Mental Health Commission of Canada

Commission de la santé mentale du Canada

Toward an Integrated and Comprehensive Equity Framework for Mental Health Policy and Programming

Needs Assessment Report

Acknowledgments

The Mental Health Commission of Canada head office is located on the unceded traditional territory of the Algonquin Anishinaabe Nation, in what is now called Ottawa, Ontario. As a national organization, we also acknowledge that we work on the traditional lands of many different nations. We give credit to their stewardship and sacrifices and are committed to recognizing and contributing to a new and equitable relationship with the First Peoples.

Our policy research work uses an intersectional sex- and gender-based plus lens to identify, articulate, and address health and social inequities through policy action. In this respect, it is guided by engagement with diverse lived experiences (and other forms of expertise) that shape our knowledge syntheses and policy recommendations. We are committed to continuous learning and welcome feedback.

The MHCC would like to thank the policy community of practice (PCOP), an internal forum that was created to foster policy coherence across the organization, for championing and guiding this initiative.

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Contents

Introduction

> As a whole the . . . experiences of emotional suffering and mental difference occur within wider historical, structural, cultural, and political contexts . . . that fundamentally influence how mental health issues are framed, named, and studied; how mental health treatment, care, and supports are conceived and implemented, and how all of these are experienced by individuals, their families and friends, and society at large (pp. 4-5).[1]

Profound and unacceptable inequities in access and mental health outcomes persist in Canada.[2-5] Closing these gaps requires that we recognize the mental health system's history of discrimination and human rights violations, along with the intersecting and systemic social, cultural, and economic factors that impact the mental health of individuals and communities.[6-8]

In response, social justice movements have created a range of frameworks, including sex- and gender-based analysis plus (SGBA+), intersectionality, health equity, anti-racism, decolonization, and mental health recovery. These frameworks help many organizations, academics, and activists address inequities across the health, mental health, and substance use health sectors, while guiding how care is positioned and produces distinct outcomes for diverse communities.

In different but complementary ways, each seeks to advance a better understanding of the impacts programs and policies have on diverse populations, not only to account for and integrate the social determinants of health, but also to promote inclusive and socially just outcomes in health, mental health, and well-being.

Yet the sheer number of approaches these frameworks represent creates challenges for implementing policy and programming not only at the Mental Health Commission of Canada (MHCC) but in the mental health, substance use health, and public health sectors more broadly.

Purpose

This needs assessment report set out to provide specific guidance on integrating a range of approaches, frameworks, and experiences into a comprehensive equity framework for mental health policy and programming. It was guided by the MHCC's policy community of practice (PCOP), an internal forum created to foster policy coherence across the organization. The guidance is meant for policy makers, partners, and other organizations and programs across the mental health, substance use health, and public health fields.

Methods

Our needs assessment adopted the principles of implementation science, which aims to fill gaps between evidence, needs, and practice. Through this approach, we considered three implementation drivers: (1) competency (i.e., developing, improving, and sustaining the ability to implement), (2) organizations and systems (i.e., environments to operationalize concepts), and (3) leadership (i.e., building buy-in and commitment from leaders).

The process of assessment involved three phases: (1) a rapid scan of literature related to various frameworks, (2) consultations through interviews with experts (n = 7), MHCC staff, and council members with lived and living experience (n = 10); and (3) a survey of a broader range of stakeholders. Participants in external (virtual) consultations and surveys were selected through the MHCC's network and included representatives from provincial and national mental health

and substance use organizations, equity-based policy institutions, and pan-Canadian health and data organizations (n = 19).

Recognizing that the terminology in this report is conceptually complex and contested, we have used glossaries from the National Collaborating Centre for Determinants of Health and the Canadian Centre for Diversity and Inclusion.

Recommendations

Five high-level recommendations for next steps emerged from this needs assessment:

1. Integrate key analytic concepts and processes, including SGBA+, intersectionality, health equity, anti-racism, decolonization, and mental health recovery, into a comprehensive framework to help guide mental health policy and programming.
2. Embed integrated and intersectional approaches, frameworks, and experiences for implementation across mental health organizations (including the MHCC) using a "whole of organization" approach.
3. Develop resources for implementation, including a model, toolkit, and training.
4. Mobilize the resources, tools, and training to support long-term implementation of equity-driven system transformation at the MHCC and in the broader sector.
5. Use steps 1-4 to create, track, and monitor the impacts and promise of an integrated equity framework and related tools.

Literature Review

This review sought to summarize the available academic and grey literature on existing frameworks, tools, resources, and/or models from organizations and researchers across Canada (see Table A1 for the full search strategy).

The following research questions were used as an initial guide for the review:

1. What are the current concepts around advancing various forms of equity-based analysis?
2. What kinds of equity frameworks, tools, resources, and/or models have been developed and operationalized across Canada? What are their comparative strengths and weaknesses?
3. What additional frameworks, tools, resources, and/or models have been produced by other mental health, substance use health, and public health organizations when implementing intersectionality, SGBA+, and health equity approaches?
4. Among these organizations, are there any examples of how these frameworks, tools, resources and/or models are applied to research, policy development, program design, implementation, and evaluation?

The literature on each framework (SGBA+, intersectionality, health equity, anti-racism, decolonization, and mental health recovery) is synthesized separately. Recognizing their distinct aims and purposes, Table A2 provides a brief comparison of their key characteristics.

