

Mental Health of Ottawa's Black Community



REPORT 2020

ACKNOWLEDGEMENTS

Ottawa Public Health respectfully acknowledges that we are located on the traditional, unceded territory of the Algonquin people. We extend this respect to all First Nations, Inuit and Métis peoples, their ancestors, their Elders and their valuable past and present contributions to this land.

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The content and the recommendations in this report represent the ideas and feedback received from the research participants in the Mental Health of Ottawa Black community research study and consultations with community leaders.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	5
Background	5
Study Objectives and Methodology.....	6
Key Findings	7
1. Beliefs and Perceptions of Mental Health.....	7
2. Protective and Risk Factors	8
3. Access to Services.....	9
4. Interactions with Mental Health Care Providers.....	10
SOCIODEMOGRAPHIC PROFILE OF STUDY PARTICIPANTS	11
DETAILED FINDINGS	12
1. Beliefs and Perceptions of Mental Health.....	12
Knowledge of Mental Health	12
Mental Health and Mental Illness: Meaning and Associations	12
Stigma and Barriers to Disclosure of Mental Illness	14
Beliefs and Attitudes about Mental Health	16
Perceived Causes of Mental Illness.....	17
Summary.....	17
2. Protective and Risk Factors	18
Self-Rated Mental Health.....	18
Taking Care of One’s Mental Health	18
Summary.....	23
3. Access to Services.....	24
Facilitators to Access	24
Barriers to Access.....	25
Summary.....	30
4. Interactions with Mental Health Care Providers.....	31
Satisfaction with Mental Health Services	31
Assessment of Provider Competencies and Attitudes	32
Summary.....	37
DISCUSSION AND RECOMMENDATIONS	38
Discussion.....	38
Recommendations	39
APPENDICES	43
APPENDIX 1: METHODOLOGY	44
APPENDIX 2: RESEARCH INSTRUMENTS.....	54
APPENDIX 3: QUANTITATIVE SURVEY TABLES	68
APPENDIX 4: GLOSSARY OF TERMS.....	76

APPENDIX 5: ANTI-RACISM AND CULTURAL SAFETY TRAINING RESOURCES	78
APPENDIX 6: REFERENCES.....	79

EXECUTIVE SUMMARY

There is a lack of representation in the current data on the perceptions, experiences and needs of Ottawa's African, Caribbean and Black (ACB) community in accessing mental health services. This study was designed to address gaps in understanding of the barriers to access, which are both structural and systemic in nature. While the ACB participants who have interacted with mental health services and providers are mostly satisfied, there are a number of significant issues and obstacles which prevent others in the community from obtaining appropriate care. Ongoing stigma, rooted in cultural sensitivities as well as racism and discrimination, are a critical risk factors. Participants who are financially stressed face additional obstacles. Study respondents identified employment and financial security, as well as the ability to receive mental health services from a provider who has a similar cultural and racial identity as the two most important factors which would facilitate improved access. Moreover, developing cultural competence within the mental health provider community is vital to building a trusting relationship between the client and the provider, and to addressing known biases which affect proper diagnosis and treatment plans. Related to this, there is a clear need for a more diverse and inclusive mental health workforce, one that better reflects and represents members of the ACB community.

Background

Black Canadians make up 3.5% of Canada's total population and 15% of the population defined as visible minorities (Census, 2016). They are culturally and linguistically diverse and include both Canadian citizens who immigrated from 125 countries and Canadian-born citizens with roots going back 400 years. The Black community has made significant contributions to Canadian politics, heritage, and the economy. However, as a result of racially discriminatory policies and practices, Black Canadians have not had equal access to social, economic, political, and cultural resources that directly and indirectly impact their health.

Racialization refers to the social process whereby certain groups come to be designated as different and consequently subjected to differential and unequal treatment (Galabuzi, 2004; 2006). The term 'racialized' acknowledges race as a social construct and recognizes that the barriers some people face

are rooted in racial prejudices. It is estimated that by 2031 over one-third (36%) of Ottawa's population will identify as racialized, with fully 29% having been born outside of Canada (Statistics Canada, 2011). Ottawa's Black community comprises the largest proportion of racialized groups in the City with more than 60,000 residents (Census, 2016).

Following the release in 2018 of the report on the Status of Mental Health in Ottawa, Ottawa's African, Caribbean and Black (ACB) community expressed concerns that the experience of their community, specifically within the local context, was not directly reflected in the findings or the data. The community highlighted the paucity of race-based data and pointed to the need for additional primary research to identify gaps and strategies and inform a community-led approach in driving interventions for more effective mental health delivery.

The research reported on here examines ACB research participants' views of mental health; how those views help or hinder the development of positive mental health; various risk and protective factors; and participants experiences accessing mental health services. Findings from this study will support the development of community-based strategies to effectively link the ACB community to quality mental health services and improve experiences for this community.

For the purpose of this report, the terms "African, Caribbean & Black (ACB)" and "Black" are used interchangeably.

Study Objectives and Methodology

The study was designed to address an expansive question about the experiences of people in Ottawa's ACB community in relation to mental health and the mental health care system. More specifically, the key objectives of this research were to:

- Assess the views and experiences of Ottawa's ACB community with respect to mental health as well as their interactions with mental health services in the City;
- Identify significant gaps and strategies to improve mental health services for ACB populations; and
- Advocate for better mental health services and supports for the ACB population.

Four pre-study consultation sessions were held with the ACB community leaders which guided the qualitative and quantitative questionnaires. A mixed method study was designed, including both quantitative and qualitative components. A total of 130 people from Ottawa's ACB community participated in the research study: 100 completed a survey which was either self-administered or interviewer-led, and an additional 30 participated in a face-to-face interview conducted by Ottawa Public Health. Another four community consultation sessions with the same community leaders were held following analysis of data to share preliminary findings and review draft recommendations. All

study participants were recruited at events and institutions, across the City, that are typically well-attended by people in the ACB community.

The interviews and surveys were structured to include questions under four broad themes:

- Beliefs and perceptions of mental health;
- Protective and risk factors;
- Access to mental health services; and
- Interaction with mental health care providers.

The findings are organized in alignment with the above-noted themes. The decision was made to integrate findings from the quantitative and qualitative research because the insights drawn from the one-on-one interviews provided helpful context to the survey results.

Key Findings

The following are the main highlights drawn from both the results of the face-to-face interviews and the survey conducted among a sample of people from Ottawa's ACB community.

1. Beliefs and Perceptions of Mental Health

When research participants were asked to rate their own knowledge about mental health, most (59%) stated they were knowledgeable about mental health.

Study participants viewed mental health as a psychological state and an ability to cope with life's daily stressors and challenges. However, when thinking about mental health, the most common descriptors were negative. Many (74%) said they feel worried or sad when they hear that someone has a mental illness.

Responses to the survey and comments by participants on experiences they have had or have heard about underscore the degree to which stigma and fear are strongly associated with mental illness. A full two-thirds (66%) agreed that most people think less of a person who has a mental illness. Furthermore, a large proportion (40%) also agreed that taking treatment for a mental health problem is a sign of personal failure. Participants expressed concerns about feeling judged and this presented a clear barrier to sharing with other members in the community or to seeking professional assistance. Cultural sensitivities and religious beliefs also play a role in perceptions about mental health, although some participants noted encouraging signs within the ACB community in the way it is approaching the subject of mental health and starting to speak about the topic more openly.

“When you tell people that you have a mental illness, there is a stigma associated with that and that would stop me from sharing. I’d rather keep it to myself.” (Female, 30-39)

The vast majority of participants (91%) attribute the cause of mental illness to difficult experiences and environmental stressors. Many (69%) also believe that genetics play a part. Of note, a small but still significant proportion of participants (25%) say that mental illness is caused by a curse or is a punishment for wrongdoing.

2. Protective and Risk Factors

Protective factors are important to maintain good mental health while risk factors may increase the likelihood of adverse mental health outcomes. Participants identified a wide array of individual, family, community and societal factors that influenced mental health.

Protective Factors	Risk Factors
Employment and financial security Secure housing Support from immediate family Feeling represented in the community A sense of belonging and positive surroundings Access to social services Faith and spirituality Access to culturally sensitive mental health services Supportive health care providers, one with whom the client identifies Self-care	Financial instability Absence of upward mobility Stigma Service providers not understanding the needs Service inequities Trauma Daily microaggressions Witnessing violence in the community Police brutality Experiencing injustice Always living in survival mode Addiction Physical illness

Study participants rated their mental health as ‘somewhat good or excellent’ similarly to a population-based sample of Ottawa residents from another survey – Statistics Canada’s Canadian Community Health Survey (CCHS) (Ottawa Public Health, 2019) (72% and 67%, respectively). They also report similar feelings of being ‘extremely’ or ‘very stressed’ on most days that are in line with the general population in Ottawa as measured in the CCHS (23% and 25%, respectively) (Ottawa Public Health, 2019).

Employment and financial security were identified as the most critical protective factors and were seen as directly enhancing their ability to access mental health resources. Beyond this, participants commented on many other factors or strategies they employ to maintain or reinforce positive mental health, including relying on or practicing their faith and spirituality, as well as self-care which manifests itself in various ways such as sleep, exercise, and healthy eating. Social connectedness was viewed as key to managing and caring for one’s health. Notably, close to nine-in-ten survey respondents (87%) said they felt ‘very strongly, strongly or somewhat connected’ to their community.

By contrast, an overwhelming number of participants referred to discrimination and daily experiences of micro-aggression as major risk factors to good mental health. Survey results show that almost half (48%) have experienced some prejudice or unfair treatment in the past 12 months, in some aspect of their lives.

“In Ottawa and Canada, one of the things that is really hard for me is racism and oppression. It’s so difficult to see people consistently striving and working and just feeling like we can’t get ahead because of the system. It is really overwhelming and that creates a lot of hopelessness which is one of the signs of depression.” (Male, 50-59)

A lack of gainful employment and financial instability were also listed among the top-ranked risk factors.

3. Access to Services

Sufficient access to adequate services is critical to meet health needs and prevent adverse health outcomes. Participants identified factors that facilitated and acted as barriers to the use of mental health services.

Facilitators	Barriers
Employment	Lack of shared identity
Similar cultural and racial identity	Unemployment
Spirituality	Discrimination and racism
Social connectedness	Lack of knowledge of resources
	Lack of cultural competency
	Language difficulty
	Long wait list
	Lack of trust in providers
	Financial instability

Just over one-third (35%) of those who completed the survey had tried to access mental health services, either for themselves or on behalf of someone else. Study participants suggested a series of facilitators and barriers to accessing mental health services which, in many respects, mirror the protective and risk factors which were identified.

In order of the frequency by which they were identified, the factors that were viewed as facilitating access to mental health service by those who had attempted to access these services included: being able to access a provider who understands one’s needs (74%), having culturally sensitive staff (71%), providing affordable services (71%), ensuring easy access (59%), proximity to services (35%) and being able to access a provider who can speak the same language (32%).

Perceived barriers centered on costs (66%), the provider not understanding one’s needs (57%), and long wait times (49%). Inconvenient locations (34%) and/or a language barrier (17%) were mentioned with less frequency. Timely access is a particularly relevant issue for some of the study participants in

Ottawa's ACB community. ACB people often face long wait lists as providers with similar cultural or racial backgrounds are under-represented in the system. Moreover, these wait times can exacerbate the situation and symptoms, sometimes with unfavourable outcomes.

The lack of affordable, accessible and culturally competent providers within the healthcare workforce is a real issue given how most ACB study participants said they would likely access mental health services – primarily in a hospital setting (55%) or a community health centre (50%). It is worth noting that the sample was mostly recruited from community health centres, which likely has some influence on this response.

4. Interactions with Mental Health Care Providers

Client-provider interactions in mental health is a critical factor in care delivery. The majority (56%) rated the service they received from a provider as either 'fair,' 'poor,' or 'very poor.' Just over one-in-five (16%) said the service was 'excellent' or 'very good,' while another one-quarter (25%) rated the service as 'good.' Interviews showed that those who reported not being satisfied with their interactions with service providers cited issues such as a poor provider attitude, lack of cultural competency, racism and discrimination, and systemic issues (i.e., clinic setup and location).

