CAMH Monitor 2013 – Part 2: Using the Data to Inform Program Planning and Policy

October 8, 2015  11:00 AM – 12:30 PM EDT
Your Co-hosts

- Provides system support, capacity building, content expertise and access to information and research for Ontario health promotion and public health audiences related to:
  - Mental health promotion
  - Substance misuse

- Consults with CAMH colleagues from across the organization (clinical, research, etc.)

- Funding provided by the Ministry of Health and Long-term Care, Health Promotion Division

- Aims to make Ontario’s mental health and addictions system more evidence-informed. Promotes the use of evidence in decision-making, develops targeted knowledge translation products and tools, and supports interactive exchanges.

- Funding provided by Health Canada’s Drug Treatment Funding Program and CAMH.
• Supports Ontario’s 10-year Comprehensive Mental Health and Addictions Strategy
• Offices across Ontario
• Capacity and expertise in knowledge exchange, implementation, equity & engagement, information management, & evaluation
• Houses EENet & CAMH HPRC
Your Co-hosts and Presenters

Dr. Jason Guriel
Supervisor, EENet
Provincial System Support Program
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Equity and Engagement Coordinator
Provincial System Support Program
CAMH
CAMH Monitor 2-Part Webinar Series

Part 1: Trends in Mental Health and Substance Use Among Ontario Adults

Part 2: Using the Data to Inform Program Planning and Policy
1. Recap of CAMH Monitor Part 1 webinar (Dr. Jason Guriel)

2. What in the 2013 CAMH Monitor speaks to equity? (Alexandra Lamoureux)

3. Alcohol Policy and the CAMH Monitor (Jason LeMar)

4. Alcohol Use and Risk Drinking Among Ethnic Groups: What We Know From the CAMH Monitor Survey (Dr. Branka Agic)

5. CAMH Monitor: Data Specific to Aboriginal Populations (Dr. Renee Linklater)

6. Q&A
Objectives

- Increased awareness of how the CAMH Monitor data reflects equity
- Increased awareness of what the 2013 CAMH Monitor data has to say about substance use among specific populations
- Increased awareness of how the CAMH Monitor data can be used to inform and address health equity issues in program planning or policy
Recap of CAMH Monitor Part 1 Webinar

A Snapshot of Alcohol Use in Ontario: 2013

**Daily Drinking**
- 675,147 Ontario adults drank daily
- 2.6x more likely in 45-64 years
- 12.7% in 65+ years

**Exceeding Low-Risk Alcohol Drinking Guidelines**
- 1,760,300 Ontario adults exceeded low-risk alcohol drinking guidelines
- 3.7x more likely in 55-64 years

**Hazardous Drinking**
- 1,353,500 in any 12 months
- 30.5% in 15-29 years

**Alcohol Dependence**
- 664,700 in any 12 months
- 5.7% in 55-64 years

**Drinking and Driving**
- 4.7x more likely in 25-34 years

Patterns of mental health and substance use in adults with low income and education

Research suggests that mental health and illness are on opposite ends of a spectrum. Indeed, they can co-exist, and are better understood as part of a continuum: one person may have good mental health while having a mental illness, while another may not have a mental illness but experience a poor state of mental health.

Some groups also appear to be more susceptible to poor mental health and mental illness. The health equity literature suggests that these differences in health outcomes are related to disparities in access to social and economic resources.

In light of these differences, it may be helpful to use a health equity lens to explore the 2013 CAMH Monitor findings: an analysis of mental health and substance use among low-income and less-educated groups.

**How is health equity relevant to mental health and substance use?**

Central to this discussion are the social determinants of health: the social, economic, and political factors that influence people’s health. Some factors that influence mental health and substance use include:
- Stigma and discrimination
- Socioeconomic status (SES), which includes income, employment, and/or level of education
- Housing
- Social isolation
- Equity and mental health also reinforce and interact with each other:
  - Health inequity means unequal access to these social and economic resources, which
Equity in Program Planning and Policy

Alexandra Lamoureux
Defining health equity

Health Equity:
Most often defined by the absence of health inequities or disparities

Health Inequity:
Health inequities or disparities are differences in the health outcomes of specific populations that are “systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.”

(Whitehead, 1992, pp. 429-445)
Why health equity?

