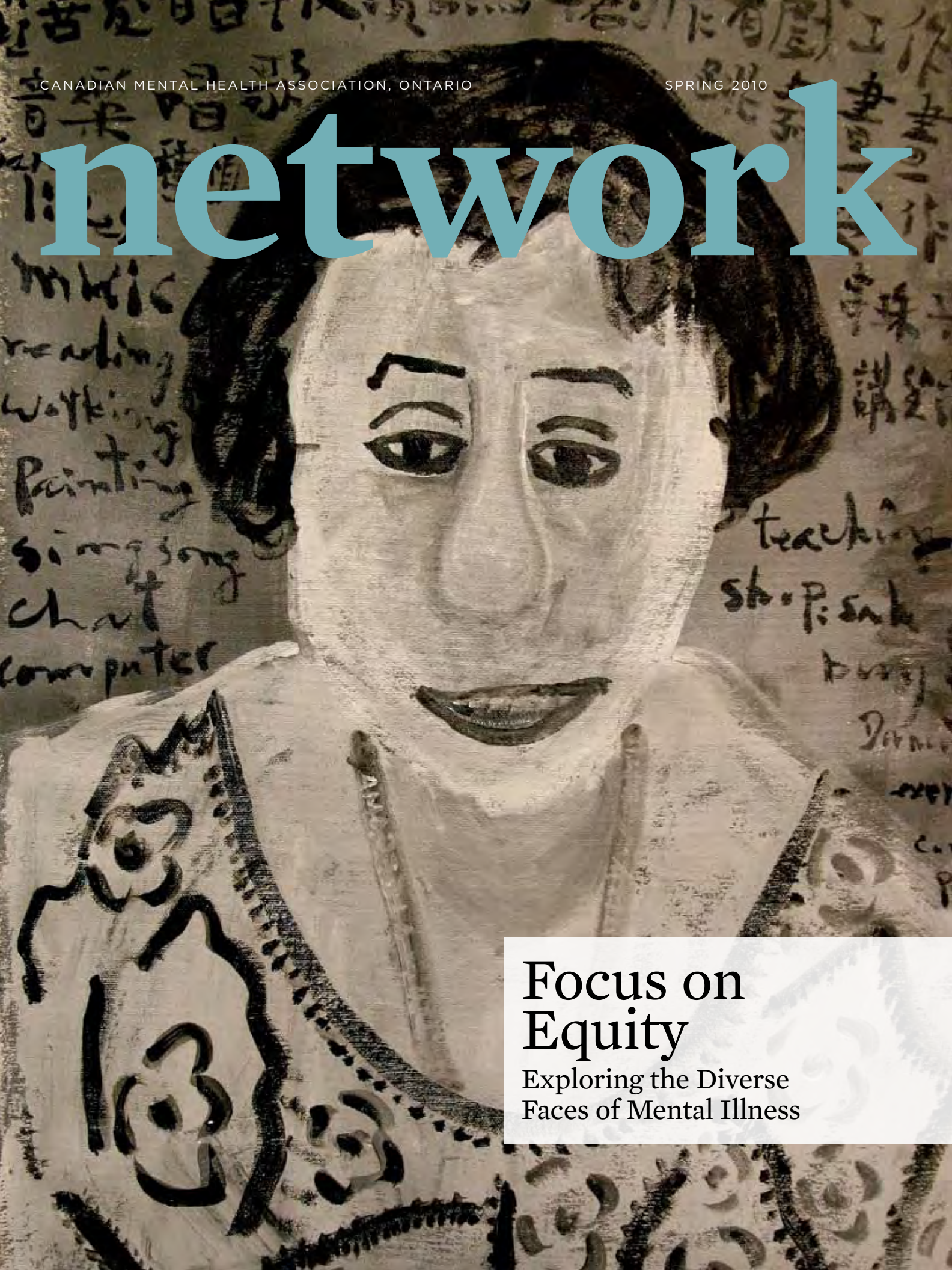
CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO SPRING 2010

# network




## Focus on Equity

Exploring the Diverse Faces of Mental Illness


KASHFI ASGAR, 2010. SEE PAGE 24 FOR DETAILS.


# Contents



LOOKING FOR THE CALENDAR? VISIT **WWW.ONTARIO.CMHA.CA/EVENTS**

## Re: Cover

Susan Lim, *Self-Portrait* (acrylic on canvas), 2009. This work was produced at Creative Works Studio in Toronto, who partnered with Hong Fook Mental Health Association and Good Shepherd to provide weekly art programs to people who speak Korean, Vietnamese and Chinese. Inside back cover: Thomas Yim, *Self-Portrait* (acrylic on canvas), 2009.


# network

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**OUR MISSION**
The Canadian Mental Health Association, Ontario develops and provides public policy advice that promotes mental health and improves the lives of people living with mental illness.

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guest editorial *by* Barbara Hall

# Mental Health & Human Rights

**Mental health issues are often thought of in the context of hospitals and medicine. But the need for inclusion and equity extend far beyond the health care system. People with mental health disabilities and addictions have to cope with discrimination and stereotypes in many other parts of their lives.**

The *Ontario Human Rights Code*'s vision is of a society that recognizes the dignity of every person so that everyone feels a part of the community and can contribute to it. The *Code* provides for equal rights and opportunities free from discrimination — including for people with mental health disabilities and addictions.

Our job at the Ontario Human Rights Commission (OHRC) is to help put this vision into practice. We're working on a human rights mental health strategy to eliminate discrimination in areas such as education, health care, employment and housing.

We have been listening to many people to find out what key human rights issues need to be addressed, and what specific projects or activities the OHRC should consider tackling. We have canvassed consumer/survivor groups and the general public, and various organizations and mental health experts. In the coming months, we will launch a strategy to serve as a roadmap for our work in mental health over the next few years.

For many years, the OHRC has worked to remove barriers and eliminate discrimination based on mental health disabilities and addictions. On the employment front, we have succeeded in affirming that employers must cooperate with employees with mental health disabilities to make sure they are appropriately accommodated. In a recent case, a Tribunal ordered a company to pay a man with bipolar disorder almost $80,000 because it did not make any attempt to accommodate him. This decision was upheld on appeal and is an important benchmark for future employment cases involving mental illness.

Our recently released *Policy on Human Rights and Rental Housing* outlines the steps landlords and other housing providers must take so they don't discriminate against people with mental health disabilities. It also looks at discriminatory opposition to affordable housing — often called NIMBYism (an acronym for Not In My Backyard) — that often prevents much-needed housing from being built because of fear about who will live in it. We are working on many fronts to fight this.

Our mental health strategy will also outline ways to increase awareness and understanding of mental health and addiction issues, and eliminate destructive stereotypes. We will continue old partnerships and build new ones to send a strong message that people with mental health disabilities and addictions must have real opportunities to succeed — in all our communities.

We are also considering other issues raised in our consultation, such as the impact of police record checks, psychiatric care in jail and issues in the social assistance, health care and education systems. We have made a submission to the Province of Ontario on its mental health strategy offering comments and recommendations that have been echoed by the Canadian Mental Health Association, Ontario.

*Offering inclusion equity to people with mental health disabilities and addictions is the right thing to do — and under Ontario's and other human rights codes, it's the law.*

Progress has been made in advancing the human rights of people with mental illness, but much still needs to be done to eliminate discrimination many people face every day.

We bring a sense of urgency to this work. Offering inclusion equity to people with mental health disabilities and addictions is the right thing to do — and under Ontario's and other human rights codes, it's the law.

*Barbara Hall is the Chief Commissioner of the Ontario Human Rights Commission.*

WHERE THE MARGINS INTERSECT

# Multiple

## Multiple Identities, Multiple Barriers

*by*
Uppala Chandrasekera

Each of us has multiple identities. We identify ourselves by our age, gender, race, sexual orientation, culture, where we live, and what we do for a living. Sometimes we self-identify as having a disability, addiction or mental illness.

Many of our identities are visible to others, but some are invisible and come out only when we disclose them. Society accepts many of our identities, but some are devalued and stigmatized. At times we are discriminated against, and forced to the margins of society.

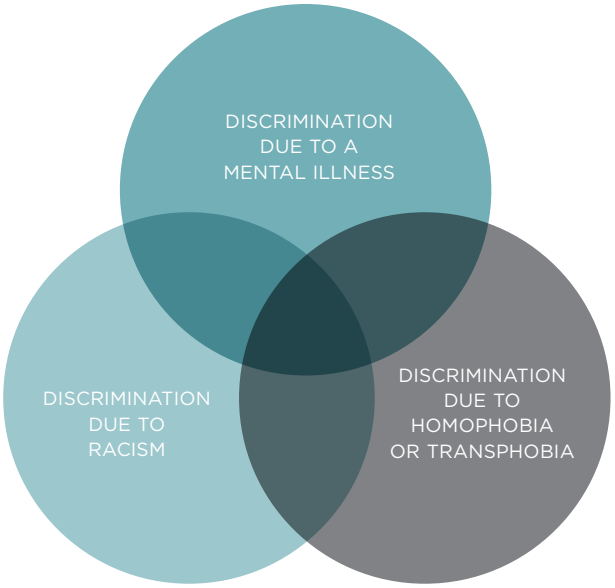
The experience of living with multiple stigmatized identities and facing multiple layers of discrimination all at the same time is known as *intersectionality*. Stigma is the negative attitudes that cause people to be labelled and stereotyped. Discrimination is the action that results from those negative attitudes.

