# Interview with Dr. Kwame McKenzie

Ryan Daniel and Grace Lee

*Dr. Kwame McKenzie*

Dr. Kwame McKenzie is the CEO of the Wellesley Institute, a non-profit organization in Toronto aimed at improving health equity through research and policy action on the social determinants of health. He is also a Professor of Psychiatry at the University of Toronto and the Director of Health Equity at the Centre for Addiction and Mental Health. Dr. McKenzie is internationally recognized for his research in the social and cross-cultural determinants of mental illness. As an academic, policy advisor, and clinician, he has published over 200 papers and 5 books and has been consulted by major news outlets such as the BBC, the Guardian, the Times, and the Toronto Star. Dr. McKenzie currently sits on the National Advisory Council on Poverty, Ontario Hospital Association, and Community Food Centres Canada.

The UTMJ had the great pleasure of discussing Dr. McKenzie's perspectives on how the social determinants of health and mental illness have emerged as key themes within the COVID-19 pandemic.

**UTMJ:** You're a strong advocate for having both a "COVID-19 plan and post-COVID-19 mental health strategy". What do you think are the most important actions that governments must take to develop an effective post-COVID-19 mental health strategy and how can the public ensure this strategy is carried out?

**KM:** It's a great question. One of the issues that we have at the moment with COVID-19 is that some studies that follow people for three or four months after a COVID-19 diagnosis – whether they've been in hospital or not – show there is a 20% chance that they'll get a new diagnosis of a mental health problem. So, we know that people who are diagnosed with COVID-19 are more likely to have a mental health problem. We also know that financial insecurity increases the risk of mental health issues. And therefore, we know that the economic impacts of COVID-19 will lead to increased rates of mental health problems. We also know that people get very anxious when they can't follow rules that are supposed to protect them. Unfortunately, the public health rules that are in place with regards to physical distancing, social isolation and getting tested or traced cannot be realistically followed by everyone, especially for those who are low-income, unable to work from home, and essential workers who are largely from equity-seeking groups. If individuals get tested, they may have to stay off work, which means they may not have enough money at the end of the month to pay their rent. These people have to make very difficult decisions about getting tested. For those that do get tested, and then test positive, what can they do? They've got no way of isolating. So, there are a lot of people who are nervous about catching COVID-19, but also nervous because they cannot take part in the public health strategies meant to protect them. Whether it is COVID-19 itself, the public health measures, the financial insecurity, the economic impacts of the lockdown, or whether you've got an existing mental health issue and can't get help, these are all reasons why we're seeing increased rates of mental health problems. As if that's not enough, we're also seeing an increase in substance misuse during the lockdown and an increase in intimate partner and domestic violence, which both have traumatic mental health consequences. If all of these factors don't add up to be one of the biggest mental health threats to society that we've had for decades, I would eat my shoes!

This problem is so patently obvious that we have to do something about it. We have to take action because of the suffering, but also because there's a moral imperative to do so. On top of those reasons, we have to realize that in a thought economy and a service economy, good mental health is actually one of our major raw materials for building back better. If you're not feeling good, you lose that entrepreneurial spirit and new ideas aren't flowing. If you're not feeling mentally healthy, you're not going to be doing your job very well. And if you're not doing your job very well in the service industry, it undermines productivity. Given that 75% of our economy is founded in service industries, you can see what will happen if we have a mental illness "tsunami", with no way of dealing with it. So that's why we need to do it.

By outlining the cause of [this mental health crisis], we get an indication of how to deal with it. There may be a need for more services, and that's straightforward. But also, there needs to be ways to stop people from getting mentally ill – and 85% of what makes you mentally ill is the social determinants of health. Of that 85%, 50% is related to income, housing, racism, and sexism, 10% is due to your environment, and the other 25% is related to your access to care. So, if you want to implement a mental health strategy, you've got to start by decreasing the number of people who get ill in the first place, which means you have to think about mental health services plus addressing the social determinants of health. This means keeping people financially secure through strategies like the Canadian Emergency Relief Benefit and the potential for a universal basic income. You've got to think about your housing strategy, and whether overcrowding is part of the problem. You've got to think about sick days and about enforcing

social distancing in public and workplace settings, so people don't get sick in the first place.