While most study participants said they were generally treated respectfully by service providers, comments about instances in which participants encountered providers whom they felt were dismissive and disrespectful were also shared with interviewers. These participants felt rushed through an appointment which is a critical issue when it comes to ensuring that clients leave with a clear understanding of the instructions and explanations being given by providers.

Nearly 30% of those who tried to access mental health services said they felt prejudice or a negative attitude towards them from their service providers, because of their dismissive behaviour (63%), comments that were made (44%), a general sense of feeling unwelcome (38%), or feeling as if they had been prejudged or that certain assumptions had been made about them (38%).

SOCIODEMOGRAPHIC PROFILE OF STUDY PARTICIPANTS

A total of 130 people from Ottawa's ACB community participated in this study. This includes 100 participants who completed a survey and 30 people who participated in one-on-one interviews.

Of the 130 respondents:

- 87% were between the ages of 16 and 39
- Just over half were women (54%), men comprise 43%, and 1% identified as non-binary
- 34% were born in Canada, while 64% were born outside of Canada
- 76% identified as heterosexual/straight, 8% as asexual, 3% as gay, 1% as queer, and 1% as pansexual

Other descriptive characteristics are identified in the profile to the right and in Appendix 3.

Demographic Characteristics of the Sample (N = 130)



01 ETHNO-RACIAL IDENTITY

Black African	81%
Black Canadian	27%
Black Caribbean	6%
Black American	1%
Other	2%

02 AGE

16 – 19	36%
20 – 29	26%
30 – 39	26%
40 – 49	5%
50 – 59	6%
60 – 69	2%

03 LANGUAGE

English only	75%
French only	2%
Both	23%
None	1%

OTHER LANGUAGES

Somali	39%
Swahili	5%
Arabic	4%
Creole	2%
Amharic	1%

04 GENDER IDENTITY

Male	44%
Female	54%
Non-Binary	1%

05 SEXUAL ORIENTATION

Heterosexual/Straight	76%
Asexual	8%
Gay	3%
Queer	1%
Pansexual	1%
Other	1%

06 RELATIONSHIP STATUS

Single	64%
Married	26%
Steady Partner (Living Together)	3%
Steady Partner (Not Living Together)	2%
Separated/Divorced	2%

07 BORN IN CANADA

Yes	34%
No	64%

08 RELIGION/FAITH

Muslim	49%
Christian	44%
African Traditional	1%
Other	1%

09 HOUSING

Lives with Family	38%
Rented Home/Apartment	35%
Owned Home/Condo	20%
Supportive Housing	2%
Boarding Home	1%

10 EDUCATION

High School or less	40%
College, CEGEP, Vocational School, Trade School, Apprenticeship Training	6%
University	53%

12 INCOME

\$0-\$29,999	22%
\$30,000-\$59,999	21%
\$60,000-\$89,999	10%
\$90,000-\$119,999	4%
\$120,000-\$149,999	4%
\$150,000 or more	7%

11 EMPLOYMENT

Employed or Self-Employed, Full Time	50%
Employed or Self-Employed, Part Time	24%
Full or Part Time Student	15%
Volunteer	12%
Unemployed & Looking for Work	9%
Not working due to disabilities	3%
Looking after children or other family members	1%
Retired	1%

* Numbers may not add to 100% as some respondents preferred not to answer.

DETAILED FINDINGS

A more detailed analysis of the study findings is provided in the sections that follow. Findings have been organized under the four main thematic headings: Beliefs and perceptions of mental health, protective and risk factors, access to services, and interactions with mental health care providers. An integrated approach to reporting has been taken, such that relevant findings from both the one-on-one interviews and the survey are reported together in order to provide a full picture of the views of study participants and highlight key responses which emerged, by topic.

Each of the four main sections integrate findings from the quantitative and qualitative research because the insights drawn from the one-on-one interviews provided helpful context to the survey results.

1. Beliefs and Perceptions of Mental Health

Mental health is defined as “a state of well-being in which an individual recognizes one’s own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to the community” (WHO, 2004). This definition implies that well-being goes beyond the absence of a mental illness. Good mental health allows one to fulfil several key life functions and activities, including, fundamentally, the ability to enjoy life, while also dealing with its inherent challenges and problems. By contrast, mental illness is a diagnosable illness characterized by a disturbance in thought and emotion, that often is accompanied by a decreased capacity to cope. Although mental health and mental illness differ, both occur on a continuum where a person can have either optimal or poor mental health, with or without mental illness.

Knowledge of Mental Health

Most survey respondents indicated that they were somewhat informed about mental health issues. When asked to rate themselves on a question using a 5-point scale, with response options ranging from ‘not knowledgeable at all’ to ‘very knowledgeable’, most survey participants indicated at least some level of knowledge. The majority (59%) said that they were ‘knowledgeable’ (45%) or ‘very knowledgeable’ (15%) about mental health-related issues. Of the remainder, almost one-in-three (30%) rated their knowledge level as ‘neutral,’ while fewer than one-in-ten (7%) indicated they were ‘not knowledgeable.’

Beyond this general self-assessment, the survey did not include a more formal evaluation of respondents’ level of understanding of mental health.

Mental Health and Mental Illness: Meaning and Associations

When asked what mental health means to them, interview participants responded in terms of an individual’s psychological state and an ability to cope with daily challenges. Some referred to concepts

such as psychological balance and emotional health, or focused on general wellbeing (i.e., “something that affects the mental wellbeing”).

“I see mental health as a stage where one is psychologically balanced and can apply their cognitive ability.” (Female, 40-49)

In some cases, participants defined mental health in terms of coping skills or an ability to manage stress, think critically and responds to crises.

“It means a person’s ability to function or mentally cope with day to day activities. The way they respond to crisis.” (Female, 50-59)

“The capacity to think critically and to think responsibly for oneself can influence your state of mind.” (Female, 30-39)

“It means physical health to me; in that you are taking time to feel good in your own body and feeling comfortable carrying out your daily tasks.” (Female, 30-39)

There was a strong connection between mental health and physical health. Some participants believed that mental illness should be seen and treated much the same as any other physical illness. In fact, participants recognized that physical health significantly impacts on mental health. And, as with physical health, there were mental health effects associated with emotional and physical wellbeing.

It was notable that several participants viewed mental health from a negative rather than from a positive perspective. Several participants spoke about mental health in the context of “something not working properly in your head,” inferring that affected individuals operate in a confused state. Some participants further described people living with mental illness as being on a spectrum, finding decision-making difficult, and affecting their behavioural patterns.

Similarly, when asked what comes to mind when you hear that someone has a mental illness, interview participants shared mostly negative responses. Persons with mental health issues were regarded as someone “who is suffering” or “who is crazy.” Other participants made references to personal weakness and fear. Approximately three-quarters (74%) of survey participants reported that when they hear someone has a mental illness, what comes to mind is ‘worried or sad,’ while just over one-third (36%) reported ‘hopeful,’ and another quarter (26%) reported ‘fear.’ These results did not vary significantly among participants who assessed themselves as being knowledgeable (either ‘knowledgeable’ or ‘very knowledgeable’) about mental health issues.

Associations with Mental Illness

Many participants associated mental illness with a formal diagnosis. When asked about someone living with a mental illness, a commonly held impression is that this individual must be undergoing therapy, be medicated, and is not able to function properly in society without medication. It was evident from the interviews that participants lacked an understanding of the continuum of mental health and mental illness, including their beliefs about mental health and their perceptions of those living with a mental illness such as depression, anxiety or schizophrenia.

“Typically, what comes to mind is that they have something like a diagnosed condition, like depression.” (Female, 20-29)

“What mental health means to me is when someone is limited in achieving their full potential because of illness” and “it could include all of the clinical issues like anxiety disorder and schizophrenia.” (Female, 30-39)

Stigma and Barriers to Disclosure of Mental Illness

The presence of stigma associated with mental illness was identified by both interview and survey participants.

Survey respondents were asked to respond to four questions/statements aimed at assessing the extent to which they feel there continues to be stigma around mental illness. The findings suggest that, although public stigma is viewed as fairly widespread, a significant proportion of respondents expressed some degree of self-stigma. Results were as follows:

- Two-thirds (66%) agreed that *most people think less of a person who has a mental health problem*. Fewer than one-in-five (18%) disagreed, and another 12% neither agreed nor disagreed with this statement.
- While almost half (48%) disagreed that *most people think that taking treatment for a mental health problem is a sign of personal failure*, about two-in-five (40%) concurred with this statement, including just over one-in-ten (13%) who ‘strongly agreed.’ A small percentage of participants (9%) neither agreed nor disagreed.
- Although most (72%) would feel comfortable, *sharing with family or friends if they needed help with their mental health*, about one-quarter (27%) of participants indicated that they would not. The degree of comfort in sharing with family or friends does not vary markedly even among those who said they were ‘very/somewhat strongly’ connected to their community (76% said they would be comfortable; 24% would not).
- Among those who said they were ‘somewhat/not at all comfortable’ sharing with their family or friends if they needed help with their mental health, the reasons given (in order of frequency) as

to what would prevent them from sharing their concerns and situation with family or friends were as follows: 46% 'don't want to be judged,' 33% 'don't want to appear weak,' 16% expressed a 'lack of trust,' and 10% cited 'fear' as a barrier to sharing.

The interviews offered additional insights. About half of all interview participants responded in the affirmative when asked whether they would be open to sharing with their family or friends if they needed help with their mental health. Some said they would be willing to share with their partner only, while others might reach out only to very close friends or family members. As one participant commented:

"Yes, I think in my generation, a lot of us are more open than our parents on these issues and we are trying to educate ourselves on how to improve our mental health by normalizing these conversations and not sweeping it under the rug." (Female, 20-29)

Stigma and fear were some of the barriers to talking openly regarding their mental health. Participants mentioned cultural sensitivities that precluded mental health conversations, including the community's stereotypical attitude towards men who report having mental health issues, in addition to parents who don't understand what it means to talk about mental health. On this latter point, more exploration of the extent to which knowledge levels, including sensitivities and misperceptions, impact willingness to discuss this subject is required.

Other barriers to more open discussions about mental health and mental illness included, fears of being judged, not wanting to worry or distress family and friends, and fear and uncertainty as to how others may react, or what they might say in response.

"When you tell people that you have a mental illness, there is a stigma associated with that, and that would stop me from sharing. I'd rather keep it to myself." (Female, 30-39)

"I have children and it really scares me to talk to them about some things going on in my head. I don't know how to do that." (Female, 40-49)

Some participants raised the issue of stigma in relation to mental health and mental illness. As a result, when these terms are linked to a particular individual there is a tendency to think less of that person or to be dismissive. For example, some felt that people may question: "What brought them to that state? What are they going through?" Or, they may conclude that "it must really be tough for them or they might not be strong enough to deal with life stresses." This perspective or position is thought to lead to further discrimination, leaving those affected feeling ostracized.

Participants also reflected on the wider impacts of mental illness, particularly on family members who are providing care for someone with a mental illness. The point was made that caregivers may themselves experience some negative effects within their community, including outcomes such as feelings of being judged, discriminated against, marginalization and possibly suicidal ideation. In this respect, the stigma around mental illness can be extensive and may also be deeply felt by those living with or caring for an individual with a mental illness.

Beliefs and Attitudes about Mental Health

Peoples' beliefs and attitudes about mental illness are shaped by a broad range of factors, including socioeconomic status (i.e., education and household income), immigration status/cultural beliefs, religion, personal and/or family influences, social norms, and the media.

Educational attainment and household income surfaced as key drivers of views and attitudes on mental health and mental illness among the ACB population who took part in this study. Interview participants stated that formal training and education had a generally positive influence on their mental health. For example, a health care worker who participated in an interview commented, based on her practice experience, that there is a strong correlation between household income, employment status and mental health. Specifically, she pointed out that those with poorer mental health were typically unemployed and living in households with lower incomes.