Stigma and discrimination are two significant issues facing people with mental illnesses. Society is often unable to see past the psychiatric diagnosis, and so, having a mental illness often means that your identity is nothing more than the illness itself. When you have a mental illness, you are often treated with disrespect: you may be excluded, ridiculed, bullied or made the victim of violence. And you may be subjected to discrimination and barriers that prevent you from accessing housing, employment, education or equal treatment in the health care system.

Having a mental illness is one stigmatized identity. What happens when you have multiple stigmatized identities, face multiple barriers and multiple layers of discrimination all at the same time? The following is a look at the lived experiences of people with mental illness in two historically marginalized groups: LGBTQ (lesbian, gay, bisexual, transgender, queer) and racialized communities.

**Living with a mental illness in LGBTQ communities**

People in LGBTQ communities with a mental illness often face stigma and discrimination because of their sexual orientation and/or gender identity in addition to their illness. "The key issues that are unique to our communities are the impact of heterosexism, homophobia and other forms of discrimination based on sexual orientation and gender identity," says Lori Ross, PhD, a scientist in the Social Equity and Health Research division at the Centre for Addiction and Mental Health (CAMH) in Toronto. Ross and a team of CAMH researchers explore the determinants of mental health for LGBTQ communities, and examine the impact of heterosexism (the assumption that all people are — or should be — heterosexual), homophobia (the irrational fear, hatred, prejudice and negative attitudes toward homosexuality and people who are gay or lesbian), transphobia (the irrational fear or hatred of transsexual and transgender people) and other forms of discrimination on mental health.




INTERSECTIONALITY: THE EXPERIENCE OF LIVING WITH MULTIPLE STIGMATIZED IDENTITIES, FACING MULTIPLE LAYERS OF DISCRIMINATION, AND FACING MULTIPLE OPPRESSIONS, ALL AT THE SAME TIME.

"The stress of carrying a stigmatized identity can have an impact on mental health," says Ross. "Unfortunately, there still is a lot of discrimination within the mental health system that makes it difficult for people to access mental health care without discrimination on the basis of sexual orientation or gender identity." The discrimination resulting from heterosexism and homophobia can be obvious and direct. Clients may experience blatant acts of homophobia, such as name-calling or labelling, from other clients or from health care staff. Discrimination can also be invisible and embedded in the system. For example, in many hospitals and health care clinics, the intake forms that clients must fill out only allow them to self-identify as male or female and not as any other gender identity. Furthermore, same-sex partners and other chosen family members are often not recognized, and they frequently do not receive the same level of access to information or involvement in care as the families of heterosexual clients.

Having a mental illness is one stigmatized identity. What happens when you have multiple stigmatized identities, face multiple barriers and multiple layers of discrimination all at the same time?

> "The stress of carrying a stigmatized identity can have an impact on mental health. Unfortunately, there still is a lot of discrimination within the mental health system that makes it difficult for people to access mental health care without discrimination on the basis of sexual orientation or gender identity."
>
> *Lori Ross, Centre for Addiction and Mental Health*

There are some issues that are unique to LGBTQ communities that have an impact on mental health. One issue is the stress and anxiety of coming out. "The first step is coming out to yourself, and coming to terms with your own identity,"says Scott Anderson, the research coordinator on Ross's team at CAMH. A part of that process is coming out to your family, friends and the people in your life that are important to you. "Generally there are concerns about being accepted: Will your family still love you? Will they still support you? Will your friends still be your friends? And then there is the broader world that you deal with — work or school — can you come out there? Do you feel safe to come out there?" LGBTQ people constantly have to assess the level of risk involved with coming out — of potentially being shunned by their friends or family, of being harassed, taunted or excluded at school or in the workplace.

"One thing people often don't realize is that coming out is a lifelong process," says Ross. "There certainly is for most people a crisis period when you come out to yourself, and you come out to your immediate family members. But it doesn't just stop there … whenever you start a new job or when you move into a new neighbourhood, you have to make decisions about when and how you choose to disclose your sexual orientation or gender identity… and it can have a long-term impact on your mental health."

Although the stigma of having a mental illness exists in LGBTQ communities, just as it does in all of society, these individuals tend to be "supportive of the idea of going for counselling or therapy," says Anderson. Within LGBTQ communities, many peer support groups and organizations exist — at least in larger cities — to provide support during the coming out process. However, LGBTQ-specific services typically only address the stress and anxiety of LGBTQ-specific issues, and are not well equipped to deal with serious mental illnesses, such as schizophrenia and bipolar disorder. Unfortunately, when accessing mainstream mental health services, many of these individuals are faced with stigma and discrimination.

In a recent study, Ross's team used an Internet-based survey in which they asked approximately 275 people from LGBTQ communities and 100 heterosexual comparison participants about their levels of satisfaction with the mental health care they received in the last 12 months. The results revealed that LGBTQ clients had "very high unmet needs for mental health care," says Ross, with many individuals stopping services because they experienced discrimination.

LGBTQ communities have a long history of being pathologized by the mental health system. For decades, homosexuality was listed as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which provides criteria for identifying and classifying mental disorders. With much activism from the LGBTQ community, it was finally delisted in 1973, only to be supplanted by another pathologizing classification: gender identity disorder (GID).

"Gender identity disorder pathologizes gender identities that fall outside of male or female," asserts Anderson. Some people feel that the term is necessary for providing transgender and transsexual individuals a way to access medical services as they transition (the process whereby transsexual people change their external appearance and bodies to match their internal gender identity). Others find that taking on a psychiatric label to access services is problematic. In Ontario, sex reassignment surgery is only covered by OHIP if someone has a GID diagnosis. This creates a Catch-22 for transgender and transsexual people: get the diagnosis (and the OHIP coverage) or pay for the expensive surgery yourself.

The status of GID is precarious. The diagnosis is currently being reviewed by the American Psychiatric Association, and LGBTQ communities are actively working to have GID delisted from the DSM. The process for sex reassignment surgery will likely be reassessed and changed based on the outcome. The Gender Identity Clinic at CAMH is the only place in Ontario that can approve someone as suitable to have access to sex reassignment surgery covered by OHIP. "And it is offered through a clinic that has not had the most positive relationship with the trans community as a whole," says Ross. Fully aware of their reputation in the trans community, senior management at CAMH have been actively trying to ensure the community's concerns are met. They have developed partnerships with various community agencies that work directly with LGBTQ communities, including Sherbourne Health Centre and Rainbow Health Ontario.

"At an institutional level, I strongly believe that CAMH is trying to walk the talk around equity and diversity," says Ross. "There is a deep commitment to making sure that the needs of not just LGBTQ communities but marginalized communities in general are addressed here. But we have a long history that has to be undone before the community is willing to embrace CAMH as an institution that has the best interest of the LGBTQ people in mind."

STAFF AT ACROSS BOUNDARIES PUT ON A FASHION SHOW FOR CLIENTS TO CELEBRATE BLACK HISTORY MONTH

**Living with a mental illness in racialized communities**

In addition to the stigma of their mental illness, racialized individuals often face stigma and discrimination due to racism. Although there are no standardized definitions of racism, the concept generally refers to prejudice and discrimination against individuals or groups based on their race and/or ethnicity. Racism can be direct, such as making jokes, name-calling, using racial slurs, stereotyping, excluding people and intimidating or harming them through hate crimes. Racism can also be expressed indirectly by social and institutional policies, practices and procedures that exclude racialized groups and create barriers that reduce access to housing, education, employment and health care services.

Whether it is through direct actions or systemic discrimination, research indicates that racism continues to influence how racialized people are treated. Individuals in racialized communities are more likely to live in poverty, have lower levels of education, live in substandard housing and face multiple barriers to accessing health care services.

"With racism, we name it, we deal with it, and we move past it," says Sulekha Jama, a program manager at Across Boundaries, a mental health centre for racialized populations in Toronto. "It's important to acknowledge [to clients], you're not going crazy, racism exists, it's actually happening to you, and we're going to support you through it. You have the right to get all the services you need."

Across Boundaries provides various programs that integrate skills building, social and recreational activities and case management services. Using an anti-racism framework, this unique community-based agency provides individual, group and family support and community outreach programs. Most clients at Across Boundaries are immigrants and refugees from countries such as Afghanistan, Somalia, Sri Lanka and Uganda. Some are racialized people born and raised in Canada. Across Boundaries also supports people who are homeless, uninsured and often considered "illegal."

Through her experiences as a community mental health worker, Jama has witnessed how people of colour aren't taken seriously if they are suspected of having a mental health issue. A few years ago, a woman had an allergic reaction to some antibiotics she was prescribed. The woman fainted and was rushed to the emergency room. "When she woke up, she was surrounded by a crisis team," says Jama, "They assumed that she had a mental health issue and that she had *intentionally* overdosed on drugs. The woman had a bad reaction to the medication the doctor gave her. But just because she's Black, they assumed that she was on drugs." It wasn't until the blood test results came back three hours later that the hospital staff finally believed that the woman was telling the truth. Jama states, "This is so eye-opening... the barriers in the health care system are incredible!"