GBA+ and SGBA+

Description

Rooted in the feminist movement, the gender-based analysis (GBA) analytical framework continues to evolve. First introduced as a federal policy in 1995, it was expanded to include "plus" (GBA+) in 2011.[9] GBA+ is an analytical tool for assessing systematic inequalities arising not only from the intersection of sex and gender but with other identities as well, such as race, ethnicity, religion, age, sexual orientation, and mental or physical disability.[10] Because researchers and policy analysts also use SGBA+ to emphasize the differences between sex and gender, this report adopts that term, except when discussing specific GBA+ frameworks.[11,12]

Application

GBA+ has been operationalized as a feminist federal policy tool to ensure that analyses consider policy impacts on diverse populations, based on the social determinants of health.[13] The goal of GBA+ is to broaden what counts as authoritative policy knowledge and produce more equitable and socially just outcomes across policy fields.[14] In this way, GBA+ focuses on the pursuit of gender equality, while taking an additive approach to intersectionality (the "+").

The Department of Women and Gender Equality (formerly Status of Women Canada) is mandated to manage GBA+ and has become the primary administrative mechanism for gender equality across the federal government.[15,16] Key steps for implementing GBA+ in policy are outlined in Table 1.

Table 1. Key Steps for Implementing GBA+ in Policy[17]

GBA+ Step	Explanation
Identify issue	Identify the context for the initiative and policy issue, as well as the related gender and diversity issues
Challenge assumptions	Ask what assumptions have been made, if there is a perceived neutrality of policies, if gender/diversity implications might be obscured by assumptions of uniformity
Gather the facts: Research and consult	Get a better picture of the issue through research and consultation: obtain disaggregated data, identify data gaps, seek out multiple viewpoints in consultation
Develop options and make recommendations	Use research to inform advice, indicate how options respond to gender/diversity issues; suggest how to adapt proposal to address differential impacts, barriers
Monitor and evaluate	Ensure evaluation framework highlights data gaps, identify unintended outcomes/negative impacts on diverse groups, enable adjustments to address issues

GBA+, which has been widely cited in the literature and implemented in organizations that include the federal government, has also been adapted to strengthen intersectional, health equity, and cultural safety frameworks. Yet, while various GBA+ adaptations are widely available across Canada (including an Inuit- and Métis-specific tool), its implementation and success have been inconsistent.

A lack of consensus exists in the academic literature and in community activism circles on the usefulness of GBA+ for advancing gender equality, social justice, and equity across health programs and policies.[18-24] Positive responses reference the benefits of the many associated

resources and tools available (which are flexible and adaptable).[25] Others point to limitations with the GBA+ framework. These include:

- privileging binary genders (while focusing on women) over other forms of oppression
- discomfort with power, inequality, and social justice perspectives
- excluding community-based voices
- failing to meaningfully include certain population groups, such as Indigenous and 2SLGBTQ+ communities and organizations
- a lack of accountability mechanisms[26-29]

Challenges

Some researchers see GBA+ as an "incremental radicalism" that falls short of a fully integrated intersectional approach.[30] Although progress has been made, much work remains to be done to strengthen its value for diverse populations and precisely identify who benefits and who is excluded from programs, policies, and priorities (including related resource allocations).[31-33] The results of the literature review suggest that GBA+ must focus on more than just sex and gender and include numerous other variables and power dynamics that interact and impact mental health policies and programs.[34-38]

Intersectional analysis

Description

Proposed in 1989 by Kimberley Crenshaw and grounded in Black feminist scholarship and activism, intersectionality is an approach to policy and programs that encourages critical reflection on the complex relationships and interactions between individual and social factors that lead to inequality.[39]

An intersectional approach focuses on more than one category of identity. It sees race, class, gender, sexuality, ethnicity, nationality, ability, and age as reciprocal constructing elements and goes beyond an itemized list of social determinants of health.[40,41] The approach also challenges power relations to inform social justice.[42] It is grounded in a process of "revealing harmful biases, assumptions, stereotypes, exclusions, and oppressive effects of policy interventions," which prevent the realization of health equity at individual and community levels (p. 4).[43] Intersectional analysis sees programs and policies as structural domains of power that can be effectively harnessed for social change, including the creation of environments to support well-being, social inclusion, and health equity.[44]

Application

Olena Hankivsky has made a major contribution by bringing intersectionality to health research over the last decade and developing the intersectionality-based policy analysis (IBPA) framework whose[45] two core components provide guiding principles and 12 overarching questions to help shape the analysis (see Table 2). The principles involve intersecting categories, multi-level analysis, power, reflexivity, time and space, diverse knowledges, social justice, and equity.

Table 2. Guiding Questions for Intersectional-Based Policy Analysis (IBPA).[46]

Overarching Questions:
Descriptive: 1. What knowledge, values, and experiences do you bring to this area of policy analysis? 2. What is the policy 'problem' under consideration? 3. How have representations of the 'problem' come about? 4. How are groups differentially affected to this representation of the 'problem'? 5. What are the current policy responses to the 'problem'?
Transformative: 1. What inequities exist in relation to the 'problem'? 2. Where and how can interventions be made to improve the problem? 3. What are feasible short, medium and long-term solutions? 4. How will proposed policy responses reduce inequities? 5. How will implementation and uptake be assured? 6. How will you know if inequities have been reduced? 7. How has the process of engaging in an intersectionality-based policy analysis transformed: a. your thinking about relations and structure of power and inequity? b. the ways you and others engage in policy development, implementation and evaluation? c. broader conceptualizations, relations, and effects of power asymmetry in the everyday world?

Intersectionality has led to a conceptual shift in how researchers, health professionals, and policy makers capture "different dimensions of policy contexts, including history, politics, everyday lived experiences, diverse knowledges and intersecting social locations." It also provides an innovative structure for critical policy analysis that generates "transformative insights, knowledge, policy solutions and actions that cannot be gleaned from other equity-focused policy frameworks" (p. 2).[47] In this way intersectionality moves from the descriptive to the transformative in terms of public health, mental health, and substance use health policy.