Of note, there was a marked difference between responses from participants who were born in Canada, and who had received some education in Canada or worked in social fields, compared to first generation immigrant participants. The former was more likely to acknowledge psychological problems and to be more attuned to their own mental health, while first generation immigrants seemed very aware of the stigma associated with mental health issues. Although both groups agreed that cultural context has a strong influence on their beliefs and attitudes towards mental health, first generation immigrants were more likely to adhere to those beliefs while the latter often secretly reached outside their community for mental health services. That said, an encouraging number of participants stated that they were noticing a cultural shift within their community in the way they are approaching the subject of mental health and that more people in their communities were beginning to speak openly about their experiences.

The influence of religion on attitudes and beliefs was also evident, as some participants suggested that an individual living with mental health issues might be “detached from purpose or disconnected from God.”

Family circumstances and personal factors, such as personal and lived experiences, coping mechanisms and the openness to having conversations about mental health within the family circle were also raised as having an influence on the beliefs and attitudes people have about mental illness.

Participants spoke about the role of social norms about mental health, particularly as perpetuated through mainstream media which was seen as propagating a “one size fits all” view of the issue. As one participant stated:

“I feel there is a dichotomy on how people with mental illness are portrayed in the media. Clearly, the Western society understands mental illness in one way and I sometimes find myself trying to adapt to the Western understanding of what it means. I think the focus should be shifted to a more holistic and Afrocentric understanding as well.” (Female, 30-39)

Perceived Causes of Mental Illness

Interview participants were asked to elaborate on what comes to mind when they hear that someone has a mental illness. Several key themes were identified, notably environmental stressors, disease and genetics.

While participants employed in the mental health field, or associated with a community health centre, expressed feelings of empathy for people living with mental health challenges, others commented that the term *disease* is what typically comes to mind.

As the discussion progressed, some participants cited genetic factors as a common cause of mental illness, acknowledging that those with a family history of mental illness may be genetically predisposed.

While over two-thirds (69%) of survey respondents cited genetics as a cause of mental illness, the vast majority (91%) reported that difficult experiences and environmental stressors were causal factors. Far fewer (25%), although still a notable proportion of respondents, reported that mental illness is brought on by a curse or is a punishment for wrongdoing. As noted earlier, this particular finding underscores the role of religion and cultural beliefs in shaping perceptions about the causes of mental illness and those afflicted by it. Of note, this perception was also held by a similar proportion (25%) of participants who indicated they were ‘knowledgeable’ about mental illness, although a slightly higher share of this group (80%) indicated that mental illness can be caused by genetics as compared to the total number of participants.

Summary

There is much variability in levels of knowledge and attitudes about mental health and mental illness within the ACB research participants. Overall, negative perceptions about mental health were prevalent and these were shaped by many factors including, levels of knowledge, cultural and religious beliefs. Stigma persists as a major barrier to the disclosure of mental health problems to others. On the positive

side, participants recognized that factors such as difficult life circumstance and stress, greatly contribute to mental illness, in addition to genetic factors.

2. Protective and Risk Factors

Many factors have been identified that contribute to mental well-being or diminish mental stability (CAMH, 2012).

The Public Health Agency of Canada's (PHAC) Positive Mental Health Surveillance Conceptual Framework provided an approach to measuring mental health outcomes and determinants (PHAC, 2020). Risk and protective factors were conceptualized along four domains, including individual, family, community and society, each of which has the effect of either increasing (protective factors) or decreasing (risk factors) the potential for an individual to be resilient (Barankin et al., 2007).

This section includes survey data related to self-rated mental health followed by interview data and survey data that explores protective and risk factors that influence the mental health of Ottawa's Black community.

Self-Rated Mental Health

Self-rated mental health is a measure of an individual's perception of their mental health status.

In 2017, more than two-thirds (68%) of Ottawa residents, aged 12 years and older, reported 'excellent' or 'very good' mental health, a finding which was similar to the rest of Ontario (67%)¹. By comparison, almost three-quarters (73%) of ACB study participants rated their mental health as 'excellent' (44%) or 'somewhat good' (29%), just under one-in-five (18%) rated their mental health as 'average' and relatively few (7%) rated their mental health as 'poor'. While ACB study participants rated their mental health much the same as others in Ottawa, their stated protective and risk factors create a very different scenario for the ACB community in terms of active management of their mental health.

Taking Care of One's Mental Health

Protective Factors

Participants identified a variety of protective factors that influenced their mental health in a positive way. These are captured below using the four domains identified by PHAC. The list shown below was generated by study participants.

Protective Factors

Individual	Family	Community	Society
Practicing self-care Finding balance in different aspects of your life Staying active Healthy eating Faith and spirituality provide peace and a sense of gratitude	Support from immediate family Close linkages to extended family	Arts and culture Sense of belonging Supportive work environment Talking to people who share similar identities Supportive health care provider who I can identify with	Feeling represented in the community Safe adequate housing Access to food and necessities Secure employment Access to social services Access to culturally sensitive services Positive surroundings Positive work environment Fair treatment

Employment and financial security were the most important protective factors. These factors were directly associated with enhanced access to resources and greater protection from risk. Participants who are able to secure employment could make positive choices to improve their mental health, including having a safe living environment and access to food and other necessities.

The second most commonly cited protective factor was self-care, which manifests in various ways, utilizing different techniques. Specifically, interview participants reported having a positive life balance, finding ways to psychologically care for oneself, exercising and healthy eating were beneficial to their mental health.

“I also know that my own self talk is really something that increases my positive mental health.” (Male, 30-39)

A number of participants mentioned other self-care practices such as establishing and keeping boundaries, maintaining a reasonable work-life balance, understanding and trying to be gentle and compassionate with oneself, going on retreats and journaling. Mindfulness practices and staying in tune with one’s mood, having regular internal checks, as well as knowing and avoiding certain triggers were some of the self-care measures participants undertook.

Some participants focussed on their physical health, including maintaining a healthy diet, practicing good sleep hygiene, specifically getting enough sleep/rest, exercising and/or going to the gym, practicing yoga and playing sports in order to care for their mental health.

“I feel mentally better on exercise and when I'm more active and when I'm more engaged in things when I'm moving and learning new things.” (Female, 30-39)

Others engaged in hobbies such as reading or watching television, music, singing, and traveling. As a general practice, finding distractions from everyday life was viewed as a helpful way to care for one's mental health.

Third, social connectedness was cited as key factor in managing and caring for one's mental health. Specifically, reaching out to family, friends and the broader community, being surrounded by understanding and non-judgemental people and staying connected to others were identified. A sense of belonging within the community is one measure of social well-being, which is strongly related to positive mental health and physical health outcomes. Sense of community belonging reflects an individual's social attachments, and their level of social engagement and participation in the community.

Among survey respondents from Ottawa's ACB community, close to nine-in-ten (87%) said they felt 'very strongly,' (15%) 'strongly,' (33%) or 'somewhat connected' (40%) to others in their community. A relatively small percentage (8%) described themselves as being 'not at all connected.' This compared with about two-thirds (67%) of Ottawa residents, overall, who reported feeling a sense of belonging to their local community in 2017, similar to the rest of Ontario (68%).

Interview participants expressed appreciation in knowing that they had a support system they could rely on if they were struggling and mentioned that belonging to a community was beneficial to their mental health. For Ottawa's Black community, having a sense of belonging and social connectedness was a critical component to accessing services, and their families and communities were a source of support in encouraging help-seeking behaviors. It is the idea or belief by some that their families and community may not understand their condition that causes feelings of isolation, stress and turmoil.

*"The narrative that there is a stigma within the community is actually highly detrimental to healing I think it would have been easier if I had known that my community was going to be so supportive."
(Female, 30-39)*

Spirituality, such as praying or meditating, was identified among the most important strategies to maintaining good mental health. Faith and spirituality provide a sense of peace, gratitude and connection, particularly when worshiping with other members of the community. Many participants stated that spirituality is an important aspect of their daily lives. Places of worship such as a mosque or a church provided them with the opportunity for peer support. Spiritual counsellors, with similar values and belief systems, provide guidance and counselling services that meet their needs. Participants stated feeling much more comfortable connecting with others from their community who share a similar faith. This provided an opportunity to meditate and pray as a way of coping with stressful life situations.

Other ways in which participants care for their mental health included seeking professional assistance or medical treatment such as counselling, and therapy. Access to social services, culturally competent services, and positive surroundings in general, were also reported as having positive impacts on mental health. The use of prescription medications and recreational use of substances, such as smoking,

offered some benefit for a few other participants. For example, one participant stated that she takes her antidepressant medications and that helps her feel better. Several participants mentioned they use alcohol, smoking or vaping as a coping mechanism to stay calm after experiencing a traumatic event or a period of stress, and they find themselves reverting to these habits to sustain their positive mental health. Another participant volunteered that the use of anti-depressant medications ‘helps me feel better.’

Risk Factors:

Participants identified a variety of risk factors that influenced their mental health in a negative way. Factors such as unemployment/poverty, discrimination and anti-Black racism, stress, and lack of access to resources ranks as the most cited by participants. These are captured below using the four identified domains.

Risk Factors

Individual	Family	Community	Society
Addiction Lack of knowledge Stress Feeling depression Biases towards mental health Physical illness Burnout and trauma as a response to injustices Feeling shame Always in survival mode Feeling overwhelmed	Unsupportive families due to competing priorities	Social stress Lack of belonging Negative surroundings Witnessing violence Negative school and work environment Social media Bullying Lack of support Judgemental communities	Unemployment and financial instability Low income Systemic oppression Discrimination and daily experiences of micro-aggression Police brutality and racism Service inequities Lack of access to resources Cultural incompetency Immigration Status Stigma

As noted in the above section, gainful employment and financial stability ranked highly as protective factors, critical in terms of maintaining positive mental health. As such, unemployment and financial insecurity were viewed as major risk factors. The comments below very clearly underscore the variability in access to mental health benefits, depending on one’s employment situation, and the resulting impact.

“I’ve looked at how to get covered for mental health services, but it took me a lot of time to figure this out. I reached out to the company to know what I was covered for and found out I wasn’t covered for any visit to the psychologist or psychotherapist; which means I will have to pay out-of-pocket for that even though the services were limited. I could not afford that” (GenderQueer, 20-29)

“I think I feel privileged enough to have a dedicated therapist from my work benefits. I try to visit twice every month and I learn a lot

about what to do and how to better manage my mental health”
(Female, 30-39)

Second, relative to employment and income, an overwhelming number of participants identified discrimination and daily experiences of micro-aggression as major risk factors for mental health. Some participants shared stories which illuminate the nature and impact of micro-aggression which can occur day-to-day for ACB people. For example, how non-racialized women, while walking by them, will clutch hard onto their purses or prefer to stand on public transit rather than take a seat beside a Black male.

Discrimination was associated with a lack of opportunity for advancement in society. As highlighted in the comment made by one participant shown below, the ACB community can face systemic discrimination in the workplace, and mental health is a lesser priority when the focus is on more urgent subsistence issues.

“It's not that mental health is not being prioritized but it's that we still face such high rates of employment discrimination. We're worrying about how we're going to put food on the table a lot of the time or how or where or when our contract is going to end that when you're thinking about mental health that's a luxury for some people to think about to be very honest.” (Female, 40-49)

Results from the survey indicated that almost half (48%) of ACB study participants experienced prejudice or unfair treatment in the past 12 months, in some aspect of their life. Data shows that the prevalence of having experienced any type of discrimination in the past five years in Canada was 15.3% (Du Mont et al, 2012).

Participants also understood how the trauma of witnessing violence, police brutality and many forms of systemic injustices impacted directly and continually on their mental health. As a result of both past and present experiences of injustice and trauma, feelings of being overwhelmed and hopelessness persist.

