeholder advocate for a recovery-based and consumer-centred approach to care. Its Ontario Trillium Foundation-supported Peer Support Toolkit Project has created the OPDI Support Core Essentials™ Program, which is being taught by a province-wide network of trainers. **Lesson learned: There is a made-in-Ontario approach to learning peer support.**

Ideally, peer support is a gift that is happily accepted. It is an act of caring, trust and reciprocal empathy. When the connection succeeds, it provides emotional relief that one's struggle against the world is not uniquely hopeless.

CREDIT: HAYLEY HART, *CIRCLE OF FRIENDS* (COLOURED PENCIL ON PAPER), 2010

CMHA Ontario and OPDI, along with other community partners, have received funding to develop and provide diabetes competency training for mental health peer support workers (see sidebar, page 11). The project will combine public education with user-friendly group awareness and self-care. The goal is to improve access to diabetes programs and services, and encourage self-management — a positive demonstration of how peer support can impact not just psychological but physical wellness. **Lesson learned: There is no health without mental health. And no health without physical health either.**

In the film *Forrest Gump*, the title character comments that "Life is like a box of chocolates. You never know what you're gonna get." This is also an apt analogy to understand peer support:

a) Just as cocoa is the base of chocolate, a common connection between two or more people is the essence of peer support. Whether it is sharing between peers, a facilitator with members of a group or a formalized relationship between a trained support worker and a client, those meaningful moments of recognition can bring insight, validation or closure to past experiences. There are many flavours of learning that take place and guidance towards recovery can result.

b) We can choose to give chocolates as well as be surprised to receive them. Peer support is no different. When I was down and out, I craved it; when life was headed in the right direction, I was generous in giving it away. Ideally, peer support is a gift that is happily accepted. It is an act of caring, trust and reciprocal empathy. When the connection succeeds, it provides emotional relief that one's struggle against the world is not uniquely hopeless.

c) A box of chocolates has become an everyday commodity available at any corner store. While peer support has not yet permeated the mental health system as widely, there has been ongoing progress. Consumer/survivor initiatives, non-incorporated peer groups, alternative businesses and patient/client councils form the stalwarts of peer support in formal settings in Ontario. Through partnerships and integration, peer supporters are now found in emergency rooms, crisis services and as part of other teams of care.

Peer support has given me a multitude of roles to play: receiver, giver, learner and systems advocate. Peers learn to listen proactively, and speak plainly and truthfully. Their authentic voices show that they have reclaimed their self-identities and are better advocates as a result. Peer support deserves to be a vital part of a healthy balance between services and supports in a future consumer-centred mental health and addictions system.

It is a treat suitable for all occasions.

Raymond Cheng is the Advocacy and Policy Coordinator at the Ontario Peer Development Initiative.

by Sheela Subramanian

Restoring *Pride*, Restoring *Well-Being*

First Nations, Métis and Inuit communities are disproportionately affected by type 2 diabetes. In Ontario, Aboriginal communities experience diabetes at three to five times the rate of the general population and face higher risk for complications and death.

While increases in diabetes rates for Aboriginal communities are often attributed to diet and lifestyle shifts, the roots of such change are not often mentioned. For Crystal MacDonald, a Diabetes Prevention Coordinator from the Six Nations of the Grand River community, the histories of First Nations, Métis and Inuit people in Canada provide insight into the relationship between mental and physical health. Colonization eroded Aboriginal autonomy through policies like the *Indian Act* that controlled every aspect of individual and community life, which had far-reaching consequences for every generation. In particular, the residential school system, which promoted isolation and assimilation through the removal of over 150,000 First Nations, Inuit and Métis children from families and communities, has had a devastating impact on minds and bodies. Given this context, Aboriginal diabetes policies and programs must make links between history and current realities.

Garnet Angeconeb attended the Pelican Lake Indian Residential School near Sioux Lookout from 1963 to 1969, and was diagnosed with diabetes 15 years later, although he believes that he was diabetic for five years before. "We were taken from our families, communities and natural environments," he explains, "and institutionalized at a young age because the government had a policy to assimilate and 'civilize' Aboriginal kids." Angeconeb, a member of the Lac Seul First Nation now living in Sioux Lookout, remembers feeling very alone and missing his family members and home. "The effects are so traumatic that they live on today and for all generations," he adds. In addition to separation from family and community, children often experienced physical,

The Ontario Aboriginal Diabetes Strategy

In 2006, the Ministry of Health and Long-Term Care launched the Ontario Aboriginal Diabetes Strategy, the result of a partnership with First Nations communities and Aboriginal organizations. The resulting document outlines a long-term approach for prevention, management, education, research and coordination of diabetes for Aboriginal communities and individuals in Ontario. Principles of the strategy include:

- A holistic perspective: an understanding of health as the physical, social, emotional, mental, spiritual and cultural well-being of the person and their community;
- The importance of self-determination and involvement of Aboriginal people at all levels of decision-making;
- The recognition of the role played by social, economic and physical environments on health;
- Access to appropriate and accessible health care services for all Aboriginal people in Ontario, regardless of residency, in a way that accommodates the cultural rights, views, values and expectations of Aboriginal people; and
- Improved, guaranteed funding and political willingness and commitment.

The Ontario Aboriginal Diabetes Strategy can be found at www.health.gov.on.ca/english/public/pub/ministry_reports/oads_06/oads_06.pdf.

emotional and sexual abuse at the hands of the school authorities. Just as important for Angeconeb, now on the board of directors of the Aboriginal Healing Foundation, was the cultural abuse that children suffered when they were prevented from speaking their languages and practicing spiritual beliefs and traditions.

Amanda Lipinski, the Diabetes Prevention Coordinator for the greater Toronto area, explains how the residential school system impacted on areas of life that are critical to diabetes work: eating habits, physical activity and self-care. Food served at residential schools reflected what is often called the "Five White Gifts" of sugar, salt, white flour, milk, and lard, butter or shortening. "There were changes in how we were thinking, feeling, but also changes to our diet and way of life," Angeconeb recalls. "A lot of people were not able to return to the way of life they led before, the traditions and living off the land. When you were back in your community, you were a stranger." Punishments often involved physical activity, such as running laps, resulting in trauma and negative associations with physical exercise for some school survivors. Angeconeb, who loved playing hockey during his time at residential school, hated the practices and drills because he was afraid of being beaten by a hockey stick if he did not perform. The experience still triggers negative emotions.

Yet a number of innovative community-based initiatives are committed to fighting diabetes by taking this history into account. Lipinski and MacDonald are supported by the Southern Ontario Aboriginal Diabetes Initiative (SOADI), a non-profit partnership of the Government of Ontario and six First Nations and Métis organizations: Anishinabek, the Association of Iroquois and Allied Indians, the Independent First Nations, the Métis Nation of Ontario, the Ontario Federation of Indian Friendship Centres and the Ontario Native Women's Association. SOADI has received support from the Ministry of Health and Long-Term Care since 1994 for the development and enhancement of programs and services that focus on education, prevention and management of diabetes. Lipinski and MacDonald are two of six SOADI regional diabetes prevention coordinators who are based in local communities to develop resources, conduct workshops, hold events and do whatever it takes to engage people and communities in preventing diabetes.

The socio-economic dimensions of history pose additional barriers for diabetes prevention and management, especially for remote northern communities where food insecurity, poverty, unemployment, isolation and lack of health care access are key issues. According to Natalia Morrison, program manager with the Northern Ontario Aboriginal Diabetes Initiative (NOADI), it is important to ensure that local priorities are identified and addressed in the north, given the diversity of issues facing different regions and communities. NOADI works to promote diabetes education and prevention, and funds community-based initiatives carried out by Aboriginal communities or organizations working with Aboriginal communities.

NOADI is able to support work that makes a link between mental health and diabetes. The group has provided funding to three diabetes projects with an explicit mental health focus, including support to a mental health centre to develop healthy recipes and to an organization that integrates psychotherapy in their work to address stress and blood glucose levels. Despite this, mental health remains largely outside the scope of NOADI's funding. The Northern Diabetes Health Network (NDHN), the organization that has implemented NOADI since 2007 with funding from the Ministry of Health and Long-Term Care, has a limited number of social workers and often has to refer out for mental health supports.

Access to health care is a challenge for remote northern communities. The Sioux Lookout Diabetes Program, established in 1990 as a member program of NDHN, provides diabetes supports to the Sioux Lookout region, Pickle Lake and 27 fly-in northern First Nations communities, including Sandy Lake First Nation, where researchers recorded the third highest diabetes rate in the world. While some local communities have diabetes workers and programs supported by federal or provincial funding, there is no direct access to broader clinical supports. To increase this access, team members visit remote communities by small plane. Challenges persist; in 2005, changes made to the federal program that provides health benefits for many

MEMBERS OF REZTORE PRIDE AT A JUNE 2010 SHOW IN GAGE PARK, HAMILTON. PHOTO: CHERIIAN B. PEARSON

Aboriginal people saw the end of funding for transportation to access some types of diabetes care, unless another medical appointment was scheduled.

