The Case for Diversity

Dr. Kwame McKenzie
Michael Antwi

Dr. Branka Agic
Andrew Tuck
Outline

• Introductions
• Aims of today
• Issues and options
• Findings from case for diversity
• Discussion – what would move implementation forwards for you
Issues and Options
Visible Minority % Change in Population from 2001 to 2011

Canada 57.3%
Canadian situation: Issues and Options

• IRER groups are more exposed to social factors that promote mental health problems and illnesses

• IRER groups have poorer access to care, poorer treatment and poorer outcomes

• Key barriers: few health equity plans or accountability, poor data, barriers to care and quality of care
Multi-level needs: mutli-level solutions

Issues and Options

• Culturally competent healthcare systems may have the potential to reduce disparities for IRER groups

• One way of achieving this is by population-based, flexible services that use the involvement of IRER communities to understand and meet their needs.

• By using local data and knowledge provinces, territories and regions tailor service development to their demographic imperatives.
RESULTS OF ISSUES AND OPTIONS?
NOT AS MUCH CHANGE AS EXPECTED
The Mental Health Strategy for Canada (2012)

STRATEGIC DIRECTION 4
Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.

Everyone in Canada should have the opportunity to achieve the best possible mental health and well-being. Currently, that opportunity does not come equally.

Simply put, people with—among other things—better incomes, more education, and stronger social networks tend to be healthier in Canada and around the world, the importance of addressing such disparities in order to improve health and social outcomes, including mental health outcomes, is increasingly recognized. Canadians Ministers of Health and Health Promotion have acknowledged that disparities in health exist and promised that “where they can be changed, we will work together with our partners in and outside governments to try to reduce or remove such differences.”

This Strategic Direction focuses on what can be done to better address mental health needs that arise for people who are at greater risk of developing mental health problems and illnesses, or who experience disparities in access to appropriate mental health programs and services because of socioeconomic status, ethnicity, or other factors, such as discrimination and reasons for emigrating into Canada. The next Strategic Direction focuses on First Nations, Inuit, and Metis mental health and the impact of intergenerational trauma.

Wherever we examine factors that are common among groups of people, we also have to bear in mind that everyone’s mental health and well-being is shaped by the many interacting dimensions of their lives. We are all multi-bodied individuals. For example, the mental health needs of everyone who is part of the Immigrant population are not identical. They can differ because of other factors like gender, age, income, and because of their reasons for having emigrated. Similarly, women’s needs and issues vary depending on age, background and income. Physical and other disabilities, stage of life and spiritual and religious beliefs are other important dimensions that can have an important influence on our mental health and well-being.
Canada mental health report card

• 55 indicators covering mental health in Canada
• Traffic light system
• 5 areas refer to immigrant communities
• In 4 out of 5 we are yellow... meaning some concern or no improvement
Depression in immigrants

Focus: Diversity
Strategic Direction: Disparities and Diversity

INDICATOR: ANXIETY AND/OR MOOD DISORDERS - IMMIGRANTS

6.8%

ANXIETY AND/OR MOOD DISORDER

IMMIGRANTS

GENERAL POPULATION

2003 2005 2007/08 2009/10 2011/12
Discrimination

Focus: Diversity
Strategic Direction: Disparities and Diversity
INDICATOR: DISCRIMINATION - GENERAL POPULATION

15.4%

DISCRIMINATION

Wellesley Institute
advancing urban health

CAMH
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale
Level of stress in immigrants

Focus: Diversity
Strategic Direction: Disparities and Diversity
INDICATOR: STRESS - IMMIGRANTS

22.0%
Good self rated mental health

Focus: Diversity
Strategic Direction: Disparities and Diversity
INDICATOR: SELF-RATED MENTAL HEALTH - IMMIGRANTS

71.2%

SELF-RATED MENTAL HEALTH:
VERY GOOD OR EXCELLENT

IMMIGRANTS
GENERAL POPULATION

2003 2005 2007/08 2009/10 2011/12

Wellesley Institute
advancing urban health

Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale
Case for Diversity

• CAMH. Wellesley, MHCC
• Build case for more appropriate services
• Literature reviews
• Economic analysis
• Promising practices
• Consultation
Rate of mental illness
Mental illness rates more complex

- Different for: immigrant, refugee, racialised, born in Canada, where you live, age group
- Different for different country of origin groups
- Examples:
  - Psychosis (Anderson et al 2015)
  - CMD (Hansson et al 2010)
  - Suicidal ideation (Hansson et al 2010)
  - Substance misuse (Agic et al)
Rates of psychosis for immigrants in Ontario (Anderson et al 2015)
More complex understanding of socio demographic problems
Canadian literature on risk and protective factors

• Issues and Options: 15 key social determinants – 3 specific to IRER: pre- and post-migration factors, perceived discrimination and language