“It think that's why most of us are dealing with some type of symptom of mental illness just because of being in survival mode and constantly having to fight every day just to get basic necessities met has a really dramatic impact on the mental wellness of immigrants” (Male, 50-59)

A third risk factor associated with mental health was social stress, specifically the stressors associated with one's immediate social environment. Social stressors spanned the workplace, school (e.g., bullying, peer pressure), social media, and sense of belonging. For example, participants identified stressors including personal/family situations, daily microaggressions and discrimination from societal stressors, living in households where discussions on mental health was 'taboo', and lack of easy access to resources in the community.

Survey participants were asked how they would rate their stress level of most days. Most (75%) are at least somewhat stressed, including about one-quarter (23%) who say they are either 'extremely' (3%) or 'quite a bit stressed' (20%) daily. These stress levels were consistent among those who rated their own mental health as 'excellent/somewhat good.' Only 18% of participants reported they were 'not at all stressed, compared to 23% among Ottawa residents.

Even though there are many benefits to social media, several participants identified its negative impacts in terms of depression, anger, anxiety and feelings of isolation. For example, the rampant reports on social media about the protests on police brutality and anti-Black racism negatively affect the community over time.

Fourth, participants identified the lack of access to mental health resources as a risk factor for mental health. Lack of access included service inequities, specifically not having equal access to resources as well as access to culturally competent services.

"It's not only about access but it's about what it looks like when you get that access." (Female, 30-39)

Other risk factors identified by participants included community level factors such as mental health stigma and violence, family factors and individual factors such as pre-existing mental health issues and drug and alcohol addiction.

Summary

Multi-level and intersecting factors protect or expose people within the ACB community to risk, in terms of their mental health status. The most frequently reported protective factors were employment and income security, self-care, strong social support and connections from family and community, representation - having personnel in leadership and decision-making positions at workplaces and service delivery centres reflect the community demographic, spirituality and access to appropriate mental health resources.

While most participants self-assessed their mental health as either 'excellent' or 'good', fully three-quarters reported that they felt 'somewhat', 'a bit' or 'extremely' stressed on most days. This may be explained in terms of the multiple and intersecting risk factors identified by participants at individual,

family, community and societal levels (e.g., violence, financial instability, systemic injustices and racism).

3. Access to Services

Access to formal and informal mental health services is important for mental health and well-being. This section explores Ottawa's ACB research participants' use of mental health services and factors (e.g. predisposing, enabling, and need) associated with service use.

Factors such as education, income and race affect the need for and access to mental health services. It can be extremely challenging to access services when clients are met with additional systemic and structural barriers such as language, culture, socio-economic status, racism and discrimination. Therefore, Ottawa's ACB community often relies on its own resources to cope with mental health challenges.

Facilitators to Access

Interview participants were asked about what facilitated access to mental health services.

Several interview participants identified secure employment as a major facilitator to mental health services. Meaningful employment not only contributed to good mental health, it provided options for those experiencing poor mental health or mental illness. For example, participants who were employed full-time reported that they were more aware of available services, they had access to confidential mental health services through their employee assistance programs, and they were better able to advocate for themselves and for family members.

Other interview participants reported that they were able to access private mental health services covered by their insurance. For others, mental health services were covered through a post-secondary educational institution and/or through their gym membership.

“Having the financial burden greatly reduced by permanent employment with benefits was very helpful. I have no idea what people who don't have the type of work that I have do when they need to access mental health services.” (Female, 40-49)

A second important factor cited was being able to access a provider with a similar cultural and racial identity. Participants reported that it was extremely important to have access to a provider with shared-identities and who look like them, that will better understand their experiences of being Black in Canada. As described by one participant, the exchange between provider and client was viewed as being much more fluid when the provider's physical representation, values, and beliefs matched the client's needs.

“If I was sitting in front of another person of African and Caribbean descent, you know there's some things that I would say and either they know when to take it seriously or not and they know when to laugh about it or not. It makes it a lot easier.” (Male, 20-29)

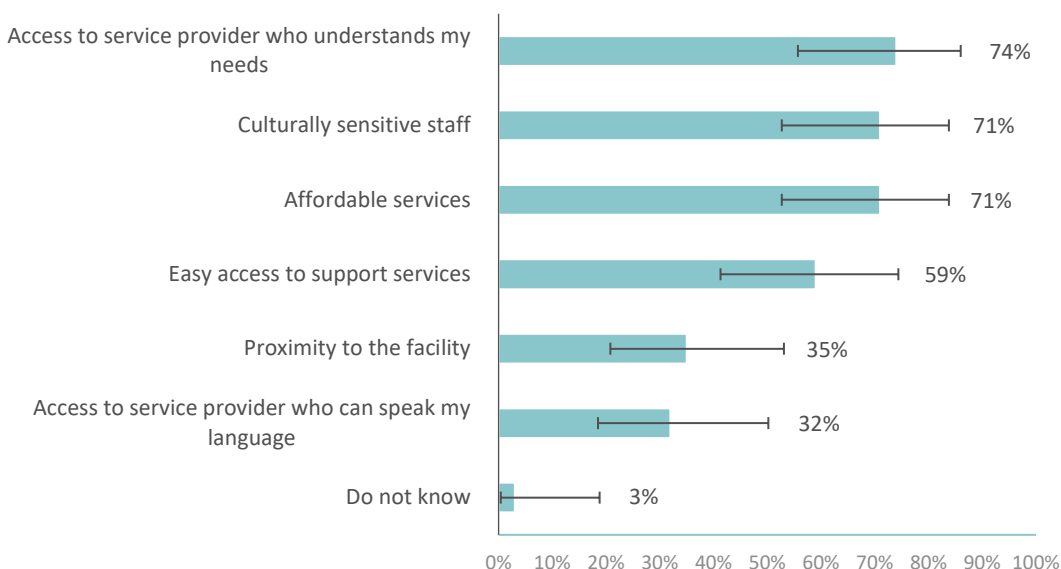
Many participants noted they rely on a religious or spiritual advisor to provide them with advice on marriage, parenting and strategies to cope with daily challenges.

One-third (35%) of survey participants reported that they had tried to access mental health services, either for themselves or on behalf of a loved one. The most frequently reported facilitators that would improve access for them include empathy (74%), cultural competency (71%) and affordability (71%). Participants who did not access mental health services (75%) reported these same facilitators would improve access for them.

Ways to Make Accessing Mental Health Services Easier

What would make your experience and access to mental health services easier? (Multi-mention)

Respondents who tried to access a mental health service for themselves or a loved one (n=35)



Barriers to Access

Many barriers to accessing mental health services were identified in the interviews and surveys.

Income/social status is a major determinant of health and access to health services. Evidence of the impact of health inequities on mental health, especially unemployment, is overwhelming. The reality for groups of people with lower socio-economic status is that they have less power and control over stressful life circumstances, particularly with respect to financial resources. Their choices, in terms of

which neighbourhood they choose to live in, the conditions of their employment and how they cope with challenges are limited.

Several participants identified cost as a barrier to mental health services such as counselling. As described by an interview participant,

“What’s difficult about those services, specifically therapy, is the cost. I would probably go more often if it wasn’t that expensive.” (Female 20-29)

Discrimination not only contributed to poor psychological health; it was also identified as major barrier to accessing mental health care. Anti-black racism is prevalent in many sectors, including the health sector, and it manifested itself in terms of lack of cultural competency and representation.

“More doctors and counsellors need to get called out for their explicit racism and the horrible impact they’re actually having on the community.” (Female, 30-39)

Several participants recounted experiences in which they felt service providers were unable to provide knowledgeable, safe and effective care and were ill-equipped to understand their clients’ needs. In most cases, service providers did not appear to know how to interact with clients of African descent in a way that was respectful. Many participants described feeling frustrated having to explain their experiences as an ACB person in Ottawa before getting the help they needed.

“I felt like I had to explain my background and my ideologies where they come from, it just took too much time and too much energy.” (Male, 30-39)

“I do not want them to see me because I do not believe I will get quality care. I think all their biases will come in once they see me. I’ve had only one positive experience, so I know they do not respect my beliefs.” (Female, 30-39)

Several participants recalled their experience (or the experience of another community member) where a situation was escalated to involve Children’s Aid Society (CAS) or the police due to a lack of understanding. In one incident, CAS was called on a client who had taken her daughter to a counsellor. The young girl wore a hijab and was fasting during the month of Ramadan. The service provider felt that the mother was being neglectful by allowing her daughter to fast and also expressed concern the young girl was being forced to cover up. Others tried to intervene to de-escalate the situation, and explain the significance of the hijab and Ramadan, but by then the CAS had already been called. This event caused the family to further isolate themselves and they did not attempt to access mental health services again. Shortly after, reports of the incident reached neighbours and others in the community, leading to wider mistrust of the system and providers.

"I just needed to have a phone number and it escalated to being admitted." (Female, 30-39)

"I went into the walk-in clinic because I didn't know where else to access mental health services. I was really struggling. The doctor at that point, without even exploring anything more, tried to get me admitted. It was like a complete escalation. There was no exploration of what was the needs or anything like that. It just went even though I had no intentions of harming myself or harming others." (Female, 30-39)

Some study participants recalled service providers who tended to structure their inquiry around the client's use of substances or experiences of abuse rather than the 'real' issue. One participant described their experience in saying the service provider "was really cold and she asked me some questions like, have you been taking any drugs?"

Other participants reported stories of over-diagnosis, over-medication and escalation that created mistrust. Participants reported feeling like providers questioned the legitimacy of a mental health issue and needed to prove that they required counselling for their mental health.

In many cases, participants who accessed services felt they received substandard help and, as a result, did not pursue further assistance or counseling following these encounters. For participants, having to educate service providers who are providing mental health services did not instill much confidence in the provider-client relationship. One participant explained that they "did not believe that any of the providers cared about him" given that providers struggle to understand, acknowledge and sympathize with the different experiences in the ACB communities. Another shared his account of a health care provider who insisted "you're not depressed you don't look depressed." As this individual commented: "It made me feel bad because it invalidated my experience."

Numerous participants indicated that when accessing mental health services, they were looking for a therapist that looked like them and who had "shared values". A participant described being "very conscious that I wanted a person of colour, a person that could understand cultural relevance." This opinion was repeated by most of the participants who felt that there was a significant "lack of representation" with "not a lot of Black people in general working in [health] care".

"They understand that sometimes, maybe folks will feel comfortable with the counsellor of a certain gender but completely erase the fact that there is a different reality for folks of colour to want access to mental health services from someone with similar life experience and a similar path within this society as well." (Male, 20-29)

The issue of long wait times arose as another barrier to accessing services. There are often long wait lists to access services which are free of charge or services providers with similar cultural and racial backgrounds. When access to community mental health services takes nine months or more, clients may turn to emergency services. Participants also commented that because of long wait times, people become sicker and their condition may deteriorate to an extremely volatile state where they may either hurt themselves or hurt someone else. “The longer you wait to address it, it just keeps getting worse. It could even end in death for some people.” It is through tragic incidents that many young men of African descent enter the justice system, and this becomes their first experience accessing mental health services.

“My ability to cope and deal with my reality was not there. The initial response I had was this is not important. This is not a life-threatening situation. This person is being overly dramatic.” (Female, 20-29)

In some incidences, the location and clinic set-up were a barrier to accessing care. One participant mentioned how she enjoyed accessing service at a centre that made a deliberate attempt in hiring diverse frontline staff from different immigrant communities. She thought it was reflective of the society and never felt out of place in there. Location speaks to culturally appropriate centres being too far away and they will have to give up school/work time to access; nothing adequate to access in their communities.

Some participants cited a lack of knowledge of available services as a barrier to accessing mental health services. Although many of the participants had access to mental health services through employment, these services were often not well promoted. Many expressed that others in similar situations only accessed services when they were either very sick or had been using substances to cope. In addition, stigma still plays a role in the decision not to seek help early.