Intersectionality is starting to be used in federal, provincial, and territorial government policy.[48] The prime minister's 2021 mandate letters to the minister for women and gender equality and youth and the minister of mental health and addictions included a commitment to "ensuring that public policies are informed and developed through an intersectional lens." The first letter also includes a call to enhance the framing and parameters of GBA+ with particular attention to the "intersectional analysis of race, indigeneity, rurality, disability and sexual identity, among other characteristics."[49] This points to an emerging integration of GBA+ and intersectional analysis.

Challenges

The current consensus in policy research is that the IBPA framework offers limited guidance on implementation and still needs explicit and user-friendly methods to translate intersectionality more effectively into practice.[50-52]

Health equity

Description

A health equity framework promotes the ability of individuals and communities to have equitable and fair opportunities to reach their fullest health potential.[53] According to Public Health Ontario, achieving health equity "requires reducing unnecessary and avoidable differences that are unfair and unjust" (para. 1).[54] In this framework, health outcomes are rooted in unequal social relations, distributions of power, and resources.[55] Therefore, health equity seeks to reduce the excess burden of ill health among socially and economically disadvantaged populations and redistribute resources to improve living conditions so that everyone can be healthy.[56-58] To this end, health equity demands a social justice approach and a transformation in how we generate institutional and policy-related change.[59,60]

Health inequities are linked to the social determinants of health and include factors such as "income, social status, race, gender, education, and physical environment" among others (para. 1).[61] These differences in health outcomes and the distribution of health resources are systematic, patterned, designed, unjust, unfair, avoidable, and actionable. They are produced and inflicted on marginalized communities due to historical and contemporary structures of oppression, discrimination, power imbalances, and social, economic, and cultural exclusion.[62,63]

Application

A health equity impact assessment (HEIA) tool supports decision making by walking users through a set of steps, questions, and processes to identify how a program or policy could positively impact different population groups.[64] Health equity and HEIA tools have been widely adapted by many organizations in Canada and internationally.[65,66] Examples include a HEIA template and workbook from the Ontario Ministry of Health and Long-Term Care[67] and an inventory of health equity tools (adapted to different populations and health issues) from researchers at the University of Victoria.[68]

Challenges

Despite this widespread adoption, diverging views exist on how to apply and implement health equity tools across Canada. Researchers have identified challenges in optimally selecting, applying, and evaluating them while noting the lack of a shared understanding and approach.[69,70]

Anti-racism

Description

Racism is a specific form of discrimination — encompassing economic, political, social, and cultural structures, actions, and beliefs — that systematizes an inequitable distribution of opportunities, outcomes, privilege, resources, and power in favour of white people. Such advantages come at the expense of other racial groups, including African, Caribbean, and Black (ACB), Indigenous, Asian, Latinx, and Middle Eastern individuals and communities.[71-73] Racism can also be directed toward a specific race; for instance, anti-Black racism, which is partly rooted in pathologizing the behaviours of people who were enslaved.[74] Examples of anti-Indigenous racism include experiments to sterilize Indigenous women and to force malnutrition on Indigenous children.[75] In categorizing people based on "similar physical and social characteristics," race is a "social construct with no biological basis and is derived from

White supremacy" (p. 3).[76] Yet racism is foundationally embedded in institutions and systems across Canada, including services in public health, mental health, and substance use health.

Pervasive racist injustices continue to be perpetrated across these services and contribute to mental health disparities for racialized and underserved populations.[77] These injustices can lead to racial trauma and stress, along with psychological injuries that "reflect the severity and symptomatology of posttraumatic stress disorder," and have other severe impacts on health, mental health, and substance use health (p. 3).[78] In previous publications, the MHCC has explored many of the ways that race impacts the mental health of immigrant, refugee, ethnocultural, and racialized individuals.[79,80]

Anti-racism represents a social movement and set of practices to address racism wherever it is found.[81,82] It seeks to both identify obvious instances of racial discrimination and dismantle the power relations within the structures of white privilege and supremacy. This includes the need to deconstruct deeply entrenched racist institutions, systems, and legacies that marginalize and ignore the priorities and well-being of racialized individuals and communities.[83,84] A literature review by Corneau and Stergiopoulos found agreement among many authors that, to reduce the impact on health, mental health, and other outcomes, "anti-racism must confront the core aspects of racism: its institutional, individual, and cultural dimensions" (p. 268).[85]

Anti-racism policy requires a strategic approach: one that prioritizes the "elimination of racial discrimination from the earliest stages of agenda-setting and when allocating resources to policy initiatives" (para. 13).[86] Accountability, evaluation, and transparency are also core aspects of anti-racist policy making. For example, community-based organizations that focus on the mental health of children and youth have recognized the need to collect racial equity data to develop culturally responsive programming and improve clinical and organizational outcomes.[87] Given the continued overrepresentation of ACB and Indigenous fatalities in police-involved mental health crisis response, including racial identifiers in police data systems, coroner's reports, social institutions, and criminal justice forms is critical to understanding the nature and extent of harms.[88-90]

Application

There are numerous anti-racism frameworks in Canada. One from Corneau and Stergiopoulos includes several key considerations, including empowerment, education, building alliances, language, alternative healing strategies, advocacy/social justice, and fostering reflexivity.[91] Another framework and toolkit by Nesbeth takes a human-rights approach to addressing racial discrimination in policy.[92] Several other resource repositories are also available.[93-96] All are designed to help individuals and organizations translate anti-racism considerations into concrete changes in health, mental health, and substance use health policy, programs, and services.