When access to the food and health care essential to diabetes management is difficult or impossible, mental health supports are especially important. "People need a source of motivation," says Morrison. "Some might say, 'Why bother? What's there to look forward to anyways?' It is important to feel like you belong, like you are a good person. To foster mental health and promote balance, hope and resilience, you need to address the socio-economic realities and include local culture and traditions in the diabetes programs."

In southern Ontario, SOADI is guided by a holistic approach to health that incorporates physical, mental, spiritual and emotional balance alongside respect for autonomy, diversity, community-based services, sharing and cooperation, personal choice and privacy.

This approach is fundamental to Reztore Pride, a youth-driven SOADI project that challenges the impacts of history on the minds and bodies of Aboriginal youth. Led by youth coordinator John Henhawk, Reztore Pride uses hip hop music to raise awareness about diabetes among young people. For Amanda Lipinski who is Métis, Reztore Pride sends a powerful message: "The idea behind the project is that physical well-being is connected to mental well-being, self-confidence, self-esteem and knowing about your community and who you are. It's about restoring the self by addressing the impacts of history on mind and body." The group released an album this year, with music and lyrics about diabetes by well-known artist Rex Smallboy, which was nominated for a National Aboriginal Achievement Award.

For Crystal MacDonald, an effective approach to diabetes prevention and management starts with the understanding that "It's not that people have an unwillingness to eat healthy and be active. It's more complicated than that." At the policy level, this requires a comprehensive strategy that not only integrates mental health, but that also addresses socio-economic issues of food insecurity, access to health care, housing and employment. Such an approach requires consistent, equitable, meaningful and sustainable funding.

"Knowing the history of Aboriginal people is more important than knowing the differences between Aboriginal cultures when it comes to programs and services," says MacDonald. Aboriginal diabetes prevention and management is strengthened through an appreciation of the broader context that shapes current realities. Both First Nations and mainstream service providers play a role in this process believes MacDonald: "Understanding who we were and what we have endured as nations is the first step to identifying and delivering effective approaches to education, prevention and management. I don't believe that we have lost our approaches to health and wellness but rather they have been suppressed by various traumatizing events over the course of time. We continue to thrive within our communities and take pride in our perseverance, gaining strength from the inner fire of every person in the circle. Every effort to build successful programs will help us to gradually uncover, layer by layer, the eternal fire that fuels our existence."

Sheela Subramanian is a policy analyst at CMHA Ontario.

BY JESSICA KWIK

ACTIVE Recovery

In a world that prefers to sit and watch, movement towards recovery — despite chronic disease and mental illness — could begin by simply moving more. And the best role models are among us.

Dora Amirault leads others to dance despite her anxiety and panic attacks. Diagnosed with rheumatoid arthritis, fibromyalgia and osteoporosis, she wanted to find a way to stay active. "I didn't let pain stop me from doing whatever I wanted to…I started line dancing for exercise. I couldn't keep up with a lot of the fast moves because of my arthritis so I decided to teach line dancing to seniors. Here I am thinking I can't do anything because I have no self-confidence, but I'm still thinking I have to do something."

Dora's seniors' line-dancing class grew quickly from 15 seniors to almost two hundred. "To be in front of 200 people was unbelievable for me and all that kept me there were the seniors who made me feel so good. I couldn't believe they liked something I was doing. I was having anxiety and panic attacks but I was having a ball."

Like Dora, many in the mental health field are starting to appreciate the connections between physical and mental health. In order to go beyond this understanding to support people in their recovery, the Canadian Mental Health Association, Ontario, in partnership with the YMCA and the York University Faculty of Health and with funding from the Ministry of Health Promotion (MHP), initiated the Minding Our Bodies project. Mental health is a priority area for the MHP's Healthy Communities Fund (see sidebar, page 20), giving an opportunity to merge mental health services and chronic disease prevention activities. Through the creation of a toolkit and an information sharing website, Minding Our Bodies helps community mental health organizations deliver programs that promote positive physical and mental health connections through physical activity and healthy eating.

The first phase of the Minding Our Bodies project (2008 to 2010) facilitated six physical activity pilot programs in different settings across the province. All the pilots have kept their programs running and similar experiences from other organizations are cropping up and are shared through the Minding Our Bodies network. This first phase of the project has generated some important lessons that can be shared with others planning similar programming.

Physical activity can be an important support on one's recovery path

CMHA Cochrane-Timiskaming's active recovery approach is one example. Clients who express interest in improving their physical fitness can be referred to "active recovery," which is not a separate program, but is an integrated part of the overall recovery support. Chris Hill, a certified personal trainer and case manager, does a separate intake to understand each client's baseline abilities as well as their interests. He tailors an activity program to these needs.

Hill describes a shift in the dynamic between himself and his clients: "Some people don't want to interact across the desk … in physical activity they get to work alongside a mental health worker or be a part of a team. It's easier for them to open up when their heart rate is elevated." Engagement in sports

THE SEARCH 4 FITNESS PARTICIPANTS IN STRATHROY SWIM TOGETHER AT THE LOCAL POOL.

helps clients build bonds and breaks the ice without having to say a word. "[It helps people] start to be sociable, build confidence, stabilize moods and reduce manic state severity and depressive lows," explains Hill.

The experience of service providers like Hill reflects the evidence from emerging research regarding the mental health benefits of physical activity for people with serious mental illness. Physical activity can improve quality of life by improving physical health, reducing the high risks for cardiovascular disease and diabetes among people with mental illness, and alleviating mental health symptoms. Recent research shows that physical activity complements traditional therapies to treat mental illness and can be a stand-alone treatment for some cases of mild to moderate depression. As a recovery-focused activity, being physically active can build an individual's skill level, provide a sense of accomplishment, foster inclusion as part of a team and support identity outside of illness.

Physical activity programs promote peer support and leadership development

Social benefits go beyond the client to the whole body of an organization and surrounding community. Some pilot programs fully integrated their program into existing practices and have noticed a shift in the organizational culture to focus on positive health shaped by consumer input. CMHA Thunder Bay brought client involvement into the heart of program planning through a multi-stakeholder advisory team known as the MOBATs (Minding Our Bodies Action Team). Clients brought their ideas and were the driving force in motivating others.

The Haldimand-Norfolk Resource Centre created the Get Moving, Get Fit, Enjoy Life program to get the entire organization physically active — including creating a gym out of a basement storage room. The pilot program trains peer specialists to provide leadership at the centre and to assume formal roles as activity buddies. A participant in the program sees peer support as the glue that holds the group together: "I think since they're going back, I'm going back. A couple more people say, if they're going, I'm going to go and it's just that constant thing…it all just kind of gels people."

Social muscles are flexed by peer leaders who give back to programs through peer support and leadership. Participants who shadow leaders can also contribute to the sustainability of the program through a cycle of training and leadership opportunities. CMHA Thunder Bay Branch discovered in their pilot program that program staff had to be replaced more often than peer leaders.

Other programs involve peer workers, such as the FRESH (Finding Recovery through Exercise, Skills and Hope) program at Toronto's Gerstein Centre. Three FRESH peer workers were hired and trained to support others in using physical activity as an important recovery tool. One worker gained the confidence to move on and find full-time work elsewhere.

Physical activity is a gateway to other health promotion activities

Unlike medications that mix with varying consequences, healthy lifestyle habits have a synergy. Physical activity may lead clients down a path to other healthy habits, such as more nutritious food choices and smoking cessation. The Minding Our Bodies project is focusing on healthy eating for its second phase.

A growing panel of experts shares insights on the topic via the Minding Our Bodies website. Dr. Kelly Arbour-Nicitopoulos, a postdoctoral fellow in the Faculty of Physical Education and Health at the University of Toronto, has interviewed women with serious mental illness regarding the acceptability of physical activity as an add-on treatment for smoking cessation. "Although the study focused on physical activity," explains Arbour-Nicitopoulos, "many spoke of diet as a part of the holistic approach to smoking cessation. People tend to eat more when quitting. As a programmer, it would be ideal to try to replace time of cigarette-smoking with programming…"

PARTICIPANT IN SEARCH COMMUNITY MENTAL HEALTH SERVICES' SEARCH 4 FITNESS PROGRAM.

THE SYMBOLIC CUTTING OF THE SKIPPING ROPE OPENS THE PHYSICAL ACTIVITY ROOM AT THE HALDIMAND-NORKFOLK RESOURCE CENTRE.