“It’s always physical, that’s what people seek help for... when it reaches a physical manifestation. The problem is when they go for the treatment, they don’t believe that it’s something that will help them...they don’t believe that counsellors will help them.”
(Female, 40-49)

Evidence suggests that not being able to speak one of the two official languages is extremely challenging, particularly for new Canadians and their families. Lack of language proficiency prevented some participants from interacting with health care providers in a way that is safe and meaningful. A client’s symptoms and challenges may be misunderstood which could lead to overmedication. In cases where interpreters are available, they might not be properly trained to interpret and deliver the messages.

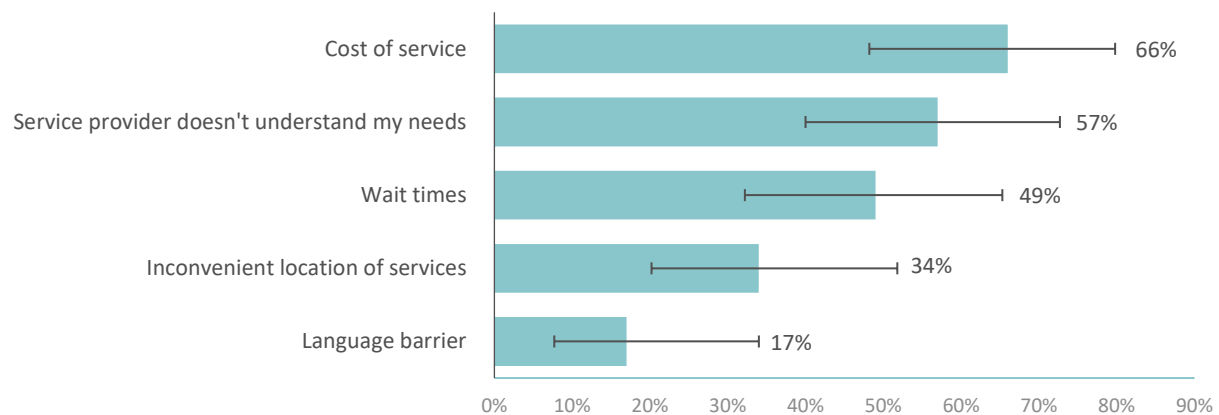
Similar barriers were identified in the survey. Among those who had attempted to access mental health services, two-thirds (66%) found the cost of the service to be a challenge. Many also said that the

service provider didn't understand their needs (57%) and that wait times were a challenge (49%), among other issues.

Most Challenging Aspects of Accessing Mental Health Care Services

What did you find most challenging about your experience trying to access a mental health service?

Respondents who tried to access a mental health service for themselves or a loved one (n=35)

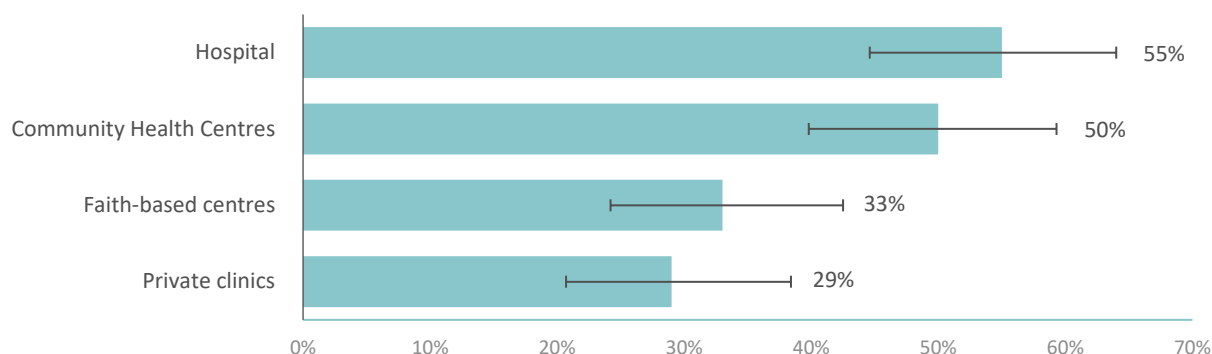


Survey respondents were also asked where they access mental health services if they or someone they knew needed mental health services. Most said they would go to a hospital (55%) or to a community health centre (50%).

Location Where Participants Would Access Mental Health Services

If you or someone you know needed mental health services, where would you access those services? (Multi-mention)

Asked of all respondents (n=101)



Summary

Major facilitators and barriers to mental health care were identified that have implications for the delivery of mental health services to the study participants in Ottawa’s ACB community.

Findings suggest that more resources are required to assist people financially in being able to access services or to ensure that services are not out of their financial reach. Beyond these types of direct interventions, the development of policies that decrease the negative impacts of social determinants of health are also critical. Providing people with opportunities for adequate employment, housing, education and removing barriers that further contribute to social exclusion is essential to good mental health.

Culturally responsive mental health services for Ottawa’s ACB population means having access to providers with which there is a shared identity and experience. The lack of mental health care providers with shared similar identities was a common theme identified by study participants. Of those who had accessed mental health services for themselves or family members, the majority described negative experiences related to their provider’s lack of awareness. It is evident that the community needs service providers who know and understand the experiences of Black clients. At the very least, it is important that service providers have knowledge of anti-oppressive practices and understand the experience of being Black in Canada. Notably, it is often understood that clients may prefer and request a certain gender for health services, but the same consideration is not given when it comes to race. It is recommended to have a practitioner who has a strong understanding of the Black experience, social justice, and anti-oppression.

A health care provider with limited knowledge of the ACB population can be dangerous and devastating. It can permanently prevent and discourage people from seeking help again.

There is a known bias in misdiagnosing Black people with major depression and schizophrenia and there is a tendency for clinicians to overemphasize the relevance of psychotic symptoms in Black people compared with other racial or ethnic groups (Gara et al., 2019).

Findings suggest that the need for timely access to services when required is also critical. When factors such as racism and discrimination, stigma, financial instability, long wait times, lack of trust in care providers and lack of coordination of care between providers are reported as barriers in accessing care, it creates a gap in the system that doesn't meet the mental health needs of the community.

Almost three-quarters said that access would be facilitated by having providers who look like them and understand their needs. Given this finding, there is a clear need for a more diverse and inclusive workforce that better reflects and represents racialized communities, in this case, an ACB mental health worker. Further work is also required to dismantle systemic barriers including cost, care coordination, stigma as well as raising awareness of mental health in the ACB community.

4. Interactions with Mental Health Care Providers

Client-provider interaction in mental health is a critical factor in care delivery and is considered the first stage to care satisfaction and healing (Myklebust et al., 2019). Negative interactions with a service provider set the stage for a breakdown in assessment that could have deleterious effects on the client. As such, it was important that this study learn from participants' interactions with their health care providers to inform the development of culturally consistent policies and practices.

Satisfaction with Mental Health Services

Findings from the survey suggest that participants who used mental health services were generally less than satisfied with the service they received. Just over one-in-ten (16%) rated the service as 'excellent' or 'very good,' while another one-quarter (25%) described it as 'good.' The majority of respondents were inclined to rate the service they received as either 'fair' (34%) or 'poor/very poor' (22%).

These same participants were also asked whether they were treated well by healthcare providers and others on staff. Most responded 'yes' (85%) to this question, although just over one-third (35%) responded strongly in the affirmative ('yes, definitely') while the majority (50%) were somewhat less positive in their response ('yes, to some extent'). Very few (3%) said they were not treated well.

The extent to which providers were viewed as 'client-centered' proved to be a key issue for study participants who had accessed mental health services. Care coordination is a key aspect of client-centric service. When interview participants were asked if their mental health providers and medical providers coordinated their care, about a third said "Yes" while the others responded "No."

Results from the survey and interviews shed further light on several concerns raised by participants.

Assessment of Provider Competencies and Attitudes

Providing Explanations and Instructions to Clients

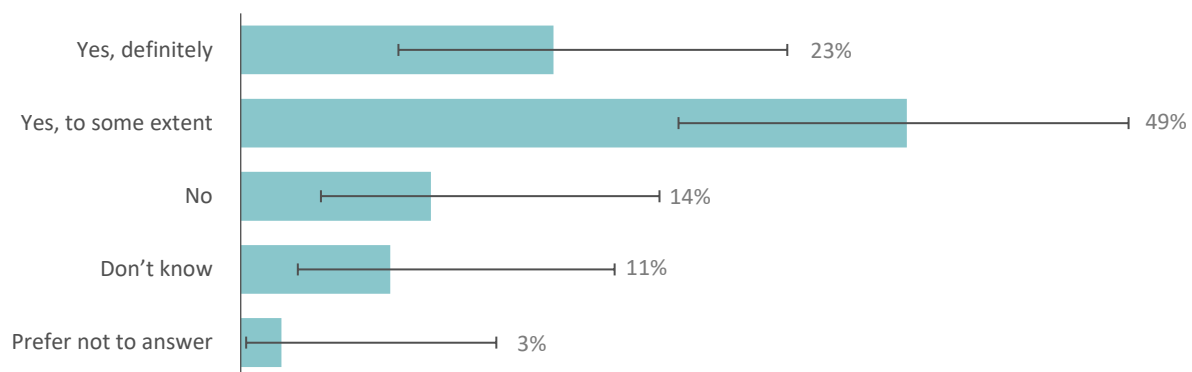
Survey participants were asked whether their condition and treatment were explained to them in a way they could understand. Just one-in-five (21%) said 'yes, definitely' this was the case, while just over half (53%) responded 'yes, to some extent,' and about one-in-ten (8%) indicated this was not the case.

Results were similar when survey participants were asked whether their providers told them what they can do to improve their mental health or gave them instructions for follow-up care: 23% 'yes, definitely,' 49% 'yes, to some extent,' 14% 'no.'

Advice on Improving Mental Health/Follow-up Instructions

Do your providers tell you what you could do to improve your mental health? Do you get instructions for follow-up care?

Respondents who tried to access a mental health service for themselves or a loved one (n=35)



This theme was explored in participant interviews as well. About half of the interview participants revealed that they (or someone they knew) had received any explanations about their mental status in a way they could understand, and this was especially the case when the explanations were delivered in plain and simple terms.

When asked if their service providers and staff were willing to listen carefully and answer their questions, about a half of the participants responded in the affirmative.

“It was right in a way I could understand. They used Grade 8 level English suitable for an average person to understand. So that was commendable.”
(Female, 40-49)

“I’ve been lucky to be at a place where my primary medical care provider also deals with a very large immigrant population from Africa and the Middle East. So, I tend to work with the assumption that hearing 15 different languages in a workplace in Canada signifies dealing with a group of people that are open to the world and understanding.” (Female, 30-39)

However, this was not the case for about a third of participants. In the analysis, we found that some did not receive explanations in an understandable way.

Some interview participants identified a clear disconnect in information sharing between service providers and their clients. For example, participants described service providers not sharing enough details about their condition, explaining things in vague terms they could not understand, and that they left without adequate access to resources to improve their knowledge and mental health literacy.

“What would be more helpful for me is having a bit more accessible ways to receive information.” (Male, 50-59)

“When explanations are provided, it should be provided in a dialogue and conversation rather than with authority or prescription.” (Female, 40-49)

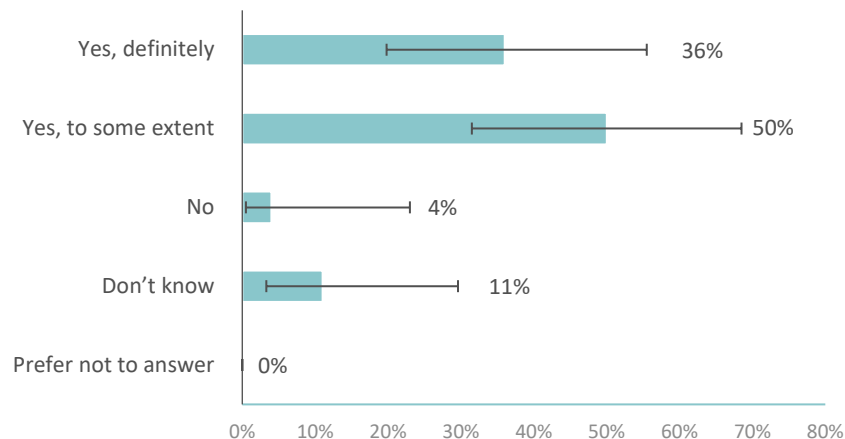
Treating Clients with Respect

Overall, most survey participants who have tried to access mental health services felt that service providers definitely (36%) or to some extent (50%) respected their beliefs about mental health. This proportion was much higher than the proportion of survey participants who did not try to access mental health services.