These frameworks and toolkits are also being taken up in broader policy reforms. For example, the federal government's 2019-22 Anti-Racism Strategy commits to "building a foundation for change by removing barriers and promoting a country where every person is able to fully participate and have an equal opportunity to succeed," based on its definition of anti-racism (Foreword, para. 2).[97]

From an implementation perspective, a case study of 102 community-based agencies in the children and youth mental health and substance use sector found organizational leadership key to changing anti-racist practices (along with intersectoral partnerships, workforce diversity, community engagement, and continuous quality improvement).[98] Other important factors

mentioned were the use of inclusive language in hiring practices and offering leadership opportunities for those who are racialized.[99] Similarly, a scoping review of anti-racist interventions in health care showed that leadership buy-in and commitment (with dedicated resources, support, and funding) and mechanisms to ensure accountability were critical.[100]

Challenges

Debates across the literature about the strengths and limitations of anti-racist frameworks for driving policy change continue.[101] While practical tools for implementation are needed, many question whether these frameworks can fully address racism given its insidious and pervasive character.[102] Some also find anti-racism limited because it "fails to conceptualize and differentiate race, ethnicity, colour, and culture as fluid constructs and reifies the terms in fixed, homogenous categories" (p. 274).[103] Another gap arises from the need to take a strengths-based approach: one that does not view racialized individuals as powerless victims who require action to be taken on their behalf.[104] From an implementation perspective, issues related to leadership commitment, time, resources, and the difficulties involved in engendering a culture of trust and transparency have also been mentioned.[105]

Decolonization

Description

Decolonization is a process focused on bringing about "'cultural, psychological, and economic freedom' for Indigenous people with the goal of achieving Indigenous sovereignty — the right and ability of Indigenous people to practice self-determination over their land, cultures, and political and economic systems" (para. 4).[106] It is also centred on community participation, respectful relationships, restitution, compassion, truth, and increased collective knowledge, accountability, and healing.[107-109]

Dismantling colonialism as the dominant model upon which Canadian society functions, while centring the needs and meaningful participation of First Nations, Inuit, and Métis, requires everyone's participation.[110] Decolonization involves the repatriation of the lands and cultures of Indigenous people and communities, as well as action to address the significant, distinct forms of oppression and the intergenerational impacts of historical and current colonial practices.[111] It further asserts an "ethic of incommensurability," which, for Tuck and Yang, recognizes what is different and sovereign about decolonization in relation to other social justice projects and the importance of critically addressing all colonial practices, even those that are not explicit.[112]

Decolonization addresses inequity and the legacy of colonialism in mental health and substance use health by drawing on knowledge, expertise, and practices that privilege Indigenous interests.[113] Led by these communities, the process includes holistic and preventive perspectives, trauma-informed care, and Indigenous culture and language.[114]

Application

Several organizations across Canada offer examples of emerging practices in decolonization. British Columbia's Office of the Human Rights Commissioner describes their approach to this work as "listening deeply to Indigenous peoples, supporting self-determination of Nations and working to dismantle structures that impede the full, equal and just participation of Indigenous peoples in all aspects of economic, social, cultural and political life" (para. 4).[115] For mental health, this can include thinking about individual "pain in the context of historical forces or

social structures or cultural dynamics," creating space for Indigenous-led and informed understandings of trauma, and disrupting systems of power (e.g., capitalism) (para. 14).[116]

From a mental health policy perspective, the Yellowhead Institute recommends that "mental health care for Indigenous peoples should be accessible, free (and funded), and colonial trauma informed, with trained practitioners available. Barriers to accessing mental health support need to be removed to ensure Indigenous persons who find the strength to seek support can do so" (p. 3).[117] A thorough response to mental wellness would also require that the impacts of colonization (e.g., land sovereignty, funding for community infrastructure, capacity building, and dealing with housing, water, and food insecurity) be addressed.[118]

Cultural safety through humility

As one approach to decolonization, cultural safety through humility has laid the foundation for more comprehensive and systematic work.[119] In terms of mental health and substance use health policy, research, and program development, it seeks to prioritize respectful engagement to make the system safer for everyone. By addressing stereotyping, racism, and discrimination across the health system, it creates space for First Nations, Inuit, and Métis philosophies and practices within health care.

B.C.'s First Nations Health Authority (FNHA) is a leader in the development of cultural safety through humility, which many governments and agencies across Canada have adopted. In 2021, FNHA partnered with the Health Standards Organization to develop a provincial cultural safety and humility standard.[120,121] The National Collaborating Centre for Indigenous Health also hosts a Cultural Safety Collection to mobilize tools and resources across the health-care system. In addition, San'yas and Wabano have made cultural safety training widely available across many provincial health systems.

Challenges

Beyond cultural safety through humility, a limited number of tools and implementation frameworks exist in Canada to provide guidance on integrating decolonial processes into mental health practice. The main findings from the literature scan include a framework for health promotion[122] and a repository of resources.[123]

Mental health recovery

Description

The mental health recovery framework orients policies, programs, and services toward empowering people to make choices around their mental health.[124] Recovery-oriented mental health systems therefore support choice, dignity, and respect[125,126] Within this framework, recovery is both self-defined and centred in respecting the autonomy, dignity, and self-determination of people with lived and living experience of mental health problems and illnesses. The MHCC has defined it in the following way:

> The concept of recovery in mental health refers to living a satisfying, hopeful, and contributing life, even when a person may be experiencing ongoing symptoms of a mental health problem or illness. Recovery journeys build on individual, family, cultural, and community strengths and can be supported by many types of services, supports, and treatments (p. 4).[127]