Expertise in health promotion activities can be found at local public health units. CMHA Thunder Bay Branch collaborated extensively with their local public health department for planning, training and evaluation. Other pilots found resources through chronic disease-focused agencies such as diabetes education centres, the Heart and Stroke Foundation and the Arthritis Society.

Partnerships can increase access to physical activity and foster mutual learning

Partnering is not only a way to leverage resources in your community and to increase access for clients, it is also an opportunity to destigmatize mental illness and share an organization's expertise. Michael Aucoin, community crisis worker at the Gerstein Centre, explains how this happened with the FRESH program: "The local YMCA gave us a discount on memberships so that we could haveup to six clients attending with a supportworker. The Y wanted to know that clients would be OK, so we educated them about our mental health and justice work."

Since each client brings their own interests, programs seek diversity in activities and resources. Haldimand-Norfolk Resource Centre sought to achieve this in a rural setting by hiring a student to liaise with recreational groups from across the area and to source donations for equipment. Program manager Susan Roach notes that "some may just want to participate in their own community versus a peer support environment." A resource list was created, including information about physical activity programs in local communities, to help clients find ways to participate in their own neighbourhoods.

The synergy among mental health organizations can also be felt when client networking is woven into programs or special events. "Mental health agencies in Hastings and Prince Edward County plan together, facilitating partnerships among staff and managers, all the way up the chain," says Matt Smith, recreationist at Mental Health Services Hastings Prince Edward Corporation. "We continue to see progress and receive satisfaction from our work by observing social networks develop among clients as a direct result of our planned outings and events. People end up hanging out together on their own time in the community."

The social side of physical activity is the real draw for many people and a reward for all participants. Dora, the seniors' dance instructor, explains how her enthusiasm for dance not only moved her beyond her own health problems, but rippled out to others: "When I'm out and doing things, I don't have as many aches and pains. My doctor once told me to take breaks when I'm dancing with the seniors. He said the social part is as important as the exercise. I just ended my 16th season with a party: 97 attended and they had a ball."

To learn more about Minding Our Bodies, visit www.mindingourbodies.ca.

Jessica Kwik is a knowledge exchange associate at CMHA Ontario.

The Healthy Communities Fund

The Ministry of Health Promotion and Sport (formerly the Ministry of Health Promotion) is adopting an integrated approach to building healthy communities in Ontario. The Healthy Communities Fund (HCF) is designed to support coordinated action in local communities through partnerships and community planning. The health promotion priority areas that are being targeted include mental health; substance and alcohol misuse; tobacco use and exposure; healthy eating; injury prevention; and physical activity, sport and recreation. Mental health organizations can participate by applying for project funding through the HCF Grants Project stream or by participating in the HCF Partnerships stream, hosted at the local/regional level by Ontario's 36 Public Health Units.

The Healthy Communities Fund has three streams:

- The Grants Project stream provides funding to local and provincial organizations for projects in the priority areas listed above. For updates on the next call for applications, watch the website at www.mhp.gov.on.ca.
- The Partnership stream promotes coordinated planning and action among community partners to create policies that make it easier for Ontarians to be healthy. Public Health Units, as host agencies, provide leadership and support to build community capacity, to engage community leaders and decision-makers to identify local priorities, and to support collaborative work to achieve identified policy priorities.
- The Resource Centre stream develops community capacity by providing training and support to help build healthy communities. The Healthy Communities Consortium provides information on a variety of areas including strategic planning, program planning and partnership-building through training, coaching and in-person consultations.

For more information visit www.mhp.gov.on.ca/en/healthy-communities/hcf/default.asp.

by Uppala Chandrasekera

Feed the Body, Feed the Mind.

Growing unemployment rates, disappearing government supports and the rising cost of living are creating a crisis of food insecurity in Ontario.

CHILDREN FROM A NEARBY SCHOOL PARTICIPATE IN SCADDING COURT'S COMMUNITY GARDEN PROJECT.

ALI JIMALEH OF SCADDING COURT COMMUNITY CENTRE SERVING A CUSTOMER AT SCADDING GREENHOUSE CAFÉ.

Food insecurity means not being able to eat a nutritious diet, not being able to access good quality foods in adequate quantities and not knowing where your next meal is coming from. For many, it means having to turn to food banks. According to the Ontario Association of Food Banks' *Ontario Hunger Report 2009*, over 375,000 Ontarians use food banks every month, and the majority of these individuals are living in poverty.

"Poverty is the main factor that causes food insecurity," says Alina Chatterjee, the Director of Redevelopment and Special Projects at Scadding Court Community Centre in Toronto. Scadding Court provides a variety of programs including settlement services, child care, literacy and recreation programs, and a host of food programs. Susanne Burkhardt, Director of Development and Community Engagement at Scadding Court, echoes Chatterjee's sentiment: "People who are living on social assistance or on minimum wage simply can't afford a healthy diet."

In their work at Scadding Court, Chatterjee and Burkhardt have observed the various ways that poverty impacts food insecurity. "The direct link between poverty and food insecurity is obvious," states Chatterjee. "If you don't have money then you can't buy food. But there are multiple indirect relationships as well. Poverty is linked to things like low education, shift work and job insecurity, poor health, poor housing, and not having the right environment to prepare food. Just imagine the stress that results from all of these compounding factors."

Living in poverty often means not having access to good quality and affordable foods. Poverty also increases the likelihood of living in a food desert, where sources of nutritious foods, such as grocery stores and farmers' markets, are often absent or tend to be unaffordable. People living in food deserts must travel long distances for food, or simply go without. The other alternative is to turn to fast food outlets and convenience stores that provide unhealthy foods that are high in salt, sugar and fat.

> "Over time, I have seen positive results from clients [with mental illnesses] who come to the community kitchen program. They begin to have appropriate weight gain and weight loss, increased physical activity, and generally a better outlook on life."
>
> *Krista Fry, Scadding Court Community Centre*

Food Insecurity, Health and Mental Health

"Food insecurity is a key determinant of health," say Bronwyn Underhill and Julia Graham, co-chairs of the Community

Health Centres' Food Security Network. The network provides leadership on food security issues in the Greater Toronto Area (GTA) and helps build capacity across community health centres to address the growing crisis of food insecurity and malnutrition. "There are many linkages between nutrition and health, and many of the clients that we treat in our health centres are nutrient-deprived," says Graham.

Food insecurity and an unhealthy diet can cause insufficient vitamin or mineral intake from certain foods, and it can also cause over-consumption of certain nutrients from other foods. Individuals living in food insecure households are more likely to face dietary deficiencies that can lead to chronic diseases, as well as difficulties in managing these diseases. The *Ontario Hunger Report 2009* found that 44 percent of households turning to food banks have at least one member who has a chronic health condition, such as diabetes, heart disease, kidney disease or cancer.

"It's easy to imagine what will happen to your body if you don't get enough of this vitamin or get enough of that nutrient," says Underhill, "but it's not so easy to visualize how food insecurity impacts your mental health." However, there are many ways that food insecurity affects the mind. There is the chronic stress of constantly searching for the next meal. There is the shame and stigma attached to needing to go to emergency food programs such as food banks and soup kitchens. In addition, there is the inherent sense of powerlessness that arises from not being able to choose the foods that you want and like to eat. These feelings of uncertainty contribute to chronic stress, which can worsen the effects of chronic diseases. Across the country, individuals living in food insecure households report experiencing poor functional health due to multiple chronic conditions, such as hearing and vision problems, chronic pain, restricted mobility, chronic distress and major depression. They are also more likely than others to go without necessary health care, such as vision, dental, medical or pharma-care, because of the cost.

People with mental illnesses are more likely than others to be living in poverty and so are especially at risk of food insecurity. Those using prescription medications for their illness often have either weight gain issues due to lethargy or weight loss issues due to a decrease in interest to eat. As well, food insecurity during childhood can lead to poor mental health in adulthood and have a long-term impact on physiological and psychological development. A few years ago, Scadding Court observed that there were a number of children arriving at their after-school program who were very hungry because they had not had a decent lunch. "Their hunger was actually affecting their participation in the program," explains Chatterjee. "We could see that children's behaviour was deteriorating, they were losing their confidence, and they didn't have the energy to participate in physical activities. It wasn't just that their health was being impacted that day, but their long-term health was also being impacted because they were unable to participate in a program that supports their personal, physical and social development." In response to this issue, Scadding Court now provides a healthy snack to every child that attends their after-school program.