> "It's important to acknowledge [to clients], you're not going crazy, racism exists, it's actually happening to you, and we're going to support you through it."
>
> *Sulekha Jama, Across Boundaries*

According to recent studies, encountering acts of racism can lead to poor mental health, including anxiety, depression, lowered self-esteem and a negative self-identity.

According to recent studies, encountering acts of racism can lead to poor mental health, including anxiety, depression, lowered self-esteem and a negative self-identity. The experience of racism often activates the body's stress response. Over time, the daily lived experience of racism can cause chronic psychological distress that can lead to poor health. It can make individuals more vulnerable to physical illness and increase high-risk behaviours such as substance abuse and self-harm.

In addition to the impact of racism, there are other unique mental health issues for racialized communities. Current research indicates that immigrants from racialized communities are more likely to experience depression than Canadian-born individuals. "We see people who never before in their lives have had a mental illness, and then they come to Canada, and now they're so depressed because they can't get a job," explains Jama. Compared to other Canadians, racialized people are two to three times more likely to live in poverty. (This disproportionate and unrelenting exposure to high levels of poverty among racialized populations is often referred to as the *racialization of poverty.*) Not even internationally educated doctors are exempt from poverty. "We have a group of Somali doctors that meet once a month, and a lot of them are depressed because they can't get work, they can't support their families, and they can't put food on the table."

New immigrants are often healthier than Canadian-born individuals; yet, over time, the physical and mental health of new immigrants begins to deteriorate, a phenomenon known as the *healthy immigrant effect*. Many expect to get great jobs once they arrive. Instead, they are confronted with countless hurdles: the long immigration process, sleeping in shelters, sometimes juggling up to three jobs while going to school, says Jama. "So their health declines and they get really sick."

Post-traumatic stress disorder (PTSD) is another mental illness that affects many refugee populations. These individuals have survived catastrophic stress, whether from experiencing a natural disaster, such as floods and earthquakes, or from experiencing or witnessing harassment, threats, violence or warfare. Jama describes one client who was a boy soldier in Uganda for almost 10 years before coming to Canada. "He drinks too much because he wants to numb himself, and block out all of the things that he did and all of the stuff that he saw.... He hears people talking, he hears the voices of the people that he hurt, and the voices of the people that hurt him." Jama also talks about refugee women from Afghanistan and Somalia who have been so traumatized from witnessing war their whole lives that they can't differentiate their past from the present. "They don't understand that the violence is not happening to them anymore, and that they're here now, and that they're safe."

Clients with PTSD are provided with individual therapy with psychiatrists on staff, or they are referred to psychotherapists in the community, who can support them to move beyond these traumatic experiences, says Jama. Across Boundaries also provides group therapy for men and women so they're not alone in coping with the range of issues relating to mental illness, racism, employment and the immigration process.

Resettling creates another unique stress for immigrants and refugees. Many newcomers, often from racialized communities, face a precarious legal status when they arrive in Canada. "The system is set to serve *legal* people only," asserts Jama. Many newcomers are undocumented and do not have an OHIP card or social insurance number, and thus they are prevented from accessing various social supports including health care, employment supports and housing. This creates a domino effect: barriers to accessing services in one area, such as employment, lead to barriers in meeting basic needs, such as finding decent housing. With services often not offered in their first language, and limited cultural interpretation services, the problem is only compounded. "There are so many barriers to access, and it's systemic," says Jama. "Often we [as health care providers] are put in a position where we have to say, we can't get you a psychiatrist that speaks your language, we can't get you housing, we can't get you a health card, you're not eligible for disability," says Jama. "All of this piles up and the client gets even more sick."

Mental health stigma exists among racialized populations, just as it does in the rest of Canadian society. "Stigma is everywhere," says Jama. "Everybody [even Canadians] comes from a society that believes that if you have a mental health issue, you are weak." Therefore, as a component of their outreach work and case management, staff from Across Boundaries go out into the community to educate families about mental health issues. They teach families about what mental illness symptoms look like, and how to help their loved ones.

But stigma, discrimination, racism and homophobia can't be addressed solely at the individual level. Anti-discrimination policies must be implemented at the organizational level. "It's important for agencies to have an anti-racism, anti-discrimination and anti-oppression framework," declares Jama. "It's important for them to have a policy and say up front, 'We are absolutely not discriminating against anybody because of colour, mental illness or sexual orientation.'"

*Uppala Chandrasekera is a policy analyst at CMHA Ontario.*

*by* Nimira Lalani

# EQUITY PUNCTUATION

Like many Londoners, I moved around a lot within the city over the 25 years or so that I lived there, as decent affordable housing was tough to come by. On my many journeys, I noticed how differently people dressed, spoke, held themselves, and what kind of racial group they came from.

IT didn't surprise me when I heard a sobering statistic — that for every stop east on the Jubilee line (one of London Underground's "tube" lines), the average life expectancy dropped by one year. So, a man living in Westminster (a relatively affluent part of the city) was likely to live to be 78.6 years old, but his counterpart in Canning Town (eight tube stops to the east and much poorer) was likely to live to 72.8. For women, the equivalent was 84.6 years in Westminster and 81.4 years in Canning Town.

Shocking? Yes. But not surprising.

Ontario may be less of an unequal society than the UK, but not hugely so. In Ontario, people on a low income are three to five times as likely as those on a higher income to report their mental health as fair or poor. There is a clear mental health gradient, with the percentage of people reporting their mental health as only fair or poor rising as their income decreases. Such a phenomenon is known as the social gradient in health.

The notion of a "postcode lottery" — whereby where you live determines how you live and how long you live — is, sadly, not uncommon and one that is replicated in Ontario as it is in other parts of the world. Other factors, such as your skin colour, age and gender, also influence the conditions in which you live, including your access to services. For example, people from certain racialized groups are much more likely to experience poor mental health, due to unequal access to decent jobs and housing. This can be complicated by such factors as age (older racialized adults have different needs from their younger, more adaptable counterparts) and gender (women are more likely to experience poverty). Sometimes we call such differences "disparities," "inequalities" or "inequities." Unlike the politically neutral term "differences," these terms imply that such differences are not natural or inevitable, but rather avoidable, unfair — and linked to where and how we live, rather than being random aberrations.

The term *social determinants of health* means what most of us have known for a long time — that factors such as income, housing, employment and race all affect our health in a holistic sense. They influence how we feel, what opportunities we will have in life, and how long we will live. But there is good news. Our systems and sectors are recognizing three truths. Firstly, we now know that health is more than the absence of disease and that we should try to promote health and well-being as important in their own right. Secondly, services and sectors must work together, so as to reflect how aspects of our lives cannot be compartmentalized; for example, if we can't afford a proper meal, it will affect our ability to learn and work: health, education and employment are all inter-related. Thirdly, if we don't make explicit commitments to equity, then we run the risk of improving health but widening the health gap between different groups in society.

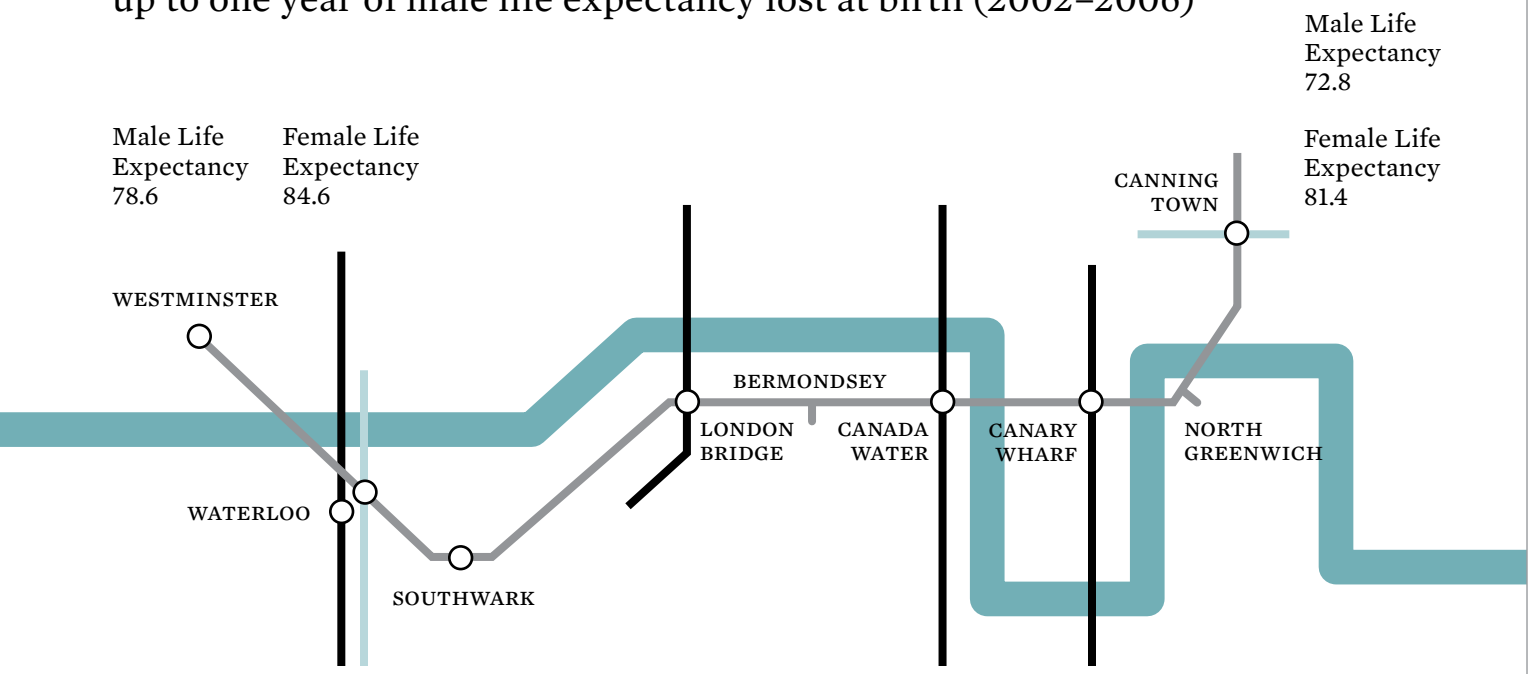
In Ontario, the Ministry of Health and Long-Term Care has made equity a strong provincial priority. The province's 14 Local Health Integration Networks (LHINs), or local health planning bodies, have created three-year strategic plans for 2010–2013 that all address equity to varying degrees. The Wellesley Institute, a Toronto-based research and policy think-tank committed to advancing health equity, is partnering with Echo, Improving Women's Health in Ontario, to develop resources and provide training on equity-focused planning and strategy development for LHINs and other stakeholders on how to make equity actionable. The LHINs will be looking at equity in a broader sense, captured by measures related to self-reported health, life expectancy and variations between such factors as income and neighbourhood.