Application

Mental health recovery is being refined and adapted by various organizations around the world. For example, two toolkits that accompany the MHCC's *Guidelines for Recovery-Oriented Practice* provide a range of implementation strategies.[128,129]

SAMHSA (Substance Abuse and Mental Health Services Administration) in the U.S. also offers several tools and resources for the implementation of recovery.[130-132] While substance use recovery has had a strong association with abstinence, shifts toward meeting people where they are at (including harm reduction approaches) and supporting them as they rebuild meaningful lives in community are taking root.[133-135]

Challenges

The main critiques of mental health recovery include the need for greater cross-cultural application and understanding around differences in society. Others see insufficiencies in the recovery approach because it can individualize social problems and obscure the structural causes of distress. So, while supporting the framework, there are calls to also redistribute social, political, and economic power and resources to address mental health concerns more effectively.[136-138] Further critiques arise around the potential of mental health recovery to diminish or sideline the role of caregivers and their support of people with mental health concerns.

In addressing these critiques and working toward mental health recovery, researchers promote community well-being and ensure that individuals with lived and living experience are at the centre of research, programs, and policy.[139] The MHCC has also recognized caregivers as vital partners in the recovery journeys of loved ones who are living with mental health problems and illnesses through the *National Guidelines for a Comprehensive Service System to Support Family Caregivers of Adults with Mental Health Problems and Illnesses.*[140]

The following consultation results provide more details on the implementation of these frameworks as well as a comparative analysis.

Consultation Results

To further understand organizational and system needs and contextualize our literature review findings, we held several key informant interviews with internal MHCC staff (n = 10) and individuals from allied health, mental health, and social policy organizations from across Canada (n = 7). We combined snowball and purposive sampling to identify external interview respondents with expertise or experience in leading, developing, or implementing equity frameworks within their organizations or practices. Prior to conducting external interviews, a survey was also completed by 19 individuals throughout the country. Respondents who completed both the survey and the interview included major health, public health, mental health, substance use health, and urban health centres across Canada.

Our internal consultations sought to understand key tensions and needs in the MHCC's operationalization and use of SGBA+, intersectionality, and health equity and to identify considerations for the development of a toolkit. External consultations had similar objectives but sought to determine needs, tensions, trade-offs, and considerations for the mental health and substance use health fields. The survey sought to glean participants' understanding of

SGBA+ (and its related concepts) and to ascertain relevant resources and implementation challenges. As noted in the Acknowledgements section, our findings have been refined through consultation with MHCC staff, council members with lived and living experience, and other external experts.

Analysis

Understanding and implementing various equity frameworks

Survey respondents were asked to rate their perceived level of understanding and ability to apply SGBA+ and other health equity concepts in their work. Figures 1 and 2 provide an overview of their replies.

Overall, most respondents rated their understanding of the concepts of health equity, intersectionality, and SGBA+ from "low" to "medium." Using a five-point rating scale, the average understanding score across these three frameworks was 2.51, with only a few participants indicating higher levels of understanding. The average implementation score across these three frameworks was slightly lower at 2.10, yet a similar pattern was found in the respondents' ability to apply these concepts. When asked about sources of information, MHCC interviewees reported learning about equity frameworks in different ways, such as external resources (e.g., formal education, online courses, and working with partners) and internal resources (e.g., workshops and training).

Figure 1: Self-Rated Understanding of SGBA+, Intersectionality, and Health Equity Concepts

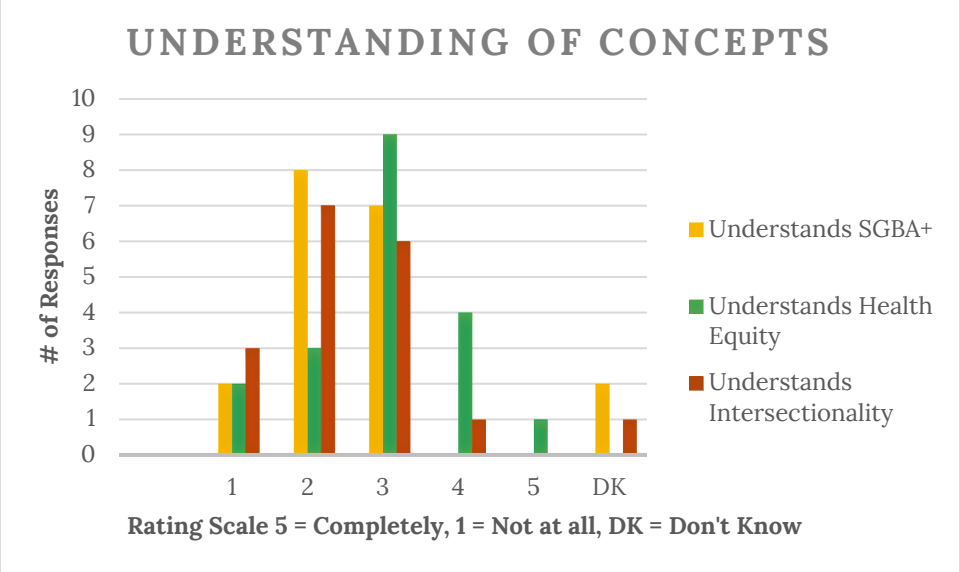
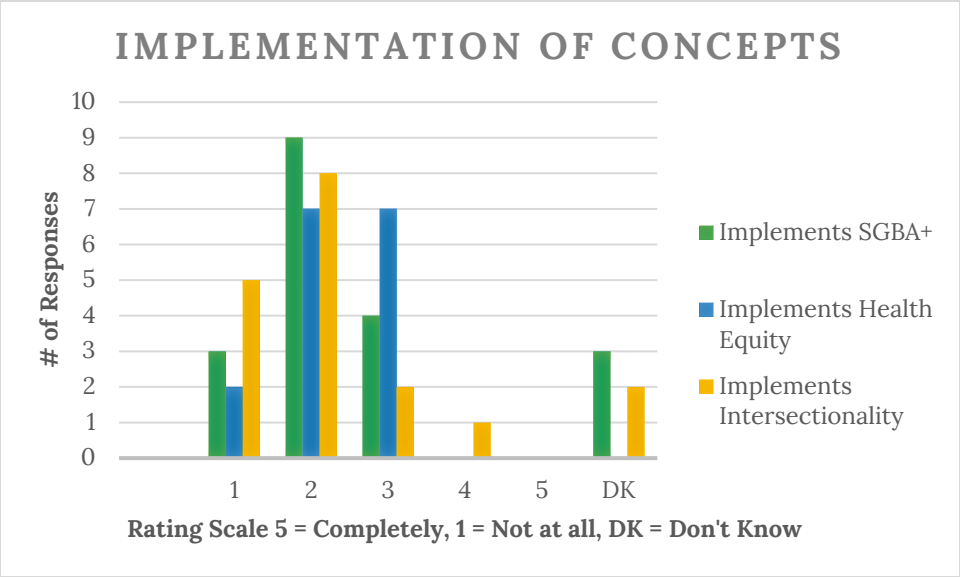