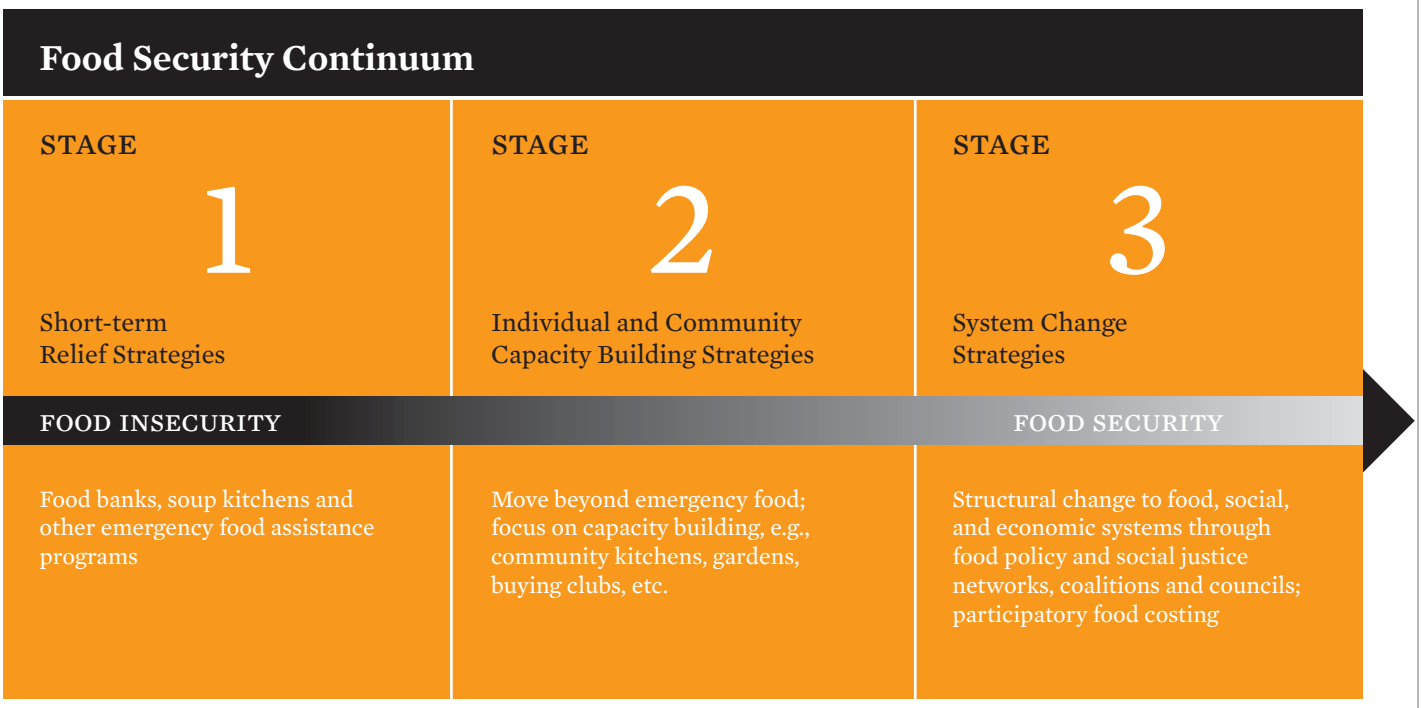
New immigrants, who are often healthier than those born in Canada, are at particular risk of poverty and food insecurity when they first arrive. "We work with a lot of newcomer families from racialized communities, and there are multiple compounding issues that impact these families," explains Burkhardt. Many immigrants and individuals from racialized communities face barriers in the labour market and challenges accessing employment and adequate income. Newcomers may not be able to find the foods that they are accustomed to eating in their home country, or they may not know how to prepare the foods that are here in Canada. Often they are unable to afford the foods they enjoy, and many emergency food programs do not provide culturally appropriate foods. Over time, the physical and mental health of newcomers begins to deteriorate and they begin to experience declining health, a phenomenon known as the *healthy immigrant effect*.

> "If you don't have money then you can't buy food. But there are multiple indirect relationships as well. Poverty is linked to things like low education, shift work and job insecurity, poor health, poor housing, and not having the right environment to prepare food. Just imagine the stress that results from all of these compounding factors."
>
> *Alina Chatterjee, Scadding Court Community Centre*

"Our food system is broken," asserts Graham. "Maybe it's working for a small percentage of the population. But for those most in need, it's definitely not working." Currently, there is no comprehensive food policy for accessing food at the municipal, provincial or federal level. Food banks and emergency food programs are just band-aid solutions to the larger systemic issue of food insecurity. As Underhill describes, "We have so much farmland and agriculture in Ontario, but there are no public policy standards to ensure that our farmers are adequately supported, or that food is priced fairly, or that the people who are working in the fields have fair labour practices. All of these issues have an impact on the food that arrives in our cities, and determines how food is physically and financially accessible."

Moving Towards Food Security for All

Collective action and a variety of different strategies are needed to address the crisis of food insecurity. The Nova Scotia Nutrition Council and the Atlantic Health Promotion Research Centre at Dalhousie University offer a three-stage



Source: *Thought About Food? A Workbook on Food Security and Influencing Policy*, developed by the Food Security Projects of the Nova Scotia Nutrition Council and the Atlantic Health Promotion Research Centre, Dalhousie University, June 2005.

approach for addressing the crisis of food insecurity (see diagram). They believe that food security must be considered along a continuum from short-term strategies that address immediate needs, to long-term strategies that aim to build food security into the future.

Stage One: Provide short-term relief strategies, such as food banks, soup kitchens and emergency food programs

There are many initiatives in Ontario that are addressing the immediate crisis of food insecurity. In addition to supporting the province's food bank programs, community-based agencies coordinate alternative ways to share healthy foods, such as hosting breakfast, lunch and snack programs. Community organizations are also beginning to incorporate food into aspects of their programming. "Whether we eat it, share it, cook it together or grow it, in everything that we do we try to think about how we can integrate a component around food security or we actually provide the food itself," says Underhill. Community health centres promote health and nutrition by hosting potlucks, barbeques, and celebrations featuring healthy foods.

Stage Two: Build individual and community capacity to move beyond emergency food services

Across the province, communities are joining together to plant and grow their own produce through community garden programs. Scadding Court works collaboratively with other agencies to promote community gardening in downtown Toronto. Seventy-five community garden plots are located in parks, in backyards of local schools and churches, on rooftops of local community agencies, and scattered across the Scadding Court property. The Hong Fook Mental Health Association, which works to support the mental health of people in Toronto's Cambodian, Chinese, Korean, and Vietnamese communities, is a long-time participant of the Scadding Court community garden program. This partnership creates a safe and supportive environment for individuals with mental illnesses to partake in community gardening. "They are a very active, social, and dependable group," says Burkhardt, "and we provide them with occasional workshops on things like composting and our healthy eating and heart health programs."

Scadding Court also offers community kitchen programs where groups of individuals can come together to learn about healthy eating and to prepare affordable meals safely. Community kitchens offer fresh fruits and vegetables, provide healthy recipes and promote a socially accessible environment where individuals can be creative with their food. They not only increase food security for participants, but have a positive effect on other aspects of an individual's physical and mental health. "Over time, I have seen positive results from clients [with mental illnesses] who come to the community kitchen program," says Krista Fry, manager of the community kitchen program at Scadding Court. "They begin to have appropriate weight gain and weight loss, increased physical activity, and generally a better outlook on life." This can also lead to reduced isolation and improved self-esteem due to the social interactions that take place in the community kitchen.

Community health centres across the GTA are also promoting the Good Food Box program as a viable alternative food source. Volunteers from Food Share, a non-profit, community-based organization, pack reusable boxes with fresh fruit and vegetables purchased directly from farmers and from the Ontario Food

Terminal. Food Share coordinates the sale of the boxes and makes deliveries to over 150 locations. The good food box is about $7 to $10 cheaper than buying produce at the local supermarket.

Stage Three: Implement larger structural and policy changes to the food and agricultural systems

Food Solutions, a recent series of research papers from the Metcalf Foundation, provides comprehensive recommendations for building a healthy, ecological, equitable and financially viable food system for Ontario. The papers recommend developing a sustainable agricultural system that supports farmers in their efforts to grow and process organic foods, and building a stronger regional processing sector to strengthen local food economies. As well, the promotion of urban agriculture would increase access to healthy, locally grown food. Support for community food centres is also essential, to help create spaces where individuals and communities can come together to grow, cook, eat and enjoy healthy food and promote food security for the future.

The Association of Ontario Health Centres (AOHC) is one of more than a dozen partners across the province who are advocating for systemic change through the *Put Food in the Budget Campaign.* "Allocating money for food in the provincial budget is essential for addressing poverty, food insecurity and other determinants of health," says Lee McKenna, Manager of Policy and Government Relations at AOHC. The group has developed a joint statement calling on the provincial government to take action in three areas: revise social assistance rates based on actual local living costs; immediately implement a healthy food supplement increase of $100 per month for every adult on social assistance; and maintain a fair nutritional supplement program for social assistance recipients, that retains at least the current budget allocation of $250 million. McKenna states that the campaign works "to gain benefits that reflect the real costs of a healthy and dignified life."