- **Legal requirements**
  - Excellent Care for All Act, 2010
  - French Language Services Act, 1986
  - Local Health System Integration Act, 2006
  - Ontario Human Rights Code

- **Professional standards**
  - Ontario Public Health Standards

- **Reducing health care costs**

- **Ethical reasons**
Equity vs Equality

Equality

Equity

Barrier removed

Image credit: Erin McPhee (artist).
Targeted and mainstream approaches

- Risk of suicide among LGB youth 14 times higher than heterosexual peers (Benibgui, 2011)
- 77% of trans people in Ontario had considered suicide, 45% had attempted. (Trans Pulse, 2010)

Targeted intervention
- LGBT Youth Line

Mainstream intervention
- LGBT inclusion in community mental health services
Populations requiring equity lens

- Fist Nations, Inuit and Metis
- Ethno-racial communities
- Immigrants and refugees
- Faith communities
- Linguistic communities
- Francophone
- Low income
- Homeless
- Age-related groups
- Disabilities
- Sex / gender
- Sexual orientation
- Rural, remote and urban

Intersectionality
What does the Monitor tell us?

Monitor Report

- Income
- Age
- Education level
- Sex / gender*
- Marital status
- Region

Additional data:
- Occupation
- Language spoken at home
- Sexual orientation (added 2014)
- Ethnicity (revised in 2012)
- Race (added 2012)
- Migration (country, date)
- *Gender identity (next edition)
Men displayed higher prevalence than women across all measures.

Substance use highest among 18 to 29 year olds, and declined with age (except daily drinking).

Substance use tended to increase with income, except for smoking and cannabis use.
Elevated distress highest among 18-29 yrs

Respondents with low incomes most likely to report elevated distress in past few weeks

Use of anti-anxiety and anti-depressants highest among women

18 to 34 yr olds were 2.7 times more likely to report suicidal ideation than respondents aged 55 and older
Alcohol Policy and the CAMH Monitor
Public Health Ontario
Health Promotion Capacity Building
• What is alcohol policy?
• Alcohol Policy in Public Health
• Alcohol data from the CAMH Monitor
• Case Study: Grey Bruce Health Unit
• Questions
What is Alcohol Policy?

- Rules to minimize or prevent alcohol-related harms
- Authoritative decisions\(^1\)
Evidence–based solutions exist

- A seminal research text
- Commissioned by WHO in 2010
- Alcohol policies need to be informed by epidemiological, theoretical, and intervention research
- Outlines importance of healthy public policies to reduce average alcohol consumption and harms\(^1\)
Tier One: Population and Prevention Approaches

1. Controlling affordability: pricing models and policies

2. Regulating the physical availability of alcohol

3. Regulating alcohol advertising and other marketing\textsuperscript{1}
4. Drinking-driving prevention and countermeasures

5. Altering the drinking context

6. Education and persuasion strategies

7. Screening, treatment and early intervention services

Tier Two: Specific Situations, Behaviours, Populations
Alcohol Policy in Public Health

1. Assessment and Surveillance

2. Health Promotion and Policy Development

3. Disease and Injury Prevention

4. Health Protection
Alcohol Policy in Public Health

1. Prevention of chronic disease
2. Prevention of injury and substance misuse
3. Reproductive health

Collecting data on legal and illegal drug use since 1977

Alcohol data includes:

- Past year drinking
- Daily drinking
- Number of drinks
- % > the Low Risk Alcohol Drinking Guidelines (LRADG)
- Binge drinking
- Hazardous drinking

CAMH Monitor and Alcohol
CAMH Monitor Alcohol Data

Drinking rates remain unchanged

% of the population who drank alcohol in the past year
Drinking rates remain unchanged

% of population drinking alcohol in the past year

% of drinkers drinking alcohol daily
Drinking rates remain unchanged

% of the population who drank alcohol past year

% total sample > LRADG guidelines

% of drinkers drinking daily
CAMH Monitor and Alcohol

Single session binge drinking rate dropping

% of drinkers consuming 5+ drinks on 1 occasion

% of sample consuming 5+ drinks on 1 occasion
In 2014 Grey Bruce Health Unit head epidemiologist presented annual health status report to the board of health

Findings:

• High rates of binge drinking
• High rates of obesity
• High rates of falls\(^4\)
Released alcohol policy template to all municipalities in the region\(^5\)

- 90% of respondents “planned to use the template to revise their MAP (Municipal Alcohol Policy) in the future”
- 73% “have used one or more components of the template to revise their MAP” \(^6\)