• New issues:
  • Violence/Victimization
  • Parents’ mental health or addictions issues
  • Food security
  • Caregiver burden/Health of a family member
New information on pathways to care
Knowledge of and pathways into service

- IRER groups seek help less often than the general Canadian population
- Primary source for information or referral: family physician
- Emergency services is the common pathway into care for IRER experiencing severe mental health problems
- Barriers to care: language, fear, shame, service accessibility, patient-provider interaction, circumstantial challenges (cost, transportation, competing priorities)
Immigrant Service Use Costs

• Immigrants and refugees use less mental health services in Ontario than non-immigrants and hence have lower system costs
  • Immigrants and refugees significantly less likely to incur any mental health costs than non-immigrants
    • Immigrants $99.3 million (average adj. cost $56.48 per person)
    • Refugees $33.2 million (average adj. cost $104.99)
    • Non-immigrants $1.55 billion (average adj. cost $128.71)
MH services costs 2008 Ontario per person means

- non-immigrant
- middle east
- east asia
- south asia
- Sub-Saharan

[Bar chart showing cost comparisons between different regions]
What we know for sure about interventions
Review of reviews

- Best, Promising or Emerging Practices for supporting, treating and/or developing programs for IRER populations with mental health or addictions problems.
- years 2000 - end 2014
- Canada, Australia, New Zealand, UK and USA.
- Scopus, Medline and PsycINFO
- 2,631 articles for which the abstracts were scanned
- 107 of those articles were read full text
Levels of evidence

- Systematic Reviews
- Randomized Control Trials
- Cohort Studies
- Case-Control Studies
- Case Series, Case Reports
- Editorials, Expert Opinions
RoR results:
Case for Diversity
Cultural competence

• Cultural competence 3 levels needed
• Organizational culturally competent interventions
  • Better diversity of services and service links
• Structural culturally competent interventions
  • New therapies or pathways to care
• Clinical culturally competent interventions
  • Training
Case for Diversity
Adapted care pathways

- Specific stepped care or integrated care pathways adapted for an ethnic group improve outcomes.
Case for Diversity
Culturally adapted therapy: general

- Culturally adapted psychotherapies improve outcomes.
- 8 systematic reviews and meta-analyses have concluded that cultural adaptation of psychotherapy improves outcomes.
- 408 studies with 41,920 patients
When should therapies be adapted?

- Determine if existing research is applicable to specific group;
- Evidence of ineffective clinical engagement with group exists;
- There are unique risk or resilience factors in a target group;
- Unique symbols of disorder;
- Evidence of limited effectiveness with group; or
- Evidence suggests generic intervention is harmful.
Culturally adapted therapy: detail

- Groups with same race participants were 4 times more effective.
- Matched therapists evaluated better, but little difference in treatment outcomes.
- Adaptation for a specific cultural group are more likely to be effective than generic.
- Modification to take account of illness models most effective.
- Impact of adaptation on outcomes greater in adults than youth.
- Impacts of adaptation strongest in:
  - Asian Americans:
  - African Americans:
  - Hispanic/Latino(a) Americans.
Case for Diversity
Children and youth

• Culturally adapted treatments for ethnic minority youth may be effective.
• Evidence for some efficacy for many adaptations, mostly in the USA
Case for Diversity
Substance misuse

- Cultural adaptation improves outcomes of substance misuse treatment.
Case for Diversity
Refugee mental health

• Good evidence that specific interventions improve the mental health of refugees.
• Good evidence for:
  • Narrative exposure therapy (NET),
  • CBT separately and in combination with medication,
  • eye movement desensitization and exposure therapy.
  • Equivocal on medication by itself
Case for Diversity Technology

- E-health may be a useful way of offering quality care to rural or remote diverse
- 2 reviews of telepsychiatry and e-health
- Participants were consistently satisfied with telecounselling.
- Programs effective with moderate to large improvements across measures of depression and anxiety in the short term. Longer term effects are uncertain.
Case for Diversity: Promising practices

- 21 user-submitted practices of interest
- 14 team identified practices of interest
- Practices across 4 provinces and 16 cities
Case for Diversity: Conclusions

• Canada diverse and becoming more diverse
• No jurisdiction has specific strategy for improving
• We have specific evidence on rates of illness, causes, sub-populations effected
• We have solutions in SDoH as well as on how to structure services and how to adapt interventions
• One size does not fit all so we need local knowledge
• But we know what to do now we need to get people motivated to do it
Case for Diversity

Mental Health Commission of Canada (MHCC)

Dr. Kwame McKenzie,
Dr. Branka Agic,
Andrew Tuck
Michael Antwi

Thank you
Questions

• What struck you about the information
• What stops service improvement moving forwards in your area?
• Is there anywhere where more information is needed?
• What is the most compelling case for change you have heard?
• What is the most useful information you have heard?
• What information will you use to move forwards?
Thank you