Service Providers Respect for Clients' Beliefs

Do the service providers respect your beliefs about your mental health?

Respondents who tried to access a mental health service for themselves or a loved one (n=35)



Interview participants did not report as favourable findings regarding their mental health providers' respect for beliefs. Several participants reported that they found mental health providers to be dismissive, disrespectful and lacking in empathy. In some instances, clients felt very rushed through the consultation and that providers were too quick to prescribe medications.

"The psychiatrist was speaking to us so horribly and dismissively. Having a bit more kindness, patience, and providing translators on site would have been helpful, because it was very challenging for me to be emotionally removed from that situation and be translating for my family member. I also did not have all the medical terminologies to explain effectively." (Female, 30-39)

"And I find that more often than not, they are rushing people in and out – they just simply prescribe medications and get you out because they have to see the next client." (Female, 30-39)

Demonstrating Cultural Competency

Cultural competency was a common theme that surfaced when participants were asked what would be helpful in improving integration and client-centered service delivery among mental health care providers. Some participants expressed a desire or, more urgently, a real need for service providers who are culturally competent which included, for example, having a health team with diverse staff, eliminating service provider bias by organizing regular cultural competency training and hiring more service providers who look like them.

“I spoke with some service providers and they had no clue what I was talking about. That literally just turned me off and they lost my trust. I don’t want to dismiss their credibility as professionals, but I think this plays a part.” (Male, 20-29)

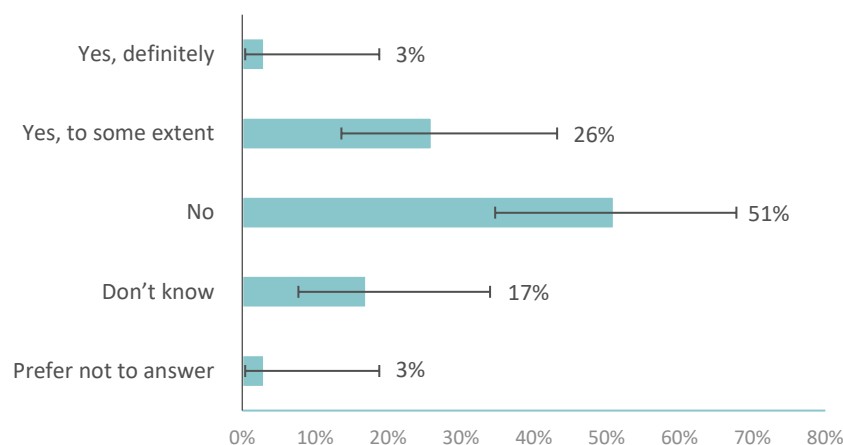
Addressing Racism, Discrimination and Prejudice in the System

Survey participants were asked if they felt any prejudice or negative attitude about them when they had tried to or did interact with their provider. Just over half (51%) felt this was not the case; however, 26% reported ‘to some extent’ and 3% reported ‘definitely’.

Feelings of Prejudicial Attitudes among Service Providers

Do you feel that there is any prejudice against you or negative attitude about you when you interact with your provider?

Respondents who tried to access a mental health service for themselves or a loved one (n=35)



Survey participants who reported feeling prejudice or negative attitudes from their provider were asked to specify why. The main reasons were feeling dismissed (63%), having comments made to them by the provider (44%), feeling unwelcome (38%), or feeling as if certain assumptions had been made about them (38%).

Feelings of Prejudice/Negative Attitudes

In the survey, while about one-third of participants, indicated that they had not experienced any mistreatment or unfair treatment by service providers, about half did say they felt some degree of prejudice against them or negative attitudes about them.

Racism and discrimination, including Islamophobia, homophobia, internalized bias and anti-Black racism, were identified by interview participants as greatly impacting their interactions with health providers. Some participants said they felt judged even before the consultation began and they usually left with negative perceptions.

"I think they didn't give me an opportunity to really explain what I was feeling, and they shut me down right away which made me not want to try to reach out again." (Female, 30-39)

"As a woman and also Black and also a Muslim, you just know it is going to be a compounded experience."
(Female, 30-39)

"I think agencies need to really enforce anti-oppressive and anti-racist policies and not punish people for talking about racism within their organizations by making those complaint processes more transparent and easier."
(Male, 30-39)

"I think sometimes it is very explicitly stated that it is because of my religion or because of my culture or my background that I am feeling this way, or that my religion, culture, community and background are not viewed as a thing of healing. A lot of the counsellors I've had have this Eurocentric Western ideal that if I just change and leave my culture, my religion and stop believing in these ideas of racism and start aligning myself with white feminist, and some Eurocentric values, then I will be happy and healed." (Female, 30-39)

The need for a culturally diverse staff in creating a culturally competent team was also highlighted by participants.

"I think we need to start hiring more Black people into the Board of Directors and Senior Management positions and not just at the frontline because, from my experience, as someone who has worked in the social service field, I can see the ways in which having people who look like you can really change the experience of accessing a service and not having to explain certain concepts because they just get it already, because they have also lived that experience." (Female, 40-49)

Participants felt that many long-standing assumptions and biases about the ACB community have led to inadequate treatment or, at worst, mistreatment.

"I always get misunderstood because of my accent."
(Male, 30-39)

"I perceived a negative attitude about me based on my sexual orientation and based on my race. I feel that those types of prejudices exist and that they compound my experience because of pervasive homophobia and anti-Black racism that is both conscious and unconscious."
(Male, 20-29)

"I experience mistreatment and unfair treatment because doctors are often not able to understand the risk factors associated with being Black or the risk factors associated with being Queer, so many times I've had to advocate for myself and come with a very strong knowledge of the health risks associated with myself and I feel that's unfair because straight White people don't have to walk in knowing one hundred and one things about themselves."
(GenderQueer, 20-29)

Summary

Research suggests that negative interactions with a service provider produce negative impacts such as heightened stress levels in clients, ultimately affecting their experiences with mental health care (Taylor et al., 2015).

While many research participants were satisfied with the care they received from mental health providers, the findings suggest that a significant proportion of participants did not have positive interactions i.e. they did not feel they were treated with respect, they felt providers were prejudiced or held negative attitudes, etc. Many participants described their health providers as lacking in compassion, being dismissive, inattentive, and being unable to address specific client issues. Lack of cultural competency created situations in which clients felt misunderstood, misjudged and misdiagnosed. Systemic barriers were identified that contributed to a lack of representation of health providers who were culturally competent and knowledgeable on Black history. These findings further support participants' suggestions to have more ACB mental health workers and trained psychiatrists in the field.

DISCUSSION AND RECOMMENDATIONS

Discussion

This study examined mental health within Ottawa's Black Community across four core themes: perceptions of mental health; protective and risk factors, access to mental health services, and client and provider interactions.

The respondent's perceptions and understanding of mental health, as well as the factors that influence mental health, provide insights into the protective and risk factors which need to be addressed to improve access to mental health services for the community and improve clients' experiences in the mental health system.

Strategies which were identified by participants include:

- Offering no-cost services for low income families and reducing/eliminating long waitlists,
- More practitioners with the following attributes and skill sets:
 - A thorough understanding of anti-oppression
 - Awareness and appreciation of the Black Canadian experience
 - A strong understanding of social justice
 - Above all, a practitioner with an ACB background.

When asked what might improve Ottawa ACB community's experience and access to mental health services, the most common request was for community-specific services. Specifically, people want to see mental health providers that reflect the diversity of their community. Importantly, people believe representation among mental health service providers will facilitate a shared culture, a better understanding of what the community is experiencing, and voiced support for specific services targeted to the ACB community.

Another important theme that emerged was improved access to services. In this regard, having the financial means to engage appropriate services was reported as a significant barrier. And, those who do access services are subjected to long waitlists. People also want to know whether they will be able to access quality mental health service when they can eventually gain access. Quality service is integrally linked to feelings of comfort that are associated with a provider who is culturally competent.

Furthermore, majority of the respondents have little knowledge of the mental health services available. As such, there is a need for more information on where to get help, mental health in general, and the

impact of mental health in their community. Participants also mentioned that community-specific services should receive stable funding and that more should be done at a system level to address racism in the mental health care system in order to advance the wellness of the ACB community's mental health. Participants emphasized the need to focus on family support, and coordination with family doctors to refer community members to appropriate services.

Unfair treatment, prejudice and racism dominated participants' responses in relation to risk factors, access to service and interactions with health care providers. Racism and discrimination are detrimental to psychological health and are directly associated with poor mental health outcomes. Furthermore, racism and discrimination are major barriers to accessing mental health services. For many of the study respondents, discrimination based on race is a common experience.

"I think if given the opportunity to talk about their experiences and to get help, if they were able to do that in a way that felt comfortable for them with people who spoke their language and who look like them and who understood what they're going through, I think it would be really transformative." (Male, 30-39)

Recommendations

This mixed-methods research study was designed to help contribute to an improved understanding of the risk and protective factors which impact the mental health of Ottawa's ACB community. The study examined factors which both facilitate access and create barriers or impediments to access, as well as the respondents' perception of mental health and mental illness.

Those who participated in the study were fully engaged in all 4 domains of the research. Their comments, based on perceptions and experiences, provided input to strategies which will help to overcome these challenges.

Based on the findings, the following recommendations are offered as a means of informing the Ottawa community, policy makers, education sector, housing sector, the justice system, community health centres, health agencies and organizations, social services and community advocates.

In addition, four separate consultations were held with ACB community leaders in May 2020 to validate and inform recommendations based on preliminary findings and based on community experiences. The recommendations align with best practice strategies to improve experiences for ACB populations. Some of the strategies aimed at strengthening mental health system includes:

- Reduce access barriers – informational (e.g. prevention and promotion strategies including materials in multiple languages in multiple venues that the ACB community accesses), tackling

financial barriers, geographic barriers (by promoting establishment of more Community Health Centres), and tackling waitlists.

- Reduce access barriers – systemic e.g. hire more representative work force, anti-oppression and anti-Black racism trainings. See APPENDIX 5 for a list of anti-oppression and anti-racism training.
- Improve cultural competency e.g. training to improve provider-client interactions. “Cultural competence training should become a standard part of the training of all professional care staff. This should be insured through standards of accreditation,” MHCC, 2010.
- Implement anti-discriminatory and anti-racism policies in workplaces and community centres.
- Increase collaboration between community agencies. For example, collaboration between settlement, faith, ethnic, mental health and other health sectors.

Using the four key pillars adapted from the Mental Health Commission of Canada’s Advancing the Mental Health Strategy for Canada: A Framework for Action framework (MHCC, 2016), recommendations have been organized to align with the four components of the research findings. These are a summary of the research recommendations.

1. Leadership and Funding structures play an important role in facilitating access to quality care by targeting investments for timely and culturally relevant services and ensuring collaboration between sectors to remove social and environmental barriers. In addition, equitable representation in leadership positions is required to make funding decisions aimed at improving access to quality mental health services for ACB communities.

- **Equitable Representation in Leadership:**
Improve representation of people of African descent in the workforce by implementing policies focused on the recruitment of counsellors, teachers, law enforcement officers and health care providers who are of African descent and who understand the unique mental health needs of ACB students, clients and the ACB community.
- **Investment and Funding:**
 - Invest and increase funding to be allocated towards the creation of culturally relevant services for ACB populations.
 - Allocate funding for mandatory anti-racism competency training for service providers and senior leadership teams at various sectors serving ACB people.
 - Increase and sustain funding to improve social policies targeted at addressing decent affordable housing, anti-poverty measures, income support, employment opportunities and safe neighbourhoods that will positively contribute to their well-being.