The Toronto Central LHIN is an example of an organization that has made an explicit commitment to health equity. Bob Gardner, director of policy and research at the Wellesley, has developed a strategic framework for the Toronto Central LHIN, laying out 12 overarching directions to reduce inequitable access to health care, tackle preventable barriers, and encourage innovation and health system transformation. The action recommendations can be essentially subsumed under two broad themes: to build equity into all planning and service provision and to invest in those interventions that are likely to have the biggest impact on equity barriers or the most disadvantaged groups. The Toronto Central LHIN has already acted on many of the recommendations, while other LHINs are incorporating similar equity initiatives into their own strategies. Within the Toronto Central LHIN, hospitals have developed equity plans of their own.

Putting the needs of the population at the centre of service delivery is a notion that is catching on. Instead of homeless people having to make a complicated

## The Jubilee Line of Health Inequality

Travelling east from Westminster, each tube stop represents up to one year of male life expectancy lost at birth (2002–2006)




LONDON UNDERGROUND JUBILEE LINE

*Source: UK Department of Health, based on analysis by London Health Observatory using Office for National Statistics data released for 2002–2006.*

and difficult journey to access mental health support, a Toronto program provides psychiatric support on-site in shelters and other places homeless people actually go. Community-based peer health ambassador programs help people navigate the convoluted process of gaining access to health information, treatment and support.

In our diverse society, it is not enough to produce information in English and French. Rather, interpretation needs to go beyond translation to influence behaviour. Interpretation includes tailoring communication media to the needs of different cultures, locating services in areas of need, and providing convenient hours. As providers and policy-makers, we need to ensure that our approach to care is flexible and responsive to the diverse needs of our populations.

This is already happening. Research, such as that being funded by the Wellesley Institute, is engaging mental health users, providers and culturally diverse communities to ensure that their voices and experiences are documented and that they contribute to practice and policy change.

In part, my role as research associate at the Wellesley involves supporting researchers on projects related to the social determinants of health, identifying connections with other relevant bodies of work, and helping them to look at the implications of their research for actionable change. Recently, this included working with the Canadian Mental Health Association, Ontario to provide input to the Ministry of Health and Long-Term Care on how best to build equity into its mental health and addictions strategy. One direction we recommended was to develop equity-focused planning tools. Based on international experience, the ministry developed a health equity impact assessment (HEIA) tool to help determine whether health services

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The term *social determinants of health* means what most of us have known for a long time — that factors such as income, housing, employment and race all affect our health in a holistic sense.

are being accessed or will have an inequitable impact on different vulnerable populations, and what can be done to improve access. HEIA was pilot tested and refined by the Wellesley in the Toronto Central LHIN and is being used in several LHINs. These tools also include more specific mental health impact assessments that systematically evaluate the potential and actual impact of non-mental health policies (e.g., transportation) on the mental well-being of communities. These tools, and healthy community planning approaches, both systematically build equity into cross-sectoral planning. Even better, they build on existing networks and community strengths, rather than starting from scratch.

Cultural competency training is another practice that has become part of the mental health professional's toolbox. Organizations such as the Centre for Addiction and Mental Health and the Hospital for Sick Children are ensuring that their staff are trained in its philosophy and practice. The need to do so is great and urgent: according to a study by Across Boundaries, a Toronto-based ethnoracial mental health centre, an estimated 32,000 people from racialized groups in the Central LHIN will have concurrent disorders (co-occurring addiction and mental health problems) while 23,000 of those will not have English or French as their mother tongue.

A good example of what can be done to address diverse groups is to look at the experience of one of the more deprived areas of East London in the UK. There a scheme that provided additional resources to family practices (the equivalent of our Family Health Teams) has proven to be effective at reaching and engaging segments of the population with more complex health and social care needs. Using a biopsychosocial approach that acknowledges the influences of biology, personal psychology and social influences (e.g., housing, income), practitioners provide comprehensive screening of patients, do on-site counselling, and refer people to organizations that can help them with any employment, housing or family issues they might be facing. Their approach to care is itself health-promoting: communication is provided sensitively and practitioners approach all patients non-judgmentally. Professional development training in cultural competency is encouraged; referrals, when they are made, are supported by practical assistance, such as writing or calling organizations on behalf of patients.

Integrating mental health into primary care has numerous benefits, including being cost-effective. But, equally if not more importantly, it widens access to whole populations — leaving no one out — and reduces the stigma often associated with mental health services.

Putting equity at the heart of mental health care is not necessarily an easy undertaking: it requires a shift in our usual approach to care, which has operated on a one-size-fits-all model rooted in a largely Western cultural perspective. We're used to the professional adopting the role of expert and the public being largely passive recipients of care. Progress is being made. There is widespread commitment to change. The demands of our pluralistic society require nothing less.

*Nimira Lalani is a research associate at the Wellesley Institute in Toronto.*

## *fast* FACTS

**1,089,140**

*Total population of Toronto Central Local Health Integration Network (TC LHIN)*

**41%**

*Percentage of TC LHIN population who are immigrants (compared with 28% of Ontario population)*

**5%**

*Percentage of TC LHIN population with no knowledge of English or French*

**24%**

*Percentage of TC LHIN population with low-income status*

**19%**

*Percentage of lone-parent families in TC LHIN*

### Top 5 communities of colour in TC LHIN

*Chinese (8%), South Asian (7%), Black (6%), Filipino (3%), Latin American (2%)*

### Top 5 home languages in TC LHIN

*English (75%), Chinese (5%), Portuguese (3%), Spanish (2%), Italian (1%)*

### Top 5 areas of birth for recent immigrants (2001–2006)

*Southern Asia (23%), Eastern Asia (17%), Eastern Europe (12%), Southeast Asia (10%), West and Central Asia and the Middle East (8%)*

*Source: Toronto Central LHIN, "Diversity at a Glance," June 2008*

BANKING ACCESSIBILITY PROJECT EVALUATION TEAM (LEFT TO RIGHT): MARY HILL, LINDSAY SNOW, DANIEL KOLADICH, ELIZABETH WHITMORE (LEAD EVALUATOR), HADAS ELKAYAM. MISSING: TOM TRUSSLER.

# A BANK OF ONE'S OWN
# CMHA Ottawa's No-Fee Banking Project

**WAITING IN A LONG LINEUP** at the bank while the tellers help other customers may be tedious. But for someone who has never had a bank account before, standing in line also represents taking control — not only of their own finances, but also of their own life.

The Banking Accessibility Project (BAP) is creating change by improving access to banking services for people with serious mental illness. Some people with mental illness may not have sufficient ID to open a regular bank account, and many rely on cheque-cashing services, whose expensive fees are a drain on their limited financial resources. Begun in 2007, the Ottawa-based project helps people with serious mental illness who receive Ontario Disability Support Program (ODSP) benefits to open a no-fee bank account and gain more control of their money.

With the assistance of several community partners, the Canadian Mental Health Association (CMHA), Ottawa Branch, worked with TD Canada Trust to establish a no-fee banking program for ODSP recipients. CMHA employees do everything from helping clients fill out bank forms and providing an identity check, to working with the ODSP office to have their cheques automatically deposited. BAP started as a pilot program with one branch and 29 participants. Following a participatory evaluation that demonstrated how successful the program has been, BAP is now expanding to 10 branch locations in Ottawa and recruiting 200 new participants.

The financial outcomes are measurable and, to some extent, predictable. ODSP recipients find that their money stretches further. According to one participant, "I have more control because I know I am not being charged fees. In the past, I didn't realize how much I was being charged." Participants reported being able to buy more groceries, better manage paying their bills, and even start building a small emergency fund.

BAP also resulted in personal outcomes that can't be measured in dollars and cents. Having a bank account has allowed participants to take charge of their lives, and to be treated with respect. "This bank has not been demoralizing or degrading or snooty," a participant noted. Doing their own banking has given participants a sense of belonging in their community. In the words of one support worker, people on social assistance who have serious mental illness "have fallen further and further out of the mainstream. And now they are getting their life together…. They have that ATM card."