Figure 2: Self-Rated Level of Ability to Apply SGBA+, Intersectionality, and Health Equity Concepts



The survey results identified a range of methods and degrees of concept application across respondents' respective organizations. While some external respondents found health equity frameworks more approachable, others found that intersectionality permitted a more thorough understanding or approach, even though it was seen as more resource intensive. Since SGBA+ is a commonly acknowledged term, many participants have become familiar with it as a part of Health Canada standards and reporting mandates. SGBA+ was viewed as prioritizing sex and gender, which could exclude or underplay other important factors such as class, race, and disability. MHCC staff who are familiar with SGBA+ concepts found it relatively easy to work with.

Organizational levers to advance a comprehensive equity framework

As respondents shared ways for organizations to implement an equity framework (see Table 3A), in practice, they were unanimous in their call to standardize and more formally adopt an integrated and comprehensive framework.

Integrating such an equity framework into project charters was the most common recommendation.* Internal and external respondents identified several additional organizational levers that could be further developed. Among them were (1) more equitable, diverse, and inclusive approaches to procurement, including sourcing and selecting vendors in response to requests for proposals (e.g., hiring more grassroots advocacy and research organizations or contractors without requiring advanced degrees), and (2) intellectual property considerations (e.g., rethinking IP rights and ownership, especially in relation to anti-racism and decolonization). Other suggestions included more diverse representation in advisory groups and events, conducting environmental scans and stakeholder mapping at the start of projects to identify gaps, and identifying and removing barriers to participation and engagement. Several respondents thought that the lack of accountability shown by having no

* This practice is already employed by the Canadian Centre on Substance Use and Addiction.

reporting requirement on an organization's use of a health equity approach was a barrier to its implementation.

Beyond reporting requirements, many pointed out that it was important to have unequivocal support from leadership in the application of health equity, given their critical role in the stewardship of an organization's culture. Some also highlighted the need for leaders to reflect on their privilege and biases as integral to their role and to project development. In addition, various participants found the need to make institutional, organizational, and societal power dynamics explicit as essential to addressing the root causes of health inequities.

Some MHCC-specific facilitators included increased collaboration across departments; leveraging equity, diversity, and inclusion initiatives; and working closely with governments and partners across the sector, as well as with community and grassroots organizations. Many were interested in drawing on the MHCC's PCOP and its policy and research team to support the development and implementation of a comprehensive equity framework, including through "early adopters" that can inspire other teams.

MHCC respondents saw applying these concepts as everyone's job, with everyone having a role to play. Many expressed an interest in fostering an organizational culture where the implementation of a comprehensive equity framework guides work at all levels.

Also highlighted was the value of human resources for implementing equity frameworks across the organization; for example, with onboarding packages that include related resource and training lists. HR could also prioritize equity as a core competency and support new and current staff to acquire such competencies. In addition, HR could re-evaluate the credentials needed for roles at the MHCC to ensure that wide-ranging knowledge and experiences are included.

Research and data

A subset of respondents emphasized the critical role of research and data in supporting the development and implementation of equity frameworks across governments and health organizations. At the same time, they acknowledged the need to have research and data that adequately captures the different health equity impacts and multiple and/or intersectional identities impacting health, mental health, and substance use health.

Without sufficient infrastructure in health data, having meaningful "conversations" and making policy decisions is difficult. Two respondents who had worked on an organization-wide strategy and implementation effort spoke of the need to build health equity indicators into performance measurement to track progress. Many also linked the role of data to improved accountability.

As well, expert reviewers pointed out the need to rethink what we consider data for change. This includes greater emphasis on lived and living experience, community voices, qualitative data, and storytelling (and other verbal strategies) as important sources for getting a fuller picture of our mental health, public health, and substance use health systems. These and other sources of data are needed to complement quantitative data and inform planning, policy, programs, and funding priorities. This more cohesive approach could fill additional gaps and lead to better responses to community needs.

Toolkits and training

In terms of the strengths and limitations of SGBA+ and health equity toolkits, while some respondents recognized the roles these have in facilitating progress, others noted a "fixation" on tools and how they are better taken as a "place to start."