There are no easy solutions, but through collective action and comprehensive social policy, there is hope for addressing the food insecurity crisis. Underhill says, "As care providers, we struggle to both meet the immediate food needs of our clients, while simultaneously trying to tackle the larger systemic issues that cause food insecurity in the first place. Larger systemic change is needed across the province and better policies must be implemented to address poverty and food insecurity."

Uppala Chandrasekera is a policy analyst with CMHA Ontario.

COMMUNITY DEVELOPMENT WORKER KRISTA FRY (THIRD FROM RIGHT) POSES WITH GARDENERS AT SCADDING COURT COMMUNITY GARDEN

fast FACTS

375,000

Number of Ontarians who use food banks every month.

43

Percentage of Ontario food bank users living on social assistance.

22

Percentage of Ontario food bank users living on assistance from provincial disability support programs.

33

Percentage of Ontarians accessing food banks who are recent immigrants (living in Canada for four years or less).

33

Percentage of families using food banks where at least one family member regularly misses three or more meals per week.

63

Percentage of households turning to food banks whose members do not consume the recommended daily servings of milk and milk alternatives.

Source: Ontario Association of Food Banks' Ontario Hunger Report 2009.

PHOTOS: COURTESY OF SCADDING COURT COMMUNITY CENTRE

The Stress of Food Bank Food

BY WAYNE ROBERTS

I was fully prepared for several days of poor eats when I took part in the Stop Community Food Centre's Do the Math media stunt earlier this April, when ten well-known Torontonians signed on to stretch a three-day ration of food bank grub for as long as possible.

But I was shocked by how quickly and completely this poverty diet impoverished me, my wife Lori and our teenage daughter, Anika.

In solidarity with 400,000 people across Ontario who have to rely on food banks every month, we stretched three days' supplies to make them last four days, and I lost three pounds for my pains.

If that were the worst of it, I would repackage some of Anika's survival recipes — peanut butter stretched with flour and milk, and beans stretched with flour, our downscale versions of hamburger helper — as The Roberts Diet, a proven way to lose three pounds in only four days of exercise-free high-carb living.

But to our surprise, meagre and nutrient-free rations, growling stomachs and low-grade headaches weren't as hard on us as the psychological strain.

We didn't expect that because food is mainly understood in our society as a commodity that fills the belly and delivers nutrients. It's widely considered that poor people on poor diets mainly suffer physical health consequences from hunger and under-nourishment. I shared that view myself, which is why I've long harped about how all society pays the lifetime costs of poverty when the bills come due for diabetes, heart disease and osteoporosis.

Such chronic diseases are often related to life on low incomes, I still believe, but other problems and illnesses are caused by something more debilitating than doing without the things money can buy — something my family suffered from after only four days. I'm talking about the mental ill-health that comes from the sensory deprivation and demoralization of impoverishment.

Evolution equipped humans with stress as a form of creative tension that triggered a rush to either fight or flight. But when life closes the door on fight and flight, what's a body to do? Something's gotta give, and it's just as likely that the spirit could give first, before the body.

The dispiriting starts at the food bank counter, where a cheerful and welcoming member of The Stop's staff asks what I would like. Would I prefer rice or pasta, he asks, holding up a bag of each. That was actually my only real choice, but we both keep speaking the fictional language of consumer freedom so I don't totally lose face and confront my reality that beggars can't be choosers. Would I like some tomato sauce and tuna with that, he asks. Food bank "shopping" is all about what has and hasn't been donated that week. How about a can of beans?

Would you like some tea? Do you have any coffee or tea with caffeine, I ask. No, we're out of that today. How about some bread, I ask. No, out of that too. Those are the only two foods I'm addicted to, I tell him. Then it dawned on me: I would never 'fess up to say anything that personal or revealing about my weaknesses to a clerk at a store, who needs no private information because my money talks for me; money means the clerk is paid to look after my desires, and I keep my needs private. Sorry, the sympathetic Stop staffer says, but we do have two onions and a potato for each of you. And how about our last lime?

Fight or flight, where are you? There's nothing I can do. I barely say thanks, and slink out of the room without saying goodbye to anyone, cross the road and wait for the bus home.

For dinner, we cook up the pasta, tomato sauce and tuna, and estimate that servings of four heaping spoonfuls each will make this last four meals. After a perfunctory toast with a glass of water and four big gulps of macaroni, Lori and Anika talk menu plans. The potatoes, onions and milk will make scalloped potatoes for a Friday night treat, and we'll split one of the chocolate bars three ways for then too.

That's about as creative and personalized as menu planning gets. Food bank food, mostly foraged from the industrialized aisles of supermarkets as their best-before date creeps up, is made for instructions to heat, stir and eat. Saving money, savouring flavour or eating healthy come with ingredients cooked from scratch. They belong in another world, where self-reliance, individual choice, control and empowerment aren't just a conceit of the middle class imagination.

The next two days is when I get to see how abundant and ubiquitous food is in our society. It's on display at all kinds of stores, and it's centre stage at most social occasions. To honour my pledge to stick with the food bank diet, I had to pass on one potluck lunch and one free dinner at an evening meeting. Everyone else ate their fill, leaving plenty of uneaten food for leftovers or to be tossed in the garbage.

This inequality adds insult to the injury of poverty. It's bad enough that we can't invite any friends over for dinner. It's even

embarrassing to go out and not be able to participate in what everyone else sees as a pleasurable way to break the ice.

It's often said that hunger is a relative term, and that hunger doesn't mean the absolute same thing in North America as it does in India or Africa. Exactly so. Hunger is also relative because food is about social relationships, not just physical contents, and therefore about exclusion as much as deprivation. To be left out when others worry out loud about eating too much, to be so overlooked that people throw out 40 percent of the food they buy without a moment's consideration as to the disgrace of hunger living beside excess, to be worthy of less thought than garbage, is to be someone who does not belong.

Fight or flight, where do I get the power, energy or sense of belonging to connect to the stress I feel?

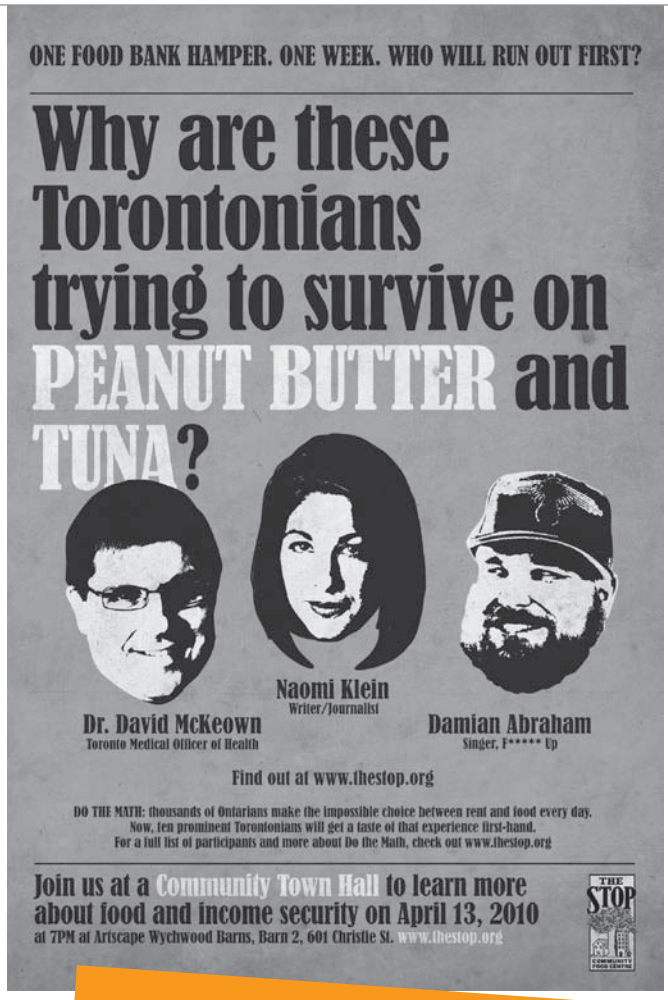
But anger and despair aren't spices provided in a foodbank diet. My only emotion is resignation. The relentless blandness of almost-stale industrial food is simply demoralizing.

I mistakenly used to think of myself as a person who didn't eat treats because I rarely eat pastries or candy. I was just oblivious to the fact that I doted on dark caffeinated coffee all day, had a blast dumping any pent-up frustration in a bootcamp workout on the way home, and then had a glass of wine with dinner, a habit I blame on a trip to Italy ten years ago. Treats are what make the deferred gratification of a knowledge economy work, because a creative knowledge requires calm, zest, concentration, will-power, discipline, forward thinking, positive energy. Although service and knowledge economy jobs don't require the physical energy and strength that food provides, they demand all the psychological energy and strength that food provides. There's a reason why McDonalds ads present their offerings as worthy of someone who deserves a treat today.