In the project evaluation, participants reported having more self-confidence and a feeling of importance that comes with doing what most of us take for granted. What makes this project so successful is that such positive outcomes could occur even though the participants' income level was well below the poverty line. As the project evaluation reminds us, there is a continuing need to advocate for increased ODSP rates. If people can master a budget on income that falls below any prescribed standard of living, imagine the possibilities when their income rises.

*Pam Lahey is a policy analyst at the Canadian Mental Health Association, Ontario.*

*WORKING WITH THE*

# Whole Picture

TITLE: *Tracks* PHOTOGRAPHER: *Harry*

Like this set of tracks fallen into disuse, so can our competitive job market switch off people with disabilities. As time passes, skills get rusty, making hunting for a job more difficult.

CMHA Ottawa's Photovoice project intends to open a dialogue with the community, policy makers and employers about work opportunities for people with lived experience of serious mental illness. Over the summer of 2008, ten newcomers to digital photography, each with their own personal experience of mental illness, learned to use Nikon Cool Pix L14 cameras and set out to capture images that reflected their thoughts about work. Through photography and personal stories, Photovoice allows people to define for themselves what is important and what needs to change.

*See the complete exhibit online at*
www.cmhaottawa.ca/photovoice

TITLE: *Connection Needed* PHOTOGRAPHER: *Candyrose Freeman*

Connection is paramount to mental health. Persons with mental illness quite often are left without social, family, or community ties. Shame, isolation and loneliness kill, physically, emotionally and spiritually. More resources for support services will guarantee a healthy community!

TITLE: *Cane and Door* PHOTOGRAPHER: *Andrée C.*

My cane symbolizes my physical limitations to work. My door symbolizes my psychological disabilities (agoraphobia). Every time I get out, it is a victory. These barriers make finding and maintaining a job nearly impossible. Unpaid work is an avenue to opportunity, to contribute, even if I have a disability. It doesn't carry the same set of rigid on-going responsibilities as paid work.

TITLE: *Bricks* PHOTOGRAPHER: *Harry*

This photo symbolizes what happens to me in a job interview. It reminds me that my disability is not invisible, not when searching for work, at least. Under the scrutiny of a job interview, a few broken bricks inevitably appear and an opportunity is lost.

After going through the application process and finally getting to meet the employer, feelings of nervousness and apprehension make me stand out as much as the broken bricks do. Job interviews are barriers to employment that I can't get past.

TITLE: *Riding It Through* PHOTOGRAPHER: *Taz*

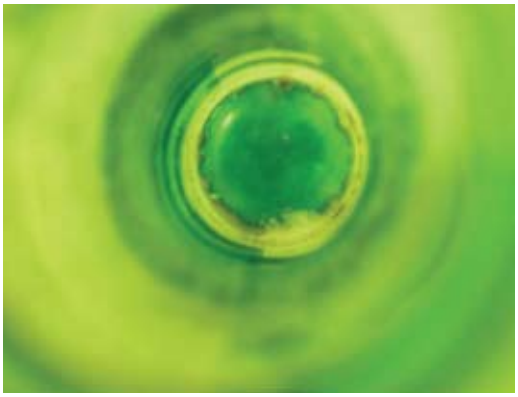
I see a man riding his bike casually and carefree. This picture represents what I want. I want to go and come to work carefree, on my terms, on my own power. The car behind the man represents the risk associated with employment. Grasping the handle bars like no tomorrow can be translated into "I don't like the job, but I will stick right through with it to the end, or stick with a dangerous job even if I don't think it is right for me." The basket represents the luggage we carry to employment, whether it be good or bad, we carry it with us.


TITLE: *Food for Health*
PHOTOGRAPHER: *Daniel Mayville*

This picture represents me, working. Part of my work is to prepare healthy snacks for CD group members. I had to learn to eat healthfully and now I prepare food for others.

My job responsibilities still cause me anxiety. I have to make sure I accomplish my tasks because there are people who depend on me.

I'm proud at the end of my shift. I'm proud of my work accomplishments and I like to make others smile.



TITLE: *Top View of a Bottle* PHOTOGRAPHER: *Toni*

This picture was taken looking down the neck of a bottle. This signifies the stigma I have run into — that people with a mental illness are not very educated and are not very intellectual. If you know I have a mental illness and talk down to me or underestimate my intelligence, you will miss the real me. I once had someone be quite surprised that I had a mental illness because she said I spoke so well.

# building an inclusive agenda

BY SANDI KENDAL

People with mental illness are one of the most excluded groups in British society. Having faced high rates of unemployment, low expectations of their capabilities from health and social service providers, as well as misplaced and incorrect public fears of dangerousness, people with mental health issues in the UK often live in poverty or debt, and are at risk of losing their home as well as social contacts and relationships with family or friends.

Work to address the social exclusion of people with mental illness has been underway since 2003. Social exclusion occurs when people are directly or indirectly prevented from participating in various aspects of life, from work to family support to leisure activities and community involvement. Since 2003, the government and non-governmental sectors in the UK have been developing and implementing policy and program changes to increase opportunities for people with mental illness to participate as active citizens.

In 2003, the prime minister directed a governmental body

called the Social Exclusion Unit (SEU) to develop an action plan to address the exclusion of people with mental health issues from meaningful employment or participation in community life. Drawing on information collected from hundreds of individuals with mental health problems, their caregivers, family members and service providers, the SEU released a final report in 2004 that identified 27 sets of actions requiring attention from all levels of government and from health and social care providers to enable people with mental illness to have the same opportunities to work and participate in their communities as anyone else in England.

The government introduced the National Social Inclusion Programme (NSIP) to coordinate the implementation of these actions. NSIP was created within the National Institute for Mental Health in England, an arms-length organization affiliated with the UK Department of Health. Created in 2004, NSIP was a time-limited initiative. It published its final report on social inclusion initiatives in 2009.

*Network* magazine spoke with David Morris, program director of NSIP, about the creation and implementation of the social inclusion agenda in the UK.

"People have multiple identities, so the only way you can advance their inclusion is through working with whole systems. You can't work to change only one part of the system and expect that multiple identities will change," explains Morris. Social inclusion is about creating equal opportunities to participate broadly in all aspects of life — areas from which people with mental illness have been traditionally excluded.

Given the importance of people's multiple identities as employees, family members, volunteers, students, friends and residents, NSIP faced a key challenge: ensuring that efforts to address social exclusion took into perspective the individual's whole life. Morris explains: "Our first challenge as a program was to repudiate the idea that social exclusion was anything other than multifactorial. Social exclusion works across domains. People are excluded in many different ways."

This broad approach may seem self-evident, but it was important to secure an appropriate balance in focus between the impact of exclusion on employment and the impact on participation in social, educational, recreational and cultural activity. While meaningful employment has undoubted positive impact on many other domains of a person's life, getting someone back to work is not the only way for that individual to be engaged as a member of the community.

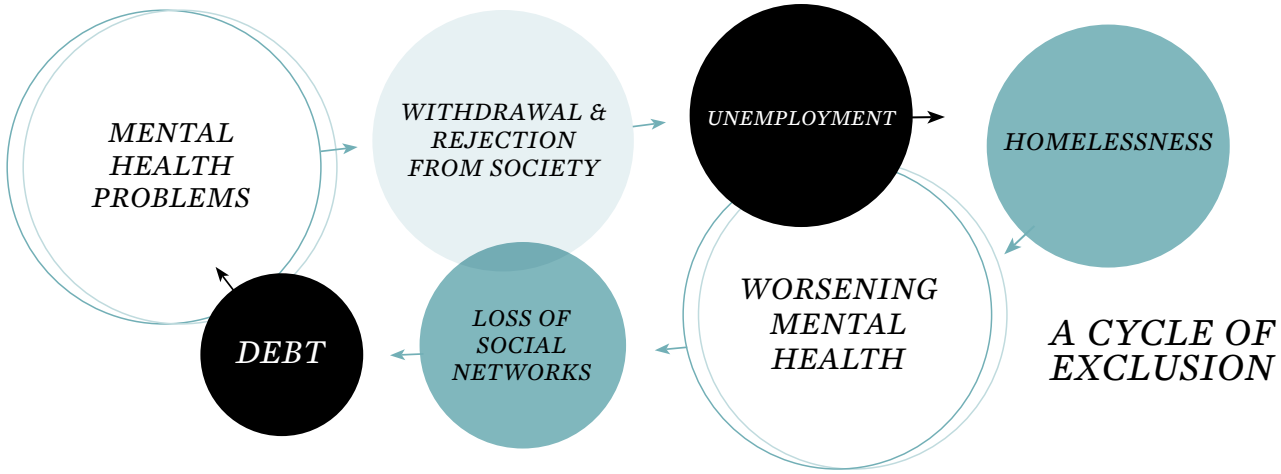
To counter what Morris refers to as the "reductionism" of some thinking on social inclusion, NSIP launched a policy implementation agenda that was purposely broad-based. "What we did with NSIP was to say, 'This is a multifactorial agenda, a multilayered agenda.' We needed to engage many different sectors, and create different types of activities in different sectors, all at once, to bring about change to ways in which social exclusion impacts." NSIP worked at the same time with professional networks, consumers (known in the UK as "service users"), employers, educational institutions, welfare benefits, and national, regional and local levels of government, and also coordinated activities that addressed broadening social networks. "We came at [this] enthusiastically with sheer breadth."