Many respondents remarked that the available toolkits could not easily be applied to their specific needs. They called for the development of toolkits that would provide further guidance on language and more specific recommendations according to type of activity or project, project stage, and knowledge product. Others pointed to the need to create a toolkit repository and cautioned against "reinventing the wheel."

Problems with accessibility and simplicity were also mentioned, as were recommendations for step-by-step guidance, flow charts, interactive toolkits, and decision-making diagrams to make tools more concrete and relevant to specific needs.

In addition, respondents recommended ongoing refinement with end users and experts while building an understanding of what works, what doesn't, and why. Some saw a need to publish "lessons learned" in developing and promoting toolkits according to different sectors.

Several MHCC respondents saw the PCOP as well-suited to providing backbone and technical support in developing and implementing a comprehensive equity framework at the MHCC (e.g., toolkits, lenses, approaches, and resources). The PCOP was viewed both as a hub for training and building the organization's capacity to apply and use its concepts and as a positive space to mobilize important conversations and problem solve equity-related concerns. Several respondents mentioned the PCOP can help standardize an integrated approach across the MHCC and monitor and evaluate implementation efforts. For example, additional equity indicators could be embedded into an internal performance measurement framework to track the impacts of any tools created.

Internal and external respondents strongly emphasized the need to engage and educate all members of an organization. Some of those who started with toolkits and capacity-building efforts noted the ease of uptake and implementation through organization-wide initiatives, starting with early adopters and champions. MHCC respondents were highly motivated to seek such training and education, and many had already done so informally as individuals or teams.

Several respondents also keenly emphasized the need to focus on capacity-building (i.e., beyond one-off training or individual spokesperson sessions), so that responsibilities for implementation could be embedded across the organization. Mandated and ongoing training, specifically tailored to different roles (e.g., policy, public affairs, programs, knowledge mobilization) and benchmarked to competencies were understood as an appropriately nuanced and sustainable approach.

At the same time, respondents felt that training alone was not sufficient. Some pointed out that training increases knowledge but does not lead to behaviour change. Others mentioned the bias embedded in the training programs of health and social policy settings. A number of respondents stressed the importance of finding more nuanced ways to think about human complexity beyond what identity factors are most popular or politically expedient to support. Many commented on the limitations of didactic training (teachers giving lessons to students), with some questioning its applicability or sustainability. All respondents wanted training that was better tailored to their needs; that is, more finely tuned to their level of expertise and role in their organization and the health system.

Conclusion

There was significant convergence across the literature review, survey, and consultation results, with each equity framework seen as having positive aspects as well as limitations. Among the six approaches mentioned, health equity was the most widely used, while GBA+ and SGBA+ had greater uptake at the federal level (offering several flexible tools). GBA+ was acknowledged as having advanced gender equality, yet its intersectional analysis is limited.

Frameworks that are focused on decolonization and anti-racism provide new opportunities to promote mental health and substance use health beyond the social determinants of health. They broaden our considerations of the unequal distribution of societal resources and ground other ways of knowing in the development of policies or programs. They also more readily account for implicit harms, stereotypes, and ideologies embedded at a systemic level and in organizational policies and practices as well as individual mindsets.

The issues raised in our assessment highlight a need for reflexive practice in program development and underscore how asymmetrical power dynamics, racism, and colonialism are re-enacted and maintained in organizations, just as in society at large. The significant and ongoing role of the social determinants of health, and their impact on mental health and substance use health, also calls into question the overemphasis on factors such as access to service and tertiary care.

Developing comprehensive and integrated equity frameworks is crucial to all aspects of the MHCC and other organizations in the sector, from program design and implementation to marketing and communications, knowledge mobilization, and effective stakeholder and partner engagement. In addition to ongoing training, toolkits tailored to specific project roles will help various departments facilitate its uptake.

Consistent with the literature on implementation science, senior leadership and administrative support is required to advance outcomes over the immediate and long term. To optimize the chances of success, such equity frameworks (and their associated initiatives) should be linked to organizational priorities, with consultation, advice, and oversight driven by diverse and meaningful representation.

Limitations

Despite the comprehensiveness of our literature review and consultation findings, many voices were under-represented or excluded from the data collection. In addition, in the consultations and survey, mental health policy practitioners were most familiar with sex- and gender-based analysis and the bulk of their experience was with implementing health equity. This asymmetry in the understanding and use of different equity frameworks warrants caution regarding the generalizability of the results and justifies the need for further consultation with practitioners who are using less well-represented equity frameworks.

Also, while Table 2A provides some preliminary comparative analysis of common principles across equity frameworks, its concepts were gleaned solely from a content analysis. Further consultation with expert practitioners who are well versed in these frameworks, especially those under-represented in this report, is needed to validate their content and understand how

the various principles outlined are related, and what their mechanisms of action are (or are likely to be).

As our needs assessment makes clear, more work still needs to be done around process, design, and comparative analysis as well as on implementation and drivers of change. The next phase of the project intends to address these limitations when creating and implementing the model and toolkit (described below).

Recommendations and Next Steps

As noted in the Introduction, five recommendations for next steps emerged from this needs assessment:

1. Integrate key analytic concepts and processes, including SGBA+, intersectionality, health equity, anti-racism, decolonization, and mental health recovery, into a comprehensive framework to help guide mental health policy and programming.
2. Embed integrated and intersectional approaches, frameworks, and experiences for implementation across mental health organizations (including the MHCC) using a "whole of organization" approach.
3. Develop resources for implementation, including a model, toolkit, and training.
4. Mobilize the resources, tools, and training to support long-term implementation of equity-driven mental health system transformation at the MHCC and in the broader sector.
5. Use steps 1-4 to create, track, and monitor the impacts and promise of an integrated equity framework and related tools.