This reality relates to a major argument put forward by the Food and Agriculture Organization of the United Nations. It's true that poverty causes hunger, they say. And just as true, hunger causes poverty, because hungry people lack the health, energy, pride, calm and confidence needed for work.

Social assistance payments in Ontario are decided on without regard for the cost of basic but nutritious food. In Toronto, a family of four is allowed $1275 a month for rent, while public health officials estimate a frugal food basket for four costs $633.78. Both expenses, not to mention a few extras like toilet paper and soap, exceed the total monthly allowance of $1782. That beggarly amount explains why Ontario has food banks.

Until we teach governments to include a formal food allowance in all income security programs, we have no choice but to donate to food banks. From now on, I'll be donating wholesome and delicious treats that send a message of hope to someone fighting to keep body and soul together.



WHAT WE GOT FOR THREE DAYS

2 CARROTS
1 LIME
1 TOMATO
3 POTATOES
4 EGGS
8 PACKETS INSTANT OATMEAL
1 BAG MACARONI
1 SERVING CHEF BOYARDEE MAC AND CHEESE
2 SINGLE SERVINGS OF YOGHURT
1 JAR PEANUT BUTTER SPREAD
1 CAN FLAKED TUNA
1 QUART MILK
1 SMALL CAN OF PORK AND BEANS
1 SMALL CAN OF MIXED VEGETABLES
1 LARGE CAN OF TOMATO SAUCE
12 CHICKEN DOGS
1 CARTON OF DECAF TEA
2 CHOCOLATE BARS

Wayne Roberts is a writer, social activist and recently retired coordinator of the Toronto Food Policy Council. This article is reprinted by permission from his blog, "Cook Globally. Eat Locally. Act Neighbourly." at www.wayneroberts.ca.

BY JENNIFER MCVITTIE

Confronting Metabolic Syndrome in Durham Region

A cluster of new and innovative programs have sprung up in Durham Region to deal with the serious health concerns of the large number of people living with mental illness who also have metabolic syndrome (MeS) or other chronic conditions. MeS consists of a group of risk factors, including obesity, hypertension and unhealthy blood sugar and cholesterol levels, and is associated with cardiovascular disease, stroke and type 2 diabetes.

The Healthy Living Program at CMHA Durham

"Clients are prescribed anti-psychotic medications, which are often sedating," explains Kelly Delaney, Healthy Living Program Facilitator at Canadian Mental Health Association, Durham Region, "leading to a sedentary lifestyle, poor motivation and a lack of physical activity. Smoking and poor eating are also factors. This leads to significant weight gain and puts them at risk for conditions such as diabetes, heart disease and high blood pressure."

A lot of Delaney's clients already have MeS, which is why she started working on a program that would encourage them to do something about it. The Healthy Living Program, funded by the Ministry of Health Promotion and Sport's Healthy Communities Fund (see page 20), began in January 2010. It's an eight-week program, with a different topic each week: smoking cessation, healthy eating, physical activity, stress management, sleep hygiene, screening/prevention, medications and looking ahead to the future.

When a client is referred to the program, they are interviewed, and asked if they want lab testing done through their doctor, to check things like blood sugar and cholesterol levels. General Practioners (GP) in the area have been very co-operative, and Delaney finds interprofessional collaboration essential in helping clients be successful. The program operates out of the Primary Care Clinic at CMHA Durham so Delaney can refer clients who don't have a GP to the clinic for health care and blood work.

The program includes an in-home personal assessment by a physical fitness expert who develops a personalized workout routine, as well as subsidized gym memberships and group workouts. At the end of each of the weekly sessions, there is goal setting related to the topic discussed that week. Then for three months afterwards Delaney sees clients every two weeks for follow-up and support.

At the beginning of the program, clients are given three anonymous questionnaires, assessing opinions about health and healthy living, personal lifestyle and health issues, and a general mood assessment. When the program ends, clients are given the questionnaires again. Clients' blood sugar and cholesterol levels are also re-tested to evaluate their progress. Promising preliminary results have already been documented. Delaney also knows that the program is working because of the personal successes of some of her clients. One woman lost 30 pounds and was able to lower her blood pressure medication as a result.

Some important effects of the program are less measurable. Self-isolation is a big issue for many clients. One woman was so anxious when she started the program that she couldn't stay for an entire session. Gradually, as they worked together as a group, the client stayed longer and longer and eventually attended an entire session. The client has now been a non-smoker for over five months and has a new healthy living goal to lose weight. She is also working part-time providing respite services to an individual who is living with a physical disability.

Delaney has already expanded the program beyond the doors of CMHA to seven sites of Community Care Durham's COPE Mental Health Program. Although the Healthy Living Program is currently funded until the end of June 2011, Delaney is hoping to extend the program indefinitely and to the larger community because of good results and high demand. "The idea seems to be snowballing right now," says Delaney, "people are starting to think that this is important and there's a lot of talk about it."

Ontario Shores Metabolic and Weight Management Clinic

In June 2007, Ontario Shores mental health facility in Whitby introduced a Metabolic and Weight Management Clinic (MWMC) to in-patient clients, which has since expanded to include their outpatient population, and now provides services to a large part of the community in the Central East Local Health Integration Network (CE LHIN).

The clinic helps clients control weight, high blood pressure, cholesterol and diabetes by giving them access to specialized resources such as medical and nursing care, healthy lifestyle programs, clinical dietitians, therapeutic recreationists and physiotherapists. Their services focus on education and reducing health risks. Over 90 percent of their clients are overweight or obese, and two-thirds have another comorbidity, generally diabetes, high blood pressure, cholesterol or MeS.

"It's a healthy lifestyle program," says Jason Moores, nurse practitioner and clinic coordinator, "but it also offers complete clinical care for these issues." Staff help clients manage insulin, blood pressure or cholesterol medications and they can send clients for outside medical testing. They also have a reciprocal referral system with partners in the community, such as CMHA Durham's primary care service.

The MWMC sees about 70 percent of their clients on site at Ontario Shores, but there are transportation and comfort issues for a lot of people. Typically the people that get involved with the clinic want to improve their health but they don't fit the traditional chronic disease programs in the community. "They can be uncomfortable with the size of the group or the information is given too quickly," says Moores, "or the follow-up appointments are too far apart." So Moores believes in "seeing patients where they are comfortable." The MWMC staff do as much off-site work as possible. Twice a month they partner with the CMHA Durham Healthy Living Program and clients can be referred to the Ontario Shores clinic for follow-up. The MWMC also provides outreach at several locations throughout the CE LHIN.

One thing Moores is especially proud of is "how we have been able to really help destigmatize mental health within the traditional chronic disease management community." MWMC staff have given talks to educate family health teams, the Ontario Hospital Association, public health services and others in the community.

DURHAM MENTAL HEALTH SERVICES CLIENT HAS BLOOD WORK DONE. PHOTO: DAVID CLARKE.

"Clients are prescribed anti-psychotic medications, which are often sedating, leading to a sedentary lifestyle, poor motivation and a lack of physical activity. Smoking and poor eating are also factors. This leads to significant weight gain and puts them at risk for conditions such as diabetes, heart disease and high blood pressure."

Kelly Delaney, CMHA Durham Region Branch

Perhaps most destigmatizing of all are the clinic outcomes, which show that people with mental illness can achieve the same results as others. Clinic statistics show that MWMC clients lose weight and keep it off: an average of three kilograms lost at three months into the program with continued weight loss. As well, high-risk diabetics are getting their blood sugar into healthy ranges. There have also been global improvements in cholesterol and significantly reduced blood pressure.

Importantly, they are also being accepted into the mainstream chronic disease management community, says Moores. In 2009, the clinic received the Canadian College of Health Service Executives 3M Health Care Quality Team Award, a national award that recognizes innovation, quality and team leadership. It was the first time the award has been given to a mental health program, and recognizes the MWMC's work in addressing a significant gap in mental health patient care.

DMHS and Seamless Care Pharmacy Metabolic Syndrome Screening Clinics

A different type of partnership has recently developed in Durham Region — between a mental health service provider and a pharmacy. Durham Mental Health Services (DMHS) recently teamed up with Seamless Care Pharmacy to offer free Metabolic Syndrome Screening Clinics in the community.

"As mental health providers we slowly realized the importance of working together on these things," says Rob Adams, executive director at DMHS. So Adams sat down with the owner of Seamless Care, Murad Younis, and they brainstormed about the problem. They decided to start simply, with blood testing and education. There is little cost associated with the program: the Seamless Care staff provide the clinical expertise and the clinics are held at the DMHS administrative offices and at one of their supportive housing facilities.