> "People have multiple identities, so the only way you can advance their inclusion is through working with whole systems. You can't work to change only one part of the system and expect that multiple identities will change."
>
> *David Morris, National Social Inclusion Programme, UK*

The result has been the implementation of a program using anything but a linear approach. "I tried to put in place a program that would try to do all sorts of different things, at different levels, in complex terms, and all at the same time." Rather than a single solution, NSIP sought to embrace multiple components and bring together different, sometimes improbable bedfellows into a common direction for change. NSIP framed this within seven key areas across an individual's life: community engagement, employment, education, housing, arts and culture, leadership and the workforce, and building social inclusion into service delivery.

Building a truly inclusive agenda has also required a more inclusive understanding of evidence. Morris explained that research evidence exploring the extent and impact of exclusion in the workplace was rapidly emerging, but that similar evidence bodies for other areas of social exclusion were not as developed. Morris advocated for a more inclusive approach to accepting evidence of social inclusion and exclusion. "We need to accept that evidence, and the origins of evidence, is a very pluralistic process... mental health [services are] characterized by the extent to which we engage service users, perhaps to a greater extent than any other area of work. [NSIP] had a 15-person-strong network of service users. That group continues to give a focus to service user narratives. There are [those who say] that's not real evidence, but evidence is to be found in many places, in many quarters. And if you look at what impacts on policy, it can often be the experience of a single person, or small community of people locally, adequately represented in government."

As such, NSIP has worked continuously to bring service users' perspectives to decision makers. "We were in a privileged position, able to connect individual service users, and their family or carers or friends, with the policy process. We could make sure to facilitate that [connection]." The result was that several key changes were made to the social inclusion agenda that were beneficial to people with mental health problems. For example, NSIP repeatedly heard from consumers that one of the principal barriers to social inclusion they experienced were the low expectations expressed by mental health




*Source: Office of the Deputy Prime Minister (UK),* Mental Health and Social Exclusion: Social Exclusion Unit Report *(June 2004)*

professionals. The same issue has been raised by consumers in Canada. NSIP and the UK government listened — service providers' low expectations were identified by both the SEU and NSIP as a key reason for the social exclusion experienced by people with mental health problems.

The SEU also identified stigma and discrimination as key contributors to the social exclusion of people with mental illness. Stigma and fears of discrimination have kept many people in the UK from disclosing their condition even to close family or friends, and discrimination has prevented a majority of employers in the past from actively recruiting someone with a mental health concern. The SEU recommended combatting stigma and discrimination through a strengthened and sustained program that would raise awareness of individuals' rights, target key audiences including employers, youth and the media, and address low expectations and stigmatizing attitudes held by people working in the public sector.

"Social exclusion is something faced by many groups," says Morris. "However, social exclusion affects people with mental health problems quite differently. The forms of stigma and discrimination that people with mental health difficulties experience have their own characteristics, based on notions of fear and risk. For me, the question of social exclusion is intimately linked in the case of people with mental health problems to stigma and discrimination. Successful policy on challenging social exclusion should also have positive outcomes on stigma and discrimination. If not, there is little purpose to implementing it."

It has now been a year since NSIP released its final report and ended. But the work of the program and its director has not stopped. Morris and a number of his NSIP colleagues have been busy establishing the Inclusion Institute at the University of Central Lancashire. The institute hopes to continue the work of NSIP in two areas. First, it aims to further develop the evidence base for social inclusion. Second, it hopes to support organizations seeking to create socially inclusive practices and approaches.

The government has set a number of cross-sector targets through Public Service Agreements for all public service providers to meet and there is a target for social inclusion on increasing the numbers of people with mental health issues or developmental learning disabilities in employment and supportive housing (known in the UK as "settled accommodation"). Setting targets will help to monitor the implementation of some programs and measure progress around such actions as hiring or training people with mental health issues. However, monitoring social inclusion initiatives (that is, taking a performance approach) is only one component of supporting organizations to become more socially inclusive.

"It's quite important to have a performance approach," explains Morris. "But it's also important to create a learning environment in which we can develop people's ideas and commitments, to empower innovative people at all levels of organizations — both 'lay' and professional — as leaders of this agenda and to change professional and organizational cultures. Social inclusion work is about a lot more than telling someone to check a box." This is particularly true when it comes to implementing the more relational aspects of social inclusion. After all, there are few metrics to measure the extent to which a previously socially excluded individual has developed a meaningful social network.

If Ontario is to take any one message from the experiences in the UK, it is to embrace the complexity of developing a social inclusion agenda. Creating a strategic framework, as the UK did with NSIP, can provide the necessary structure to implement policy at the local level. Just as individuals have more than one identity, a social inclusion agenda should have more than one focus and take from more than one evidence base to be truly inclusive.

If Ontario is to take any one message from the experiences in the UK, it is to embrace the complexity of developing a social inclusion agenda.

*Sandi Kendal is a London-based writer specializing in mental health policy.*

BY CAROLINA BERINSTEIN

# Equity & Diversity

## Key Priorities for CMHA Toronto

**FROM ITS STRATEGIC DIRECTIONS** to its daily operations, the Canadian Mental Health Association, Toronto Branch is taking on issues of equity and diversity. While the organization has always addressed these issues, a three-year strategy, launched in 2009, has established equity and diversity as priorities for the organization.

In response to the changing demographics in Toronto, "the organization felt it was important to develop an organizational strategy to guide our work," says Executive Director Steve Lurie.

A consultant was hired in 2008, in part to make recommendations on how to implement diversity and equity within CMHA Toronto. Her recommendations included hiring a full-time manager devoted to access and equity, a role I assumed in January 2009. An equity and diversity committee was also formed, made up of front-line and management staff, board members, consumer/survivors and family members, many of whom had never been involved in organizational development. The committee's central task was to develop the three-year strategy.

Initially, the group worked together to build trust and learn about the key ingredients for successful organizational change. Top priorities included capacity-building among committee members and reaching a common understanding of the various frameworks for approaching diversity work.

"I became involved in the Equity and Diversity Committee…, knowing that

DETAIL FROM THE COLLABORATIVE MURAL
*REFLECTIONS OF DIVERSITY — WITHOUT LABELS*

it will make a difference in the long run," says Kelly Stuart, a consumer/survivor who has actively volunteered her time on the committee since its inception. "Being part of the committee has helped my self-esteem in a great way."

The first significant milestone for the committee was to come up with a vision: "CMHA Toronto will provide accessible mental health services to diverse individuals and communities that are effective, meaningful and appropriate. We are committed to equity, shared knowledge, advocacy and accountability at individual, organizational and systemic levels."

This vision guided the development of the rest of the strategy. The group learned how to develop a logic model and brainstormed possible goals, objectives and outcomes. They then began to talk about activities, timelines and how to get the work done. "Initial goals and outcomes were identified and came from the committee as a whole. This encourages continued involvement by committee members," says Janet Priston, manager of cross-cultural initiatives and case management services. The strategy is not just about goals and outcomes; rather, it's a process. "We are on a journey that will take time," Priston explains.

This past November, the organization launched the strategy with a celebration that included musical performances, an art exhibit and keynote address by Dr. Kwame McKenzie, a senior scientist in Social Equity and Health Research at the Centre for Addiction and Mental Health (CAMH) and deputy director of Continuing and Community Care in CAMH's Schizophrenia Program. McKenzie described the strategy as a "stretch vision": "It's obtainable but you are going to have to stretch yourself to achieve it … it's not focused on what's wrong, but on what's going to happen in order to make things better."

Perhaps this positive focus explains why there has been little resistance to such a significant undertaking. Lurie describes the launch as a significant landmark: "The launch represents moving to another stage. How can we do all this better? How can we partner? How can we build on the partnerships we've had for many, many years? And how can we be reflective of our community and be a place where people walk in and say, 'Here I'm treated with understanding, respect and kindness'?"

CMHA Toronto's strategy is comprised of six goals that represent the key components of social service organizations: direct services, human resources, governance and leadership, partnerships and relationships with external stakeholders, systemic advocacy and organizational culture.

Its direct services goal is to ensure that services are accessible to people from diverse communities who need them. This includes supporting each department to develop and implement its own diversity work plan; developing a process for understanding who the organization is currently serving, and how this compares to the needs of diverse communities; and increasing CMHA Toronto's capacity for working with individuals and families who are not proficient in English.

In human resources, CMHA Toronto aims to identify systemic barriers in recruitment, hiring, promotion and retention practices. It is also working to ensure that all staff are skilled in working with diverse populations.

As well, CMHA Toronto is working closely with the board of directors to develop a process for including diverse communities in decision-making in the organization by identifying leading practices, assessing their training needs and providing opportunities to meet those needs.

The organization will also be looking at opportunities to boost partnerships to help meet the needs of diverse communities, as well as create and implement a plan to improve health equity through systemic advocacy.

Finally, CMHA Toronto will foster an organizational culture that embraces and promotes diversity by increasing visuals and messages in different languages that reflect its vision and multiple diversities. Steps include holding special awareness-raising events, such as Black History and LGBTQ (lesbian, gay, bisexual, transgender, queer) Pride, and establishing diversity awards to recognize achievements of CMHA Toronto community members.