2. Promotion and Prevention: The promotion of mental health awareness and prevention of factors that contribute to the negative mental health and well-being of the ACB community requires a collaborative approach with stakeholders from various sectors, including public health.

- **Mental Health Promotion and Education:**
Implement programs which promote positive mental health, build resilience and confidence, decrease risk-taking behavior and increase awareness of supports and services in schools, faith-based and community centres.
- **Capacity Building:** Increase the capacity of the ACB community to participate in knowledge transfer and exchange activities with health organizations aimed at improving the mental health experiences of the community. Provide support for community and faith-based leaders to deliver mental health literacy, resilience building and suicide prevention training.
- **Policies and Programs:**
Support and implement anti-racism programs in schools to enhance social inclusion. For example, cultural sensitivity and Anti-Racism training for administrators, teachers and counsellors.
Review school curriculum for equity gaps and commit to following the existing curriculum (i.e. teaching that there was slavery in Canada) while applying an equity lens. Introduce Afro-Caribbean history in the school curriculum.

3. Access and Services: Recommendations in this area are aimed at improving access to quality and evidence-based mental health services, treatments and supports that are existing within the community. Specific improvements are required to meet the needs of Ottawa's ACB community. There is a need for greater collaboration among the health care sector, community agencies, faith-based organizations, education, justice, and corrections sectors.

- **Investment:** Healthcare settings need to improve access to mental health services by identifying and implementing strategies that will help improve services for this population. For example, ensure service providers and cultural brokers of African descent are available to improve the cultural and language gap between service providers and clients.
 - Invest in early intervention services, de-escalation and the provision of mental health support to help prevent ACB people from entering or progressing through the criminal justice system.
- **Anti-Racism Policies:** Develop policies in collaboration with ACB communities that will embed social justice, anti-racism, anti-oppression and anti-discriminatory practices in workplaces including schools, healthcare settings and law enforcement agencies.
- **Monitoring and Evaluation:** Healthcare settings, school boards and justice sectors to support monitoring and evaluation systems that will be designed to collect data on access to services received by ACB clients and are reviewed quarterly for quality assurance.

4. Data and Research - although participants to this study did not speak directly to the need for more data and research, it is important to monitor population level information on mental health and illness and the MHCC recommends improving data collection for this purpose. A coordinated approach to mental health research and surveillance will provide enhanced understanding of the ACB community's well-being, access to services and persistent barriers. Currently, there are no protocols, processes, or systems in place to collect ACB mental health data on an ongoing basis, at regular intervals. This was clear from the recent literature review and contributes to our limited understanding of the extent of the issues.

- **Data Collection:** Promote race-based data collection at all levels, periodic monitoring and evaluation of racial/ethnicity-related variables and how these impacts health outcomes in health surveys and databases to inform future planning.
 - Develop policies that will use this data to monitor health disparities in the ACB community to reduce mental health disparities and eliminate racism.
- **Funding:** Increase funding for research and monitoring activities on mental health in the ACB community to better understand the complex ways in which the Black community experiences racism and its impacts on mental health.
- **Collaboration:** Support cross-sectoral data collection, data sharing and interdisciplinary collaborating research to better understand how mental health of Ottawa's Black community is affected by the social determinants of health.

The researchers recommend various sectors to reconvene in 12 months from the release of this report to assess progress on the outlined recommendations, to identify challenges and brainstorm on solutions, share success stories and best practices for knowledge exchange.

APPENDICES

APPENDIX 1: METHODOLOGY

Theoretical Framework

The theoretical framework for this study was based on Anderson et al.'s (1973) classic model of factors associated with health care utilisation. Although this framework isn't specific to vulnerable populations, it identifies societal (e.g. norms) and individual determinants (e.g. predisposing, enabling, illness level/need) that predict health care access, as well as influencing hospital resources and organizational factors.

Two other frameworks informed our work.

Gelberg et al., (2000) identified factors associated with accessing health services among people who were homeless. They found that predisposing factors such as living conditions, length of time in the community, victimization, and cultural norms, were major barriers to health care for certain population groups. Accessibility and availability of services, and in particular, culturally specific services, and positive interactions with service providers contribute to positive experiences as well as greater access to health care.

Kawaii-Bogue et al. (2017) identified barriers faced by African Americans in accessing mental health services, barriers to accessing treatment and barriers to effective treatment and proposed an integrative care framework. Two types of barriers were identified: Barriers to accessing treatment included stigma, cost of care, lack of transportation, and childcare. Barriers to effective treatment included misdiagnosis, disempowerment in treatment settings, and lack of specialty care services.

These frameworks were instrumental in helping Ottawa's Mental Health Study identify its key study variables and to map study themes.

Literature Review

Ottawa has the second highest proportion of racialized people in Ontario, after Toronto, and its Black community comprises 30% of this population, making it the largest racialized group. Significant health inequities have been documented among the ACB community. Racialized families are 2-4 times more likely than White families to live below the Low-Income Cut-Off (Nestel, 2012). They are also more likely to live in less advantaged neighbourhoods (Shapcott, 2007). In 2016, unemployment rates in Ottawa for Black women and men were more than two times higher than those for their counterparts in the rest of the population (StatsCan, 2020). In Ottawa, 29.2% of Black children were living in a low-income situation, compared to 11.3% of children in the rest of the population (StatsCan, 2020).

Racialized men earn 78 cents for every dollar that non-racialized men earn. The gap narrows when comparing the incomes of racialized and non-racialized women, with racialized women earning 87 cents for every dollar that non-racialized women earn. Men who identify as Black have lower average incomes than other men. They earn just 66 cents for every dollar that non-racialized men earn (Block et al, 2019).

Racialization and Mental Health Status

Racism is a strong determinant of health and living in racist environments can increase the risk of illness for racialized groups. One of the challenges of examining the independent effect of racialized status on mental health and access to health care in Canada is that other factors such as immigration and low income affect or confound its independent effect (Laveist et al., 2009).

The following findings were reported in studies examining the mental health of racialized immigrants.

- Immigrants from the Caribbean, Bermuda, East Africa and South Asia experienced a 1.5-2 times higher risk of psychotic disorders compared to the general population in Ontario (Caron et al., 2010).
- Refugee population experienced a 25% higher risk of psychotic disorders compared to immigrants (Anderson et al., 2015).
- Non-European immigrants were twice as likely as those who are Canadian born to report deterioration in physical and mental health subsequent to immigration (Bruce Newbold, 2005).
- Black immigrants were 76% more likely to assess themselves as “unhealthy” compared to other racialized groups (De Maio et al., 2010).
- Black immigrant women were significantly more likely to report experiencing poor mental health compared to White immigrant women (Patterson et al. 2016).

Pahwa et al. (2012) investigated mental health utilizing six cycles of the NPHS from 1994/1995 to 2004/2005 across seven ethnic racial groups in relation to demographic, socioeconomic, social support and lifestyle factors. Among immigrants of Black ethnicity there was a substantially higher probability for moderate/high mental distress compared to other ethnicities (Pahwa et al., 2012).

Using data from the Longitudinal Survey of Immigrants to Canada (LSIC), de Maio and Kemp (2010) found that racial discrimination was a significant predictor of a decline self-reported mental health status over the 4-year data collection period. This finding was especially evident among racialized immigrants and low-income immigrants (De Maio et al. 2010).

Canadian research on racialized status and mental health is more limited. According to studies conducted by the Centre of Addiction and Mental Health, Wellesley Institute and Mental Health Commission of Canada, some racialized groups experience major inequities in mental health.

Perceiving high levels of racial discrimination was predictive of experiencing high levels of psychological distress or depression over time (Brown et al. 1999). This longitudinal study looked at the evidence on the relationship between perceived racism and mental health. It is also important to note that there are almost no studies that have examined the relationship between racial discrimination and mental health

in the Canadian context. This further supports the compelling need for future studies which further explore this relationship and acknowledge the experience of ACB people, in order to validate their experiences and identify solutions for this population. As the saying goes, “no data, no problem, no solution.”

On an ecological level, when racialized groups form a smaller proportion of the population in an area, they are more likely to experience higher prevalence rates of mental illness (Laveist et al. 1996) such as depression (Nazroo et al. 1997), and psychosis (Neeleman et al. 1997).

Veenstra et al. (2019) conducted a longitudinal study that looked at ten cycles of the Canadian Community Health Survey. They found inequalities in self-rated mental health between Canadian adults in that Black Canadians were more likely to report fair or poor self-rated mental health compared to White Canadians. This statistical difference was entirely due to Black Canadians having lower incomes on average than White Canadians. This finding is consistent with previous research that shows that low income in the ACB population is highly correlated with poor mental health.

Examining Canadian Community Health Survey – Mental health data on prevalence rates of mental health distress and disorders in various populations of Canada, Caron et al. (2010) found that nearly 25% of Black Canadians in the low-income category reported high psychological distress compared to only 14.5% who were in high-income groups.

Racialization and Access to Mental Health Care

More Canadian research has examined access to mental health care among racialized immigrants compared to racialized people as a whole.

A scoping review on access to mental health services among immigrants to Canada identified three types of barriers: barriers to accessing information on health services; barriers due to immigrant settlement; and barriers related to the availability of appropriate services (Thomson et al. 2015). Although this research was not specific to the ACB population, it is notable that 35% of participants in this research study were born in Canada.

Anderson et al. (2015) compared pathways to care and duration of untreated psychosis for 41 individuals of Black-African descent, 40 of Black-Caribbean descent and 90 White Europeans. They found that participants of Black-African descent who experienced their first episode of psychosis were 4 times more likely to access the emergency department as their first point of contact for mental health services compared to White Europeans. Evidence from the Status of Mental Health Report in Ottawa (2018) also suggested that individuals living in less advantaged neighbourhoods have more than twice the rate of emergency department visits for mental health and addictions. Black-Caribbean participants were significantly less likely to have a general practitioner involved in their pathway to care than White-Europeans. Black-Caribbean participants had a median time of 16 months before receiving treatment, compared to 7 months for White-Europeans and 9 months for Black-African participants. The authors

concluded that Black-Caribbean participants experiencing psychosis were more likely to have aversive pathways to care compared to White-Europeans (e.g., no GP involvement, emergency department).

Research Design

The study, funded by Ottawa Public Health (OPH), was conducted over one year using a mixed-method approach, comprising both quantitative and qualitative components. The research design was informed by a deep awareness of the colonialist history of biomedical research and research in general as it pertains to Black bodies and Black people.

The quantitative component involved the collection of survey data. Both self-administered and interviewer-assisted (completed in print or on a tablet) formats were used. The qualitative component involved the collection of in-depth interview data using open-ended questions.

Sample Design and Respondent Recruitment to the Study

To be eligible to participate in this study, participants needed to identify as Black Canadian, born in a Caribbean or Sub-Sahara African country, or born elsewhere (including Canada) with a parent born in one of those regions. Additional inclusion criteria for the study were as follows:

- Aged 16 to 64 years at the time of survey;
- Resident of Ottawa;
- Capacity to speak and understand English or French and;
- Ability to provide informed consent.

The sampling frame was dynamic as sampling options were structured to capture the demographic profile of the target population. Partner community organizations such as the community health centres served as peer recruiting channels where participants were referred to the study team. A target venue-based recruitment method was used, whereby study participants were recruited at events and institutions typically attended by ACB people in Ottawa.

The study employed a multi-stage sampling approach for selection of geographic sub-units (e.g. neighbourhoods) for subsequent sampling stages that employed venue-based sampling at organized events and venues including mental health service centers, community health centres, and community events. This strategy aimed to mirror the Statistics Canada data on Ottawa's ACB population in terms of age, gender, and country of birth. Many of our interview sessions took place at our partner community health centres, that also doubled up as peer recruitment centres. Most of our interview participants worked in the health care system.

Members of the research team worked actively to develop relationships with the community and with peers in order to engage participants and promote this research and reduce community fears and distrust as barriers to participation.