Communication campaign released “Be safe. Have an alcohol-free pregnancy” \(^7\)
For more information on Grey Bruce Health Unit’s alcohol policy evolution, the Provincial Municipal Alcohol Policy Scan log into PHO’s October 22nd Webinar co-presented by Jason Weppler of Grey Bruce Health unit and Jason LeMar of PHO


Alcohol use and risk drinking among ethnic groups: What we know from the CAMH MONITOR survey

Branka Agic, MD, PhD
Outline

- Study background
- Methods
- Key findings
- Limitations
- Conclusions

Camh
Alcohol use in ethnic groups

- Substantial variations between and within ethnic groups
- Drinking patterns change over time
- 20.6% of Canada’s population foreign born; 200+ ethnic origins - data limited
- Provision of equitable services responsive to the needs of diverse ethnic groups one of the key priorities

(Hurcombe et al., 2010; Amundsen, 2012; MHCC, 2012; Statistics Canada, 2013)
Alcohol use in Ontario ethnic groups: Research Aims

1. Estimate the prevalence of alcohol use and risk drinking in the foreign-born and the Canadian-born populations by ethnic origin

2. Examine average self-reported volume of alcohol consumed per year by ethnic group

3. Explore the associations among ethnicity, country of birth, length of residence and drinking measures
Methods

- CAMH Monitor survey Jan 2005-Dec 2010 (N=13,557)

- Major outcomes of interest:
  - drinking status (lifetime, current drinking)
  - quantity/volume of alcohol consumed
  - risk drinking

- Independent variables:
  - ethnicity, country of birth, age at arrival and length of residence in Canada.
“Risk” drinking

a) Exceeding the Canada’s LRDGs

b) Consuming 5+ drinks at least once a month ("binge drinking") during the 12 months before the survey

c) Reporting hazardous or harmful drinking as indicated by a score of 8+ on the AUDIT screener

(Butt et al., 2011)
# Lifetime, current and risk drinking by ethnic group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Sample N=13557*</th>
<th>Lifetime Drinking(^{\dagger})</th>
<th>Current Drinking(^{\dagger})</th>
<th>Risk drinking(^{\dagger})</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Weighted n)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Ontario</td>
<td>13557</td>
<td>92.3</td>
<td>7.6</td>
<td>79.1</td>
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<tr>
<td>Ethnic Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canadian</td>
<td>903 (845)</td>
<td>95.9</td>
<td>4.1</td>
<td>80.6</td>
</tr>
<tr>
<td>Asian East</td>
<td>287 (439)</td>
<td>88.4</td>
<td>11.6</td>
<td>65.8</td>
</tr>
<tr>
<td>Asian South East</td>
<td>90 (141)</td>
<td>67.4</td>
<td>32.6</td>
<td>49.6</td>
</tr>
<tr>
<td>Asian South</td>
<td>374 (658)</td>
<td>58.1</td>
<td>41.9</td>
<td>44.5</td>
</tr>
<tr>
<td>Caribbean</td>
<td>111 (159)</td>
<td>91.2</td>
<td>8.8</td>
<td>73.0</td>
</tr>
<tr>
<td>African</td>
<td>102 (124)</td>
<td>84.7</td>
<td>15.3</td>
<td>69.4</td>
</tr>
<tr>
<td>East European</td>
<td>844 (874)</td>
<td>96.3</td>
<td>3.7</td>
<td>84.7</td>
</tr>
<tr>
<td>Central-West European</td>
<td>7013 (6417)</td>
<td>96.4</td>
<td>3.6</td>
<td>84.0</td>
</tr>
<tr>
<td>South European</td>
<td>1808 (1713)</td>
<td>95.5</td>
<td>4.5</td>
<td>84.4</td>
</tr>
<tr>
<td>North European</td>
<td>217 (164)</td>
<td>97.5</td>
<td>2.5</td>
<td>90.9</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>38 (48)</td>
<td>83.3</td>
<td>16.7</td>
<td>62.5</td>
</tr>
<tr>
<td>Other</td>
<td>760 (953)</td>
<td>85.7</td>
<td>14.3</td>
<td>72.3</td>
</tr>
</tbody>
</table>