Another important component of the strategy has been to promote a culture of continuous learning for staff, board members and service users in their daily lives. A series of collaborative art projects has been one way to raise awareness of the issues. In the first art project, consumer/survivors explored the meaning of diversity and inclusion in their lives by creating a collaborative mural entitled *Reflections of Diversity – Without Labels*. A community artist, Julie Jarvis, was hired to work with consumer/survivors at three different drop-ins. Calling it a "creative spark," Jarvis encouraged people to participate as they wished, providing no one commented

> "How can we be reflective of our community and be a place where people walk in and say, 'Here I'm treated with understanding, respect and kindness'?"
>
> *Steve Lurie, CMHA Toronto*

on anyone else's work. In response to the question, "What would a world look like where you felt included?" clients took paintbrushes, glitter and markers in hand, filling the canvas with vibrant colours until there was no white space left. They then added their own black silhouettes against the bold background, creating a striking effect.

The second project, entitled "The Power of Words," explored the power of language and how it affects our relationships, communication and understanding. Each staff member was asked to make his or her own name tag (using shiny paper and other materials), and then clients used these labels as part of invitations they made to staff to join the art project. It was a way of flipping the power dynamics, with clients inviting staff, rather than the other way around. Participants then carried on a conversation through the art. One would paint a brushstroke, then another would add her own brushstroke in response.

Training has been a big component of the project. To date, 120 staff have participated in a day-long core training session introducing them to equity and consumer participation issues. This compulsory training engages participants to think about their social location, privilege, and individual and systemic discrimination. They also learn what mental health recovery is and how it can be put into practice. Workshops are being offered in addition to the day-long training on topics such as LGBTQ issues, human rights, Aboriginal issues, dis/ability issues, newcomers and spirituality. Ten people with lived experience of migration and mental health issues will also be trained to deliver workshops at places frequented by newcomers and consumer/survivors in Ontario (see sidebar).

As the journey continues, we will continue to evaluate our progress, celebrate our successes, and learn from our challenges.

*Carolina Berinstein is the access and equity manager at CMHA Toronto Branch.*

## OPENING DOORS
## Strengthening Participation for Immigrants and Refugees with Mental Health Issues

*CMHA Toronto has developed the following series of workshops to be delivered by people with lived experience of migration and mental health issues at places frequented by newcomers and consumer/survivors in Ontario.*

**Building Bridges: Anti-Racism 101**
Ideal for people who are familiar with the idea of multiculturalism and diversity but have not been introduced to anti-racism. This two-hour interactive workshop uses Forum Theatre to explore and understand issues of racism, diversity and anti-racism.

**Working Across Differences: Anti-Mentalism Meets Anti-Racism**
This two-hour workshop is for people who are ready to look more deeply at racism and its relationship to other forms of discrimination, including the stigma associated with mental health diagnoses.

**Journeys to Canada: Stories of Migration**
This two-hour workshop explores experiences of migrating to a new country, including stress, mental health issues, culture shock, racism and resiliency.

**Mental Health and Mental Wellness 101**
Ideal for people unfamiliar with the Canadian mental health system, the workshop promotes a broad understanding of mental health that incorporates the social determinants of health. The workshop is designed to establish connections between individual understandings of and experiences with mental health and the mental health system in Canada.

**Our Journeys Through Mental Health: A Story-Based Approach**
Using a narrative approach, this two-hour workshop explores a wide range of experiences in the Canadian mental health system. We recommend that this workshop be offered in conjunction with Mental Health and Wellness 101.

*For more information or to register for these free workshops, contact CMHA Toronto at 416-631-9896 ext. 239 or openingdoors@cmha-toronto.net.*

research snapshot *by* Nandini Saxena

# Vulnerable Populations Need Greater Access to Mental Health Care

Where people live, their immigration status, cultural background, income and education are just some of the factors that impinge on people's access to timely, appropriate mental health care in Ontario. Resulting inequities clearly affect their health, well-being and life opportunities, as demonstrated in the three studies highlighted here.

These studies found significant inequities in how mental health care is accessed and experienced, particularly for people with low socioeconomic status (SES), including the homeless, immigrants and refugees.

"It's clear we're not reaching everybody who is affected by mental illness and health inequities. The need is still great," observes Brenda Toner, head of the Women's Mental Health Program at the University of Toronto and co-head of Social Equity and Health Research at the Centre for Addiction and Mental Health (CAMH). However, there is cause for some optimism. "Mental health equity research is finally on the map," says Toner, "and people are paying attention to it."

The research described here reflects just a piece of what is happening in mental health equity research at universities across Ontario. Toner observes that an increasing number of calls for proposals are focused on exploring mental health equity from a province-wide perspective. The next step is to ensure that research findings are shared with those who can make systemic change.

Findings from these three studies will help policy-makers, service providers and others understand the problems faced by different communities and create change that will allow everyone in need to access appropriate mental health care in a timely way.

While culture, immigration and socioeconomic status are significant factors that influence a person's access to appropriate mental health care, there are other factors equally as important, such as age, race, ethnicity, country of origin, physical, mental or language ability, gender and gender identity, sexual orientation, religion and spirituality, education and marital status, asserts Toner. "[If you] look at the social determinants of mental health — including violence, poverty, stigma, discrimination, racism, sexism, gender role socialization, ageism and various other environmental and social oppressions — and how they relate to all of the various factors I just mentioned, you've got an opportunity to look at so many intersections.

"We need to honour all of the different marginalized groups as well as look at intersections. We don't want to lose sight of specific groups."

At CAMH, Toner is a co-investigator on a study co-led by Dr. Kwame McKenzie and Dr. Samuel Noh. Funded by the Canadian Institutes of Health Research, this project is designed to train 50 fellows in the social determinants of mental health — a focus that has not traditionally been a significant part of health professionals' education.

"The whole idea is to equip the next generation of health professionals with the tools to identify and be sensitive to the social determinants that influence mental health and illness," explains Toner. "Wouldn't it be great if we all had access to mental health care that is sensitive to the social determinants of health?"

> "It's clear we're not reaching everybody who is affected by mental illness and health inequities. The need is still great."
>
> *Brenda Toner, Centre for Addiction and Mental Health*

## [snapshot]

### Socioeconomic status affects access to psychiatric care

"We want people who need care the most to get care faster," comments Dr. Leah Steele, whose nine-year cohort study looked at access to psychiatric care according to socioeconomic status (SES) by neighbourhood in Toronto. The study used census and health services data from 1995 to 2004, covering 1.4 million adults in Toronto who had not received mental health care from a physician in the previous three years. Level of education was used as a measure of SES.

Despite the full coverage that OHIP provides to people using psychiatric services, results show that people's SES influences whether or not they are given a referral and how quickly they are able to see a psychiatrist. For example, people living in the highest SES neighbourhoods were twice as likely to receive a referral from a family doctor for psychiatric care. At the same time, those most likely to try to access mental health care lived in the lowest SES neighbourhoods. Individuals who went to their family doctor for a mental health reason and who lived in higher SES neighbourhoods were also 30 percent more likely to receive a referral for psychiatric care. Women living in lower SES neighbourhoods had to wait three months longer for a referral than did women from higher SES neighbourhoods.

"The most striking finding from this study is that one-third of people see a psychiatrist without a referral," observes Steele. "This is not really supposed to happen. In a gatekeeper system, people are supposed to be referred by a family physician." Steele explains: "These are the people that know how to navigate the system." Bypassing the system meant that people living in the highest SES neighbourhoods had to wait for dramatically shorter time periods to see a psychiatrist than those in the lowest SES neighbourhoods who sought a referral from their family doctor. The difference was about 10 months.

"We have a system of universal health care and would hope that those treatments which are fully covered by the health care system… would be available to all. The opposite is true," remarks Steele. "Services are least accessible to those who need them the most." Steele emphasizes the need to have targeted programs and targeted incentives to improve access for socially disadvantaged groups.

*L. Steele, R. Glazier, M. Agha, and R. Moineddin (2009). "The Gatekeeper System and Disparities in Use of Psychiatric Care by Neighbourhood Education Level: Results of a Nine-Year Cohort Study in Toronto."* Healthcare Policy *4(4): e133-e150.*

## [snapshot]

### Homeless recent immigrants would benefit from access to employment

Homeless people born in Canada tend to become homeless because of mental health or addiction challenges. By contrast, recent immigrants (those who've arrived within the last 10 years) are more likely to become homeless due to unemployment, a lack of income or housing problems, according to a recent study. Researchers examined the relationship between immigrant status and health status in a representative sample of 1,189 homeless people in Toronto. Individual surveys were administered during in-person interviews.

Led by Dr. Stephen Hwang, a scientist with the Keenan Research Centre at the Li Ka Shing Knowledge Institute of St. Michael's Hospital, the study found that recent homeless immigrants living in Toronto have fewer substance use, mental health and physical health problems than others who live on the streets. The findings indicate that even homeless recent immigrants show what is known as the *healthy immigrant effect*, a phenomenon in which newer immigrants are generally healthier than people born in Canada, but whose health deteriorates over time.