When you are building back your economy with a focus on mental illness, you need to decide whether you're going to focus on the groups that were hit the hardest. In Toronto, these are people living in certain parts of the city: racialized populations, people with low income, and women between the ages of 18 and 54. You've also got to think of strategies at the population level that people don't usually talk about. One is how you help people help themselves. For instance, what do I tell people about mental health literacy? How they can stay resilient? How can they stay well? What can people do for themselves? Another part is how you help people help others. For instance, how can someone become an ally and a buddy? How can they deal with somebody who is in crisis and needs help? We don't have to teach people to become psychiatrists, but we should teach people mental health first aid, just like we teach physical first aid. This would include how to deal with suicide. The number of people feeling suicidal has increased during the pandemic, and we need to be able to tell people where to go. The next layer up is the implementation of help lines. We need to determine what a helpline looks like. What are the different types of help lines? Do we use traditional calling or texting or online self-guided therapy? What self-guided therapy is feasible for online use? Can we translate these helplines into different languages, and can they be used by young, middle-aged, and older people? These are all questions that must be answered. In the UK, they introduced a new form of talk therapy for older people who are suffering from depression due to the COVID-19 pandemic. This therapy was specifically engineered to be done not over a smartphone, tablet, or iPad but over an old-fashioned phone. These are the types of smart technologies that can adapt what is available to address a particular population group.

After you've thought about all these services, you need to think about how people can access them. Some will be online, some will be face to face, and some will be in traditional areas, such as a hospital or a family doctor service. But most of them will have to be in places you wouldn't necessarily expect. This includes your pharmacy or other settings with a low barrier to treatment that is easily available and backed by social support. We have to have good clinical treatments, but due to their high cost, our focus should be on helping people help themselves so that they can use non-clinical treatments that are much easier to scale up and much cheaper. In essence, our goal should be to get everyone to be decent therapists.

That's roughly what you do and what it looks like. It's really not rocket science, and everybody knows what to do. That isn't the problem. The problem is getting people to do it. And that problem is the age-old problem in politics, which is the gap between people's positions and their intentions. The position of all politicians will be "you're right, we need more mental health services". But they don't do it. That's going to be the big issue over this period of time. We need to move politicians from just saying, "yes, yes, yes, this has to be done", to taking action and doing it.

**UTMJ:** In June, you published an article called "Austerity and COVID-19" where you talked about how the disastrous impact of COVID-19 was, in many ways, precipitated by "austerity policies" that reduce social and healthcare supports. Can you speak more about how you've seen this play out in Ontario?

**KM:** The basic model for what happens with austerity policies is that the healthcare system is like a furnace that is just about good enough to heat the house at zero degrees. When you go below zero, it doesn't work. Every winter, during flu season in Ontario, it was like the temperature went down to minus five degrees. The healthcare system would struggle, and we would have to resort to hallway medicine. Now we're in the middle of the COVID-19 pandemic, and the temperature is at minus 20 degrees. The healthcare system just can't cope. Some people would say it is working so hard that it could actually explode. People are getting ill, frontline healthcare workers are getting ill, everyone is burning out and things are just not working as well as they should. That's the problem with austerity. In the UK, between 2012 and 2018, they calculated that 120,000 to 130,000 people died from preventable causes because of austerity. That's what happens. The system stops working and capacity is never dealt with. In Ontario, we have austerity policies. People can call it what they want, but Ontario spends the second least per capita on health out of any province, and with healthcare, you get what you pay for.

**UTMJ:** Recently, you tweeted that the "APA's Apology to Black, Indigenous and People of Color for Its Support of Structural Racism in Psychiatry" is a "first step" before seeing "how they improve what they do, how their system works, and clinical practice". What do you think needs to happen in order to avoid platitudes and move beyond this first step?

**KM:** You're always happy when you see that people acknowledge that they've done something wrong. But, if somebody steals your wallet and says, "Sorry, I've stolen your wallet" but doesn't give it back, then you're not happy. Just saying "sorry" isn't good enough. They [the APA] have had a planning committee in place since May or June 2020. I'd be very interested to see what they come up with. I've been working with other people on chapters of the DSM-V [Diagnostic Statistical Manual – Fifth Edition], which is produced by the American Psychiatric Association, with the goal of making the approach to diagnosis of mental health disorders more culturally appropriate. So that's one thing that will make diagnosis work better. I'd be interested to see what they do to make treatments work better, which would mean that research would have to be more equitable and would have to properly include Black patients. I'd also be very interested to know how they get Black staff at all levels of power in organizations like the APA to make decisions and rules. I'd be very interested to know how they're going to protect Black prisoners, because that is a particularly important issue. Finally, I'd be very interested to know how they make access to mental health services more equitable