"The key to this kind of thing is to have really good partners," says Adams. The Seamless Care staff ask basic health questions and conduct physical tests including blood pressure, weight, body mass and blood sugar screening for diabetes. They also screen clients in relation to lifestyle issues such as nutrition and exercise. Then they connect with the client each month to monitor their progress and to continue to provide support to clients through education about healthy lifestyles, such as exercise, nutrition and how they can support their own health. If a problem is detected, DMHS will help a client access medical support and assist in the appointment and follow-up.

Throughout the program, people are encouraged and supported to make lifestyle changes, something that has gone beyond the client population. As an agency, DMHS is now trying to instil the same positive changes among their staff, like providing healthy food during staff functions, establishing a staff walking group, and, perhaps most importantly, providing staff with the time to enjoy the benefits of these changes. It's a "whole mind shift for everyone," says Adams, "it's not just about the clients, but the whole community."

Jennifer McVittie is e-content developer at CMHA Ontario.

PAUL GORCZYNSKI IS A PHD CANDIDATE IN THE DEPARTMENT OF EXERCISE SCIENCES AT THE UNIVERSITY OF TORONTO. PAUL USES BOTH QUALITATIVE AND QUANTITATIVE METHODS TO EXAMINE ENVIRONMENTAL FACTORS THAT INFLUENCE WEIGHT GAIN IN INDIVIDUALS WHO LIVE IN MENTAL HEALTH SETTINGS. HIS RECENT RESEARCH USED PHOTOVOICE TO LOOK AT CLIENT PERSPECTIVES ON WAYS TO INCREASE PHYSICAL ACTIVITY AND IMPROVE DIETARY BEHAVIOURS AMONG INDIVIDUALS WITH SCHIZOPHRENIA WHO ARE OVERWEIGHT OR OBESE AND WHO ARE TAKING ANTIPSYCHOTIC MEDICATION.

by Diana Ballon

Obesity and Mental Illness

OBESITY IS NOT SIMPLY A CONDITION THAT APPEARS AS WE HEAD INTO ADULTHOOD. ABOUT ONE IN FIVE CANADIAN CHILDREN IS OBESE, PLACING THEM AT RISK NOT ONLY FOR CHRONIC HEALTH PROBLEMS SUCH AS CARDIOVASCULAR DISEASE, TYPE 2 DIABETES, HIGH BLOOD PRESSURE AND HIGH CHOLESTEROL — BUT FOR A HOST OF MENTAL HEALTH PROBLEMS AS WELL.

While we have long known of the link between obesity and mental illness, there are many less-explored aspects of this relationship. The following three studies each lend insight into unique elements of this association: the first looks at how the environment of an in-patient psychiatric unit may actually contribute to obesity; the second looks at the reciprocal link between depression and obesity (in other words, how each condition increases the risk of developing the other), and the third examines the alarming prevalence of obesity among children and youth, and what has and should be done to decrease kids' vulnerability to becoming overweight.

[snapshot]

In-patient psychiatric setting may contribute to patient obesity

The environment may not be the main cause of obesity among patients taking antipsychotic medication, for which there are known metabolic side-effects. But the environment is still likely a culprit, according to this recently published study.

In a study by investigators Guy E.J. Faulkner, Paul F. Gorczynski and Tony A. Cohn, 25 staff members were interviewed at an in-patient psychiatric unit at the Centre for Addiction and Mental Health in Toronto to examine how the setting might be contributing to patients' obesity.

Speaking to a range of employees — clinical, support and administrative — the researchers were able to identify several factors on the in-patient unit contributing to what they term an "obesogenic" or obesity-promoting setting:

- vending machines selling high-calorie drinks and snacks throughout the hospital
- limited number of water fountains because of the risk of water intoxication syndrome for patients who drink excessive amounts of water — providing fewer alternative options to soft drinks and other sugary beverages
- buffet service on most wards, resulting in patients overeating and even hoarding foods that they then eat throughout the day
- unhealthy food and drink options both within the hospital and at more affordable places in the neighbourhood, such as convenience stores and inexpensive diners
- closed staircases, which — while necessary for safety reasons — result in patients relying on elevators.

The authors acknowledge real limitations to what can be provided in a psychiatric setting, because of safety concerns, financial limitations and wanting to respect the patients' autonomy to choose what they want to eat or drink at a time when much less may be under their control. This includes allowing patients some choice in what they eat and drink, and in whether they wanted to sleep in and miss breakfast in the morning.

However, they do suggest that psychiatric services could look at the nutritional content of food services they provide; find ways to encourage physical activity — for instance, by having walking programs; and offer nutritional education.

They also suggest that clinicians in other settings could put in place a systemic framework, "such as the analysis grid for environments linked to obesity," or ANGELO model, which can help to identify and prioritize ways to intervene in the environment. This model divides the environment into four types: physical (what is available), economic (costs), political (what rules are in place) and social cultural (attitudes and beliefs).

G.E.J. Faulkner, P.F. Gorczynski and T.A. Cohn (2009). "Psychiatric Illness and Obesity: Recognizing the 'Obesogenic' Nature of an Inpatient Psychiatric Setting." Psychiatric Services, *60 (4): 538–541.*

[snapshot]

Depression increases risk of obesity, while obesity increases risk of depression

People who are obese have a 55 percent greater risk of developing depression over time, while people who are depressed have a 58 percent greater risk of becoming obese, according to a recently published article in the *Archives of General Psychiatry*. The researchers found a stronger association between depression and obesity (defined as having a body mass index, or BMI, of 30 or more) compared to the link between depression and being overweight (or BMI between 25 and 29.99). The authors' findings were based on a meta-analysis of 15 studies found through a computerized literature search. To the authors' knowledge, this is the first meta-analysis of long-term studies examining the bidirectional link between these conditions: how depression affects the prevalence of obesity, and in turn how obesity affects depression.

The authors describe the biological link between depression, overweight and obesity as complex and "not definitive." However, they surmise that the association may be linked to the potential role that inflammation and certain brain pathways (namely, hypothalamic-pituitary-adrenal axis [HPA-axis] dysregulation) play in both depression and obesity. They also cite studies suggesting that a greater risk of type 2 diabetes and insulin resistance involved in obesity could create alterations in the brain and increase the person's risk of becoming depressed.

Psychological factors are also likely contributors: being overweight and perceiving yourself as overweight can create psychological distress in some cultures, such as the U.S. and Europe where thinness is seen as a beauty ideal. Disturbed eating patterns, eating disorders and physical pain linked to obesity may also increase people's risk of depression. There could be other reasons for increased weight gain as well: neuroendocrine disturbances could play a role, as could an unhealthy lifestyle, not exercising enough, having a bad diet and taking antidepressants.

These findings could have important clinical implications. The authors recommend that care providers monitor depressive patients' weight, and that they monitor mood in overweight or obese patients.

F.S. Luppino, L.M. de Wit, P.F. Bouvy, T. Stijnen, P. Cuijpers, B.W.J.H. Penninx and F.G. Zitman (2010). "Overweight, Obesity, and Depression: A Systematic Review and Meta-Analysis of Longitudinal Studies." Archives of General Psychiatry, *67 (3): 220–229.*

[snapshot]

Obese kids more likely to have mental health problems

Obese children are often rejected by their peers, feel badly about themselves and are labeled according to negative characteristics that go far beyond their appearance, such as being "stupid," "mean" and "lazy." In summary, obesity, particularly for children, is one of the most stigmatized public health concerns. It is also more likely to result in psychiatric diagnoses than other chronic health conditions. Studies have found that kids and youth who are obese have "[h]igher than average rates of depression, anxiety, eating disorders, social withdrawal and behavioural problems."

Unfortunately, being overweight in childhood is not so uncommon. In the past three decades, "the prevalence of overweight young people has tripled" both in Canada and worldwide. The causes of obesity are not surprising: lack of activity, poor diet, less physical education in schools and more TV, video games and computers. Economics also plays a role, with lower-income communities in Canada having more fast food outlets and variety stores where the cheapest foods also tend to be the least healthy. In these disadvantaged neighbourhoods, less access to safe playgrounds and parks, and fewer organized physical activities make it more difficult for kids to get regular exercise.

Today childhood obesity is benefiting from legislation and programs being put in place to try to discourage unhealthy eating and promote better exercise. Last year, British Columbia enacted legislation to restrict trans fats in schools and restaurants, while in Sweden, TV and radio ads targeting kids under 12 have been banned since 1991. Many Canadian communities have organized "walking school buses," in which adults chaperone a group of kids walking to school. While studies indicate that many programs "designed to prevent childhood obesity" do not significantly reduce kids' BMI, programs lasting longer than six months produced much better outcomes. Other meta-analyses found that preventive programs did help to increase kids' physical activity levels, promote less sedentary behaviour and result in less unhealthy eating.