"The study does suggest that recent immigrants who become homeless do so for economic reasons," comments Hwang. Rapid interventions might help them get back on their feet more quickly than it could for people with more mental and physical health problems, surmises Hwang. Job skills, training and employment are all interventions that could help recent immigrants re-establish themselves, but are not necessarily what would be most effective for homeless people born in Canada.

Mental health is still a concern for recent immigrants. The rates of mental health problems amongst homeless recent immigrants are generally higher than the rates found amongst Canadians not living on the streets, according to the study. This finding indicates the need for mental health services that are culturally appropriate.

Addressing these issues is "particularly important in a country like Canada," remarks Hwang, "where our economic well-being depends on attracting and promoting the success of immigrants."

> Providing culturally appropriate services is "particularly important in a country like Canada, where our economic well-being depends on attracting and promoting the success of immigrants."
>
> *Dr. Stephen Hwang, St. Michael's Hospital*

*S. Chui, D.A. Redelmeier, G. Tolomiczenko, A. Kiss, and S.W. Hwang (2009). "The Health of Homeless Immigrants."* Journal of Epidemiology and Community Health *63: 943-948.*

## [snapshot]

### Immigration status and cultural background affect mental health service needs

Unemployment, poverty, a lack of recognition of foreign credentials and the challenges of settling in a foreign country negatively affect the mental health of recently arrived government-assisted refugees (GARs), according to a recent exploratory study by researchers at Access Alliance. The study focused on the Sudanese, Karen and Afghan communities in Toronto.

GARs also experienced other mental health stressors, including such traumatic events as conflict, torture, forced migration, forced separation from family and delays in family reunification. They also have limited say in where they move to in Canada and little choice in accepting the government transportation loan that must be repaid within three years of arriving in Canada. One study respondent talked about how GARs feel when faced with signing the many legal documents necessary to come to Canada: "You are so desperate… you just sign any document [including the loan document] just to come to Canada."

This qualitative exploratory study used focus groups and interviews to gather data and was grounded in the principles and practice of community-based research. The study looked at the following questions:

1. How do different GAR communities understand and address mental health?
2. What are the key mental health issues faced by GARs?
3. What is the path of mental health of GARs over the period of settlement?
4. How does the immigration process affect their mental health?

Study findings showed that GARs keenly understand the negative effects that these experiences have on their own and others' mental health. However, results show that existing mental health services in Canada do not effectively address the particular mental health needs of these Sudanese, Afghan and Karen communities. Ruth Wilson, research coordinator for the project, comments, "Mental health is defined and therefore practiced using Western models of care, which leaves a lot of newcomers in the margins of that care." Vulnerable populations need greater access to mental health services, says Wilson.

The study also identified a number of positive factors that these groups possess, such as the support of communities and families, and feelings of resiliency and optimism in the face of tremendous barriers.

> "Mental health is defined and therefore practiced using Western models of care, which leaves a lot of newcomers in the margins of that care."
>
> *Ruth Wilson, Access Alliance*

*Sharmila Shewprasad, Ruth Marie Wilson, Dr. Yogendra Shakya and Dr. Carles Muntaner. Determinants and Risks for Mental Health of Newly Arrived Government Assisted Refugees in Toronto. Research Coordinator, Ruth Wilson, Access Alliance — Multicultural Health and Community Services.*

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KASHFI ASGAR CAME FROM BANGLADESH IN 1993. ART WAS HER FAVOURITE CLASS IN HIGH SCHOOL. SHE NOW LIKES TO EXPLORE PATTERN AND COLOUR IN HER PAINTINGS. PAINTING AND WORKING WITH CLAY AT THE CREATIVE WORKS STUDIO HAS BOOSTED HER SELF-ESTEEM AND BROUGHT HER A SENSE OF REAL PEACE. ASKED TO DESCRIBE HER PAINTING, KASHFI SAYS: "THIS IS A PORTRAIT OF A WOMAN MAKING A SPACE FOR HERSELF."

the gold standard *by* Michelle Gold

# Now Is the Time for Action on Health Equity

**EQUITY IMPLIES SOCIAL JUSTICE AND FAIRNESS.** Equity in health is defined as the absence of systematic disparities in health among diverse populations who have different levels of social advantage or disadvantage due to different positions in the social hierarchy.[1] Health equity strategies create opportunities and remove barriers to achieving health. They involve the equitable distribution of resources needed for health as well as equitable access to services and supports for people who are experiencing poor health. Thus, equity strategies are intended to "level up" the health of disadvantaged populations.[2]

A focus on equity in health tackles the elimination of systemic differences in health status between diverse populations; while the focus of equity in health care is to closely match services to level of need and reduce barriers to access. A focus on equitable and appropriate access to health care, while essential, will not be adequate to address the fact that the broader conditions in which people live are equally, if not more of, a predictor of health status than health care. Based on an accumulating evidence which has only been strengthened over time, the World Health Organization (WHO) has affirmed that "by far the greatest share of health problems [are] attributable to broad social conditions."[3] The social determinants of health are shaped by the distribution of money, power and resources. Lack of equitable access to the social determinants of health is associated with health inequities — the unfair and avoidable differences in health status.

Reducing health disparities is addressed through social and economic policy, policy collaboration and coordination across governments, and cross-sectoral partnerships. Whole-of-government approaches are essential — we must work across ministries and portfolio boundaries to achieve a shared goal. These approaches should engage government and non-governmental organizations to collectively address challenging public issues in an integrated and coordinated manner. Whole-of-government approaches have been used in many Commonwealth countries, including Canada, to support government reform processes and bring together diverse stakeholders.

An international review of whole-of-government initiatives identifies several lessons learned. To be successful, these initiatives need to receive the same status as distinct policy, departmental or sector initiatives, to generate adequate recognition and incentives for taking action. These initiatives should also involve individuals and institutions beyond government — in municipalities, non-governmental organizations, as well as grassroots community advocates. Whole-of-government approaches need to be cooperative, rather than imposed from the top down.[4]

British Columbia's whole-of-government strategy, ActNow BC, was designed to make that province "the healthiest jurisdiction to ever host the [Olympic] Games." A recent WHO review of ActNow BC identified two success factors for this targeted change. First, such a strategy needs high-level leadership. In BC, the premier and his cabinet supported this strategic agenda and ensured it was actioned by senior bureaucrats in multiple ministries. Secondly, the government built momentum by initiating action without necessarily having optimal conditions in place for implementation. In BC, the government supported partnerships with external stakeholders who were first ready to take action, recognizing that the government could not accomplish all targeted directions on their own.[5]

## Ontario needs high-level provincial leadership to facilitate new ways of working in concert to resolve health inequities.

In Ontario, many local and provincial stakeholders have been flagging health disparities and advocating for health equity strategies for a number of years. Momentum is building and there is a desire by many stakeholders to work together. But we still need high-level provincial leadership to facilitate new ways of working in concert to resolve health inequities. The Ministry of Health and Long-Term Care has created a health equity unit that is developing new policy in this area, but results have not yet been broadly communicated. The ministry now has the opportunity to promote a whole-of-government approach that engages all Ontarians.

The soon-to-be-released 10-year mental health and addictions strategy for Ontario needs such coordinated action to be successful. This is because mental health and addiction issues are complex and multifactorial. In developing the strategy, the Minister of Health and Long-Term Care has consulted widely with stakeholders, including involving an inter-ministerial committee. A July 2009 interim discussion paper proposing key elements for the future strategy, entitled "Every Door is the Right Door," asserts that "Ontarians and their Government believe that the health system should be guided by a commitment to equity and respect for diversity in communities in service to the people of Ontario." [6]

With this in mind, the Canadian Mental Health Association, Ontario and the Wellesley Institute jointly responded to the ministry's invitation to receive advice from stakeholders on developing the strategy. We recommend that equity be incorporated as a core principle in the strategy and provide specific advice on how this can be done. The way to address equity is two-fold. First, identify disparities, attend to equity issues in all service delivery and planning, and reduce barriers to equitable access to services. Secondly, using available data in Ontario, begin to analyze where equity impact will be greatest. We recommend that a proportion of investments be targeted to at-risk populations to improve their health status.[7] We also recognize that additional data and indicators must be collected.

Our proposed equity "roadmap" for mental health and addictions recommends that a focus on equity in health care should be built into all planning, programs and services. This can be achieved by using equity-focused tools and by identifying relevant data and targets for Ontario. Applying an "equity lens" means asking the right questions as filters to guide planning and delivery of services. Incorporating mental health impact assessments and health equity impact assessment processes is equally important. The Wellesley Institute and the ministry, together with the Toronto Central LHIN, have piloted an impact assessment tool that analyzes the potential impact of programs on disadvantaged populations. Continuing work is underway to incorporate equity impact assessment in planning for LHIN-funded services.

Setting clear targets for equity outcomes is essential to drive equity strategies. All jurisdictions with comprehensive equity strategies set targets. Because health disparities are rooted in social determinants of health, we also recommend that Ontario lead with a whole-of-government approach to mental health and addictions that coordinates and fosters cross-government accountabilities. The Adelaide Recommendations on Healthy Public Policy call for a commitment to health in all policies. This approach "aims to address complex health challenges through an integrated policy response across portfolio boundaries." [8] The strategy can also be enhanced by community-based collaboration and place-based approaches.

The impact of achieving health equity can extend far beyond enhancing individual well-being. It would also contribute to fostering social cohesion, economic productivity and healthy communities in Ontario.

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