Note: * Estimates based on unweighted sample. \(^{\dagger}\) Estimates based on weighted sample; Def: Lifetime drinking (percent reporting drinking alcohol in their lifetime); Current drinking (percent reporting drinking alcohol at least once in the past 12 months); Risk drinking [percent that reported one or more of the following 1) Exceeding the Canada’s Low Risk Drinking Guidelines (LRDG) defined as a weekly consumption of 16 or more standard drinks for men or 11 or more standard drinks for women, or exceeding a daily consumption of two drinks for women and three drinks for men in any given day over the past week; 2) Consuming five or more drinks at least once a month (“binge drinking”) during the 12 months before the survey (considered an indicator of “risky single occasion drinking”); 3) Reporting hazardous or harmful drinking as indicated by a score of 8 or more out of 40 on the AUDIT screener.
Percentage of ethnic groups that reported risk drinking by immigration status (Canadian born; immigrant arrived in Canada <19 years old; immigrant arrived in Canada ≥ 19 years old)

- Canadian**
- East Asian
- South East Asian**
- South Asian**
- Caribbean**
- East European*
- Central-West European***
- South European**
- North European*

<table>
<thead>
<tr>
<th>Percentage Risk Drinkers</th>
<th>Born in Canada</th>
<th>Arrived in Canada &lt;19 yrs old</th>
<th>Arrived in Canada &gt;=19 yrs old</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian**</td>
<td>25</td>
<td>40</td>
<td>42</td>
</tr>
<tr>
<td>East Asian</td>
<td>20</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>South East Asian**</td>
<td>15</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>South Asian**</td>
<td>10</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Caribbean**</td>
<td>5</td>
<td>48</td>
<td></td>
</tr>
<tr>
<td>East European*</td>
<td>10</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Central-West European***</td>
<td>5</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>South European**</td>
<td>10</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>North European*</td>
<td>15</td>
<td>40</td>
<td></td>
</tr>
</tbody>
</table>

*** p<0.001; ** p<0.01; * p<0.05
Group average yearly alcohol consumption with 95% C.I.
Risk drinking by high and low volume consumption—ethnic group and length of residence in Canada

Figure 1: Risk drinking use by High and Low volume Consumption Ethnic Groups and Length of Residence in Canada
Key findings

- Pattern of alcohol use in the country of origin an important predictor of immigrants’ consumption pattern.

- Immigrants who arrived in Canada <19 years old more likely to report risk drinking.

- Longer duration of residence in Canada may have either positive or negative effects on immigrants' alcohol use.

- The degree of change in drinking measures between being born in Canada vs. outside of Canada varied significantly with self-reported ethnicity.
Limitations

- Findings are based on cross-sectional data
- Potential sample selection bias
- Results based on self-report
- Aggregation of some ethnic groups
- Small sample size in some groups
Conclusions

- New insights into the dynamics of alcohol use in Canada’s ethnic groups

- Important for the development and targeting of interventions

- More research needed to investigate factors that influence alcohol use in immigrants from particular ethnic groups.
References


Acknowledgements

- Dr. Robert Mann
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- Ms. Anca Ialomiteanu
- Dr. Gabriela Illie
Thank You

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CAMH Monitor: Data specific to Aboriginal populations

- The results 1996-2014 – category for Aboriginal populations
- Recently revised demographic identifier
- Limitations: self-reporting/possible under reporting, not able to distinguish sub-groups, and smaller number of respondents
Reflecting on the Data: Substance use among Ontario Aboriginal and Non-Aboriginal Adults 1996-2014

- 874 Aboriginal respondents compared to 45,397 (18 cycles)
- Alcohol use and daily drinking less prevalent for Aboriginal populations (76.5% vs 79.9% and 2.3% vs 5.8%) – Aboriginal respondents more likely to report heavy drinking episodes monthly (32.4% vs 24%), hazardously or harmful (23.1% vs 13.2%), drive after consuming 2 or more drinks in previous hour (23.1% vs 13.2%)
- Aboriginal respondents report higher rates of smoking cigarettes (43.8% vs 20.5%)
- Aboriginal respondents report higher levels of cannabis use in past 12 months (23.5% vs 11.8%)
Respectful data collection and use

• OCAP Principles: Ownership, Control, Access, and Possession - First Nations control data collection processes in their communities

• Data sharing agreements – new demographic category

• Supporting population and community use of data
Discussion
Questions/Comments?

Please type your questions in the chat box
Thank you!

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