C. Schwartz, C. Waddell, J. Barican, O. Garland, L. Nightingale and D. Gray-Grant (2010). "The Mental Health Implications of Childhood Obesity." Children's Mental Health Research Quarterly, *4 (1): 1–20. Vancouver, BC: Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University.*

Diana Ballon is a Toronto writer and editor specializing in mental health issues.

by **Michelle Gold**

CHRONIC DISEASE PREVENTION & MANAGEMENT OPPORTUNITIES ARE ALL AROUND

ONTARIO'S CHRONIC DISEASE prevention and management framework evolved out of the original chronic care model developed in 1996 by the MacColl Institute for Healthcare Innovation in the United States. Evidence was accumulating that clinical practices designed to treat acute illness were not resulting in effective outcomes for patients with chronic conditions. The MacColl Institute recommended that health care providers utilize evidence for decision-support to guide clinical care; multidisciplinary teams be created to provide a broader range of health services; information systems be developed to plan visits and protocols for treatment; and education and support be offered to patients, in order for them to actively participate in the management of their chronic conditions.

In 2003, British Columbia developed an "Expanded Chronic Care Model," which incorporated prevention and health promotion into the original framework. Ontario's current chronic disease prevention and management (CDPM) framework is an adaptation of the British Columbia approach. The BC model envisions health care organizations using evidence and other decision support tools; and collaborating with the community sector to provide comprehensive, coordinated services and support for individuals to be active in their own self-care. The framework identifies health promotion and prevention as integral strategies for addressing chronic conditions — at both the individual and population level. Healthy public policies, community action and supportive environments are an essential part of the framework to reduce both the burden and the incidence of chronic conditions.

The BC model is a milestone framework in developing a more comprehensive approach to chronic conditions, by incorporating the strategies identified in the World Health Organization's 1986 Ottawa Charter for Health Promotion. The actions are known to promote health and prevent disease. Although the BC model operationalizes the conviction that "health is more than the absence of disease," further evolution of the expanded chronic care model is needed. Indeed, the developers of the BC expanded chronic care model anticipated and encouraged that their model generate further discussion and enhancements to prevent and manage chronic disease.

Given the recognition of the need for ongoing evolution of the CDPM model, the time is now to enhance Ontario's approach by integrating directions to address the association between mental health and chronic physical conditions. Ontario's CDPM framework does not require alteration per se. Rather, directions arising from the framework model should be inclusive of addressing mental health and mental illness. Here at the Canadian Mental Health Association, Ontario, we have been raising issues and opportunities for promoting mental health, supporting people with mental illnesses, and addressing the prevention and management of co-existing mental illnesses and chronic physical conditions within Ontario's CDPM framework. We believe that while there is good work taking place in some locations within the province and via several provincial initiatives, much of this work is taking place in isolation. Policy-makers, funders and stakeholders need to work together to incorporate mental health within Ontario's CDPM directions.

The need to address mental health and mental illness within Ontario's approach to chronic conditions is timely as Ontario inaugurates its CDPM framework with the implementation of the diabetes strategy.

There are three key causal relationships between mental health and chronic physical conditions that are justification for broadening Ontario's current, limited approach to CDPM.

People living with chronic physical conditions are at risk of poor mental health. Individuals who experience heightened symptoms such as chronic pain and/or activity limitations oftentimes experience distress as well as isolation from social supports, resulting in depression and anxiety at twice the rate of the general population. The stigma associated with mental illness can also serve as a disincentive that keeps people with chronic physical health conditions from seeking help, resulting in missed opportunities for early identification and treatment of poor mental health.

People with mental illnesses are at greater risk of chronic physical conditions. Mental illnesses can alter hormonal balances and sleep cycles, while some psychotropic medications have side-effects that increase vulnerability to a range of physical conditions. Moreover, individuals living with serious mental illnesses frequently face high rates of poverty, unemployment, lack of stable housing and social isolation. These circumstance increase vulnerability of developing chronic physical conditions. Regardless of the precedent and antecedent conditions, having co-existing mental illness and chronic physical conditions is likely to result in lesser quality of life, extended illness and poorer health outcomes.

Poor mental health is a risk factor for chronic physical conditions. This is a lesser known fact but equally compelling. Poor mental health influences the ability to engage in preventative self-care; for example, engaging in physical activity and eating a healthy diet. People experiencing poor mental health may also be less able to communicate their physical symptoms and needs; and so early identification and intervention opportunities are missed. Alternatively, physical symptoms may be either ignored or downplayed in individuals with a recognized mental health condition, due to health provider stigma. This situation has been well documented and is known as "diagnostic overshadowing."

The need to address mental health and mental illness within Ontario's approach to chronic conditions is timely as Ontario inaugurates its CDPM framework with the implementation of the diabetes strategy. The Ministry of Health and Long-Term Care acknowledges that their experience with the diabetes strategy will set the foundation for implementation of other chronic disease strategies. People with schizophrenia are at greater risk of diabetes as a result of poverty and some antipsychotic medications increasing the likelihood of developing metabolic syndrome, a known risk factor. Discouragingly, diabetes in these individuals is often not diagnosed or treated. The Ministry of Health and Long-Term Care provided sponsorship funds to CMHA Ontario to hold a think tank on Diabetes and Serious Mental Illness in 2009. Knowledgeable stakeholders came together and proposed 20 strategic actions to improve diabetes prevention and management in people with serious mental illness, but they are not yet being addressed through any coordinated, provincial approach. There is a need for enhanced collaboration across the health system and with government decision-makers to plan for a comprehensive health system and better health outcomes for people with mental illness, as well as people with chronic physical conditions at risk of poor mental health.

Other existing initiatives on which to build include the leadership of the Ontario Chronic Disease Prevention Alliance (OCDPA), of which CMHA Ontario is a member, who recognize mental health as a risk factor for chronic physical conditions, and have incorporated common messages on promoting mental health and addressing the determinants of health in all the work that they do. OCDPA hosted a forum, also in 2009, that identified actions various non-governmental organizations committed to take to "move forward as a system."

Concurrently, Ontario is finalizing a 10-year mental health and addictions strategy for the province, the directions of which will likely include increased emphasis on early identification of poor mental health; greater attention to addressing mental health in the primary health care setting; supporting collaboration between health sectors to leverage resources and scope of practice; and attention to fostering healthy communities as a strategy to promote mental health. This "health in all policies" perspective requires the involvement of multiple ministries. It will be important here again to set out expectations that link cross-ministerial and cross-sectoral initiatives within Ontario's mental health and addictions strategy to the province's work on chronic conditions.

This issue of our magazine has profiled a few of the initiatives taking place in Ontario that visionaries, early adopters and champions are taking to address the co-relationship between mental health, mental illness and chronic physical conditions. Given that "there is no health without mental health," all Ontarians have the potential to benefit from a comprehensive and coordinated approach to how we address chronic conditions. Provincial leadership is needed to coordinate this whole-of-government, inter-sectoral approach — the momentum exists to move this important issue forward.

For more information about CMHA Ontario's work on chronic conditions, visit www.ontario.cmha.ca/cdpm.

Thank You!

CMHA National Office thanks Desjardins Financial Security for their generous support of National Mental Health Week five years in a row and their continued sponsorship of our annual National Conference.

Desjardins Financial Security continues to be a committed partner in mental health leadership and has been exemplary and instrumental in assisting CMHA in our efforts to improve workplace mental health for all Canadians.

The generosity of Desjardins Financial Security will ensure that we continue to inform Canadians about mental health issues and the valuable services and programs available in their communities.

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CANADIAN MENTAL HEALTH ASSOCIATION
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Workplace Mental Health Promotion: A How-To Guide

A high-quality, research-based, practical tool to improve the health of individuals and organizations.

Mental health promotion within a workplace positively affects those with and without mental illness. The focus of this guide is on creating mentally healthy workplaces that promote positive mental health and well-being for all employees. This dynamic web-based resource includes downloadable resource lists, tools, case studies and templates.

Using a comprehensive workplace health promotion approach, the guide incorporates a continuous process that looks at environmental improvement, personal empowerment and personal growth.

For more information and to explore this resource, visit **wmhp.cmhaontario.ca.**

THCU at the Dalla Lana School of Public Health, University of Toronto

works well

CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO
ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE, ONTARIO

The Workplace Mental Health Promotion guide was developed by The Health Communication Unit (THCU) at the Dalla Lana School of Public Health, University of Toronto, in partnership with the Canadian Mental Health Association, Ontario. This is the latest in a series of resources on workplace health promotion developed by THCU.

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ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE, ONTARIO

180 DUNDAS STREET WEST, SUITE 2301
TORONTO, ONTARIO M5G 1Z8