To advance these recommendations, the MHCC will focus on developing a comprehensive and integrated equity model, which will go out for public review in 2023. That model will anchor the development of a framework and toolkit to support implementation within the MHCC and across the mental health, substance use health, and public health sectors. The process for creating the model and toolkit will build on the findings and limitations of this needs assessment. Moving forward, the MHCC will continue to monitor and evaluate these recommendations and the project as a whole, including the model, framework, and toolkit.

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Appendix

Table A1: Literature Scan Methodology

Journal and Grey Literature Scan	
Search terms	"intersectionality" OR "GBA+" OR "EDI" OR "health equity" AND "public health" OR "mental health" OR "substance use" OR "mental health policy" OR "anti-racism" OR "cultural safety" OR "decolonization" OR "recovery" OR "mental health program" OR "mental health research" OR "program development" OR "program implementation" OR "program evaluation" OR "organizational change" OR "organizational capacity" AND "Canada"
Inclusion/Exclusion parameters	Dates: 2012-2022
Databases	The databases that will be used are publicly available (e.g., Google Scholar) and privately available (e.g., university databases and ProQuest).
Grey literature from specific organizations	1. CAMH Health Equity Office 2. Centre of Excellence for Women's Health 3. Wellesley Institute 4. Public Health Offices — municipally, provincially, federally (PHAC) 5. Systems Planning Tables — Provincial System Support Program, The National Collaborating Centre for Determinants of Health's Organizational Capacity for Health Equity Action Initiative

Table A2. Comparison of Key Characteristics Across Equity Frameworks

Domain/Framework	Sex- and Gender-Based Analysis[1]	Intersectionality[2]	Health Equity[3]	Anti-Racism[4]	Decolonization[5]	Mental Health Recovery[6]
Seeking social justice: Targets systemic barriers, health access and outcomes for specific group(s) of interest	E	E	E	E	E	E
Problematizes approach to segmenting issues, populations, research, and/or policy responses	E	E	E	E	E	NR
Attention to power	E	E	E	E	E	E
Emphasizes structural over individual conditions	E	E	E	E	E	NR
Necessarily involve land repatriation	NR	NR	NR	NR	E	NR
Rooted in human rights	E	NR	E	E	V	E
Reflexivity: Attention to unconscious bias, assumptions, prejudice, and discrimination	E	E	E	E	E	E
Interrogating vested interests via attention to sociohistorical and contemporary framing/ communication of problem domain	NR	E	E	E	E	E
Community-led or driven: Meaningful representation, inclusion, and engagement of those most marginalized and/or affected in policies, programs, and initiatives	E	E	E	E	E	E
Emancipatory aims: Emphasizes self-determination as objective, and/or as part of good governance	NR	NR	NR	NR	E	E
Diverse representation in workforce, organizational structures, leadership	NR	NR	E	E	NR	E
Centring multiple overlapping oppressions and dynamic and interactive identity markers with structural factors	V	E	NR	NR	E	V
Centres awareness, resource development, and capacity building as vehicles of change	E	E	E	E	NR	E
Available toolkits use reflective prompts to drive implementation or use	NR	E	NR	NR	NR	E
Calls for increased alignment of government, non-government, civil sector	NR	NR	E	E	E	E

Domain/Framework	Sex- and Gender-Based Analysis[1]	Intersectionality[2]	Health Equity[3]	Anti-Racism[4]	Decolonization[5]	Mental Health Recovery[6]
Commitment to epistemic pluralism	E	E	NR	NR	E	E
Concerns of being co-opted, displaced, or exploited (as a framework)	NR	NR	NR	NR	E	NR
Beyond policy development: Specific role of knowledge mobilization and strategic communications	E	E	NR	NR	NR	NR
Tracking progress via changes in targeted funding allocations (versus health disparities)	E	E	E	E	NR	NR
Tracking progress via performance measurement and accountability tools	E	NR	E	E	NR	E
Seek to build evidence: Current available data and/or statistical methods as impediments	E	E	NR	NR	E	NR

Legend
[E] Explicitly referenced
[V] Vaguely or indirectly referenced
[NR] Not referenced

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Table A3: Organizational Levers for Advancing Equity Frameworks

Organizational Levers	Examples
Diverse and inclusive organizational culture	• Diverse, inclusive, and representative workforce • Equitable access to opportunities for professional development • Power sharing and co-development of projects • Engagement, buy-in, and awareness from all levels of the organization, including board, senior leadership, and director levels • Policies that ensure equitable access to benefits and fair compensation • Inclusive workplace practices (e.g., pronouns in e-signatures)
SGBA+ and health equity embedded into organizational priorities	• Leveraging requirements of funder (e.g., Health Canada) • Systemic application and evaluation of strategic priorities • Linking corporate equity, diversity, inclusion, and anti-racism (EDIA) work to program activities
Strategic partnerships and procurement	• Equitable approaches to procure expert external advice (e.g., equitable support and amplification of smaller organizations with less capacity; actively engage groups often left out of decision making) • Proper and adequate compensation • Anti-oppressive and decolonial approaches to hiring and procurement/RFPs (e.g., considering non-graduate degrees, opportunities to relinquish intellectual property rights)
Resources and training	• Organization-wide strategies that require training and evaluation of health equity competencies (e.g., procurement, research, project development, project evaluation) • Mix of required regular training and self-directed training (e.g., lunch and learns)
Accountability and evaluation	• Linking integration efforts from strategic planning or priorities into performance measurement and reporting • Ongoing tracking of progress

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