in the United States, so that they have culturally capable practitioners along with interventions that are equitable. They [the APA] need to acknowledge that we require a system that allows people to access care when they need it, which is linked to the social determinants of health. That means there needs to be services like housing and income supports. They [the APA] need to think of how they can use their muscle to produce benefit systems so that people who can't work don't live in poverty. So, they must examine their own house. They have to measure how people are trained, to discipline people who are injuring Black and Indigenous populations, and to hold providers accountable for offering equitable care. Finally, if they say that they're guilty of supporting systemic anti-Black racism, then they must understand that the system is wider than the APA. Closing their eyes to that is to be part of the problem. So, let's see how far they go. But overall, they have to go further, as does the Canadian Psychiatric Association. It's easy to point to the American Psychiatric Association because they decided that they were going to release a statement on Martin Luther King Jr. Day. The Canadian Psychiatric Association will also say that anti-Black racism is wrong, but I haven't seen the same ownership of the problem. Ownership of the problem and action to make the proper reparations is what we should be doing in Canada, as well as in the USA.

**UTMJ:** COVID-19 has given health professionals a unique opportunity and platform to speak out about gaps in the healthcare system to an audience who might not otherwise be listening. As an advocate, policy advisor, and clinician, how do you think health professionals can take advantage of their amplified voices in this unique time to drive lasting change in the healthcare system?

**KM:** Well, I don't actually consider myself an advocate. I'm a researcher. And what I do is knowledge translation to try and leave a policy change. I produce facts that inform evidence-based policy, which produces ammunition for other people to advocate. I'm really about producing change through developing alliances. The difference in COVID-19 is that governments, at the moment, are listening to facts and listening to researchers. One of the most important things that we can do is to make hay while the sun shines. There are a number of strategies in place right now, like safety and demographic data collection, to direct prioritization of services. We've been breaking down silos so that the hospitals are getting into the communities. The message is not to question whether it is "your job" or "my job", but instead to say, "let's just get the job done". We've been thinking about increasing the reach of health services so that we don't have hallway medicine and all the other deficiencies that we've had previously. I think that having gone through COVID-19, and everybody seeing what a mess Ontario is in, we realize the need for a more organized system. Physicians need to be thinking about how we take our places, as system thinkers and leaders, to help build back better. I don't think that's an individual responsibility. We've all got to do our bit, but I think we've got to organize together because 10% of all provincial tax money goes to physicians. The only way we make things better is if all physicians are on board. We've got this huge lever of power (we've always had a big lever) but we often use it for ourselves, rather than using it systematically for the good of patients and populations. I think we all need to wake up to that fact. COVID-19 has made it much clearer that we have a social responsibility to build back better. We have to be thinking at a systems level if we want to improve the health of the population, and if we don't do it, no one else will. We need to take action. We need better primary health care, because it makes everything else better. We need better housing and income supports, because that's not only fair, it's also healthy. We need to decrease stress because it's healthy and good for the economy. We know all this because we're doctors. We need to use our voice to be clear that being healthy is fundamental for our economy. It's fundamental for the population. We are just one of many groups that are guardians of health, but we have the luxury of a lot more money and a lot more political power than anybody else. We should use that responsibility to be public servants and drivers of positive change.

**UTMJ:** What general advice do you have for healthcare professionals in training (such as medical students, nursing students, and pharmacy students) in light of this pandemic?

**KM:** My basic advice is to have fun and do your job well. I'm an old geezer with my way of doing things, but by the time the next generation is in power, the world will have changed. From my perspective, medicine is obviously the best profession in the world. But it's a privileged position that gives everybody a good wage and income. That wage and income is much better if you're doing good, not just for yourself, but for other people. So, go out there and do good, keep organized, keep safe, keep innovating, and keep on pushing forward. As human beings, we're on this journey to make things better. That's what we do. That's how we moved from caves to the moon, right? So, stay with that game. The game is social development and producing a healthier, more caring society. Stick with it, do not get cynical, and good things will happen. That's just my perspective. It has been good enough for me and I hope it will be good enough for other people. At the end of the day, everybody's got to live their life and find their way of doing things. Somebody may come along and tell you how to live your life. Don't listen to them. Listen to yourself.