The effectiveness of adopting peer-driven venue-based recruitment methods in mobilizing for health research from ACB communities was demonstrated in two previous studies (Tharao et al., 2014; Gray et al. 2008).

Research Instruments

The research questions were developed and designed in consultation with ACB community leaders over four community meetings held prior to the launch of the survey. The research instruments were generated entirely by the study team and validated and approved by members of Ottawa's Black community.

Three research instruments were developed: a qualitative interview guide, a quantitative survey and a sociodemographic survey.

The in-depth interview questions were in large part created from community consultations. The quantitative survey questionnaire was developed based on findings from the qualitative interviews.

The qualitative interview guide (see Appendix 2) included 11 semi-structured and open-ended questions designed to explore four main areas:

1. Beliefs and Perceptions of Mental Health
2. Protective and Risk Factors
3. Access to Mental Health Services
4. Interactions with Mental Health care Providers

The quantitative survey (see Appendix 2) included 23 self-administered questions, components of which mirrored the qualitative questions. The survey questionnaire was designed to capture information on respondents' socio-demographic background; mental health knowledge and perceptions of stigma; accessing care and treatment; social capital; racism and discrimination; and access to and use of health systems and services. It included a mix of questions that have been used in similar studies with other population groups across Canada.

This mixed-method design allowed for the integration of quantitative and qualitative data as the data from each instrument combined to create a holistic view, addressing the key objectives of the research study. This method ensured that the study findings were grounded in participants' experiences.

Lastly, a 15-question socio-demographic survey (see Appendix 2) was administered after obtaining consent and before each survey or interview. This questionnaire was comprised of questions capturing data on culture, gender, education, income, employment, social and physical environments, which all play an important role in the mental health of an individual.

Data Collection Methods

Data collection was undertaken between April 2019 and November 2019. Prior to fielding, ethics approval was obtained from the Ottawa Public Health's Research Ethics Board.

All participants were asked to complete either a survey or an interview, but not both. In-depth interviews took place over a single session lasting up to 60 minutes. Self-administered or interviewer-assisted surveys also took place over a single session with an average completion time of between 15 to 20 minutes. All interviews were conducted by the study coordinator. The collaborating community partners assisted with peer recruitment and many interviews took place at the community health centres. Participants who completed the interview or the survey received a \$25 VISA gift card in recognition of their time and effort.

Participants could elect not to answer any question in the survey without penalty. Participants were also able to withdraw from the study at any stage and would remain entitled to receive the full honoraria. In order to ensure the safety of research subjects and if questions from the survey were 'triggering,' a list of mental health resources was provided to all participants.

The confidentiality of study participants was maintained through various processes at each stage of data collection. All identifying information was anonymized by creating a unique code for each participant. The code was created after obtaining informed consent and no personal information was used in the process. With respect to confidentiality, data records and computers were properly secured. Participant data was coded and files/folders and computers where data was stored were all password protected.

A total of 130 ACB people participated in the study. 100 surveys were completed; 30 individual interviews were conducted.

Four pre-study consultation sessions were held with the ACB community leaders which guided the qualitative and quantitative research questionnaires. Following the conclusion of the research study and analysis of data, additional four community consultation sessions were held with community leaders who advice on research instruments. These consultations provided an opportunity to discuss preliminary findings and inform recommendations.

Data Analysis

Data from both the interviews and the survey were collected and analyzed separately but interpreted together providing a deeper understanding of participants' responses across four broad areas or

domains: beliefs and perceptions related to mental health; protective and risk factors; access to services; and interactions with health care providers.

All interviews were transcribed, and verbatim and thematic analysis was carried out. NVivo software facilitated data management and storage. The commentary from participants was analyzed. For the most part, the themes identified were categorised under the four sections mentioned previously.

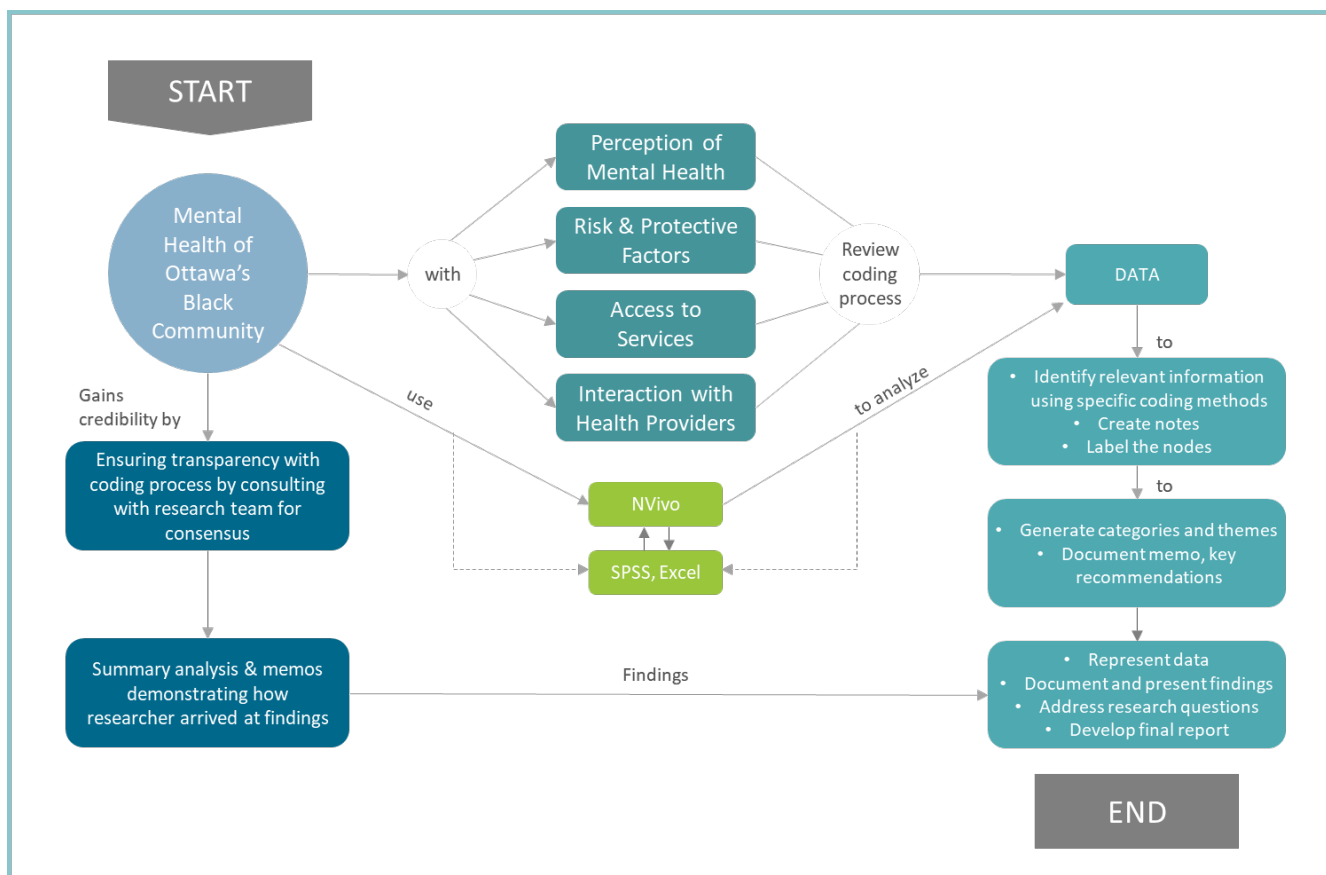
The data from the self-administered or interviewer-assisted survey was analyzed using a statistical software package (Stata) and Microsoft Excel.

The recommendations were largely informed by study findings and were developed in consultation with ACB community partners over four sessions.

Study Analysis Map

This process map shows the high-level processes and steps that were required to complete the study over a one-year period, from conception, to data analysis, and report writing.

Study Analysis Map



Limitations of the Study

It is important for those interpreting or using the data and findings from this report to be aware of the study's limitations. These include:

- The language used to promote and conduct the research was limited to English and French. This restricted participation from those members of the ACB community with limited or no fluency in either official language.
- The surveys were administered over a six-month period. This timeframe had an impact on the ability of the study team to reach more widely across the city to conduct larger-scale peer recruitment and to consider other avenues to further explore emerging themes in different phases of the study. A longer study duration may have yielded a larger sample size.
- The difference in study participants' perceptions with respect to the concepts of mental health and mental illness have, no doubt, affected how some participants responded to the questions. Nevertheless, the study was intended to gather perceptions which are valid indicators of the views and experiences of the ACB community, regardless of how well-informed participants were on the topic of mental health and mental illness.
- The recruitment of participants to the study relied heavily on the cooperation and collaboration of peer groups and partner organizations, and a venue-based sampling approach. Although researchers were able to easily recruit participants, there was no sampling frame and no specific hard or soft quotas were established to ensure specific sub-groups were included in the total sample proportionate to their representation within the wider ACB community, such as francophones, those of Caribbean descent, or the 2SLGBTQIA+ community. This would have been beneficial and ultimately would result in a more representative cross-section of the ACB population in the final sample. As participants were not randomly recruited and most participants were recruited from community health centres and social events, the results may be biased toward the ACB population who use community health centre services and representative of the wider ACB Ottawa population. It is also important to note that a large sample of the participant were from the Somali community. This was primarily due to this community's attendance at one of the recruitment sites.
- The target age of our participants was between 16-64 years. However, 87% of our surveyed and interviewed participants were in the younger demographic (below 40 years), mainly due to older participants refusing to participate in the study when they learned it is about mental health. This further explains the real difficulties in having discussions on mental health in the ACB community, especially with the older age groups.

- Due to small sample sizes, data analysis did not explore data breakdown by gender, age, ethnicity etc., except for the sociodemographic data. Also, analysis was not focused on specific vulnerable subgroups e.g. women, refugees, seniors, etc.
- Finally, rather than stopping recruitment once saturation was achieved, the total target sample was capped at n=30, for qualitative interviews and n=100 for the survey. Included in the final sample were responses from a number of participants who did not understand the questions, but nevertheless proceeded to complete an interview or survey. Given the limited sample, this data was retained rather than excluded from the final analysis.

APPENDIX 2: RESEARCH INSTRUMENTS

Qualitative Interview Guide

One on one semi-structured in-depth interviews

It is important to hear from community members about their perception, understanding and experiences in relation to mental health and in accessing/receiving mental health care.

At Ottawa Public Health, we are working with the community to identify strategies to improve residents overall mental health. In this process, it is crucial to understand people's understanding of mental health and their experiences with the mental health care system. We hope to use what you tell us today to contribute to service improvement and increase service providers understanding of challenges faced by members of the ACB community.

Your input and ideas are important to us and we appreciate the time you are taking to discuss this important topic. The conversation will be recorded so that we can reflect on your comments later. All the comments you provide will be held on a secure, password-protected computer. We will ensure that any comments you share cannot be linked to you by name, your area/type of service to the community or your affiliation. As your comments are logged, we will ensure that you will not be identified based on your responses. This should not take longer than 45-60 minutes.

The following questions are related to **values, beliefs and attitudes** about mental health and mental illness.

- 1) What does mental health mean to you?
 - What comes to mind when you hear that someone has a mental illness? What do you think influences your beliefs and attitudes about mental illness? Where do these beliefs come from? (exploratory questions)
- 2) How do you take care of your mental health?
 - Is there anything specific you do to stay mentally healthy? If you need help with your mental health, would you be open to share this with family or friends? If no, what prevents you from talking openly about your mental health? (exploratory questions)
- 3) In your opinion, what factors influence your mental health in a positive way?
 - What might be some factors, which negatively affect your mental health or the mental health of people in your community? (exploratory questions)

We would like to know about your experiences in **accessing** mental health services for yourself or someone you know. As you answer these questions, please indicate the type of service you were trying to access (e.g. Emergency room, family physician, walk-in clinic, psychologist, telephone line, justice system, peer-support groups, faith-based centres, etc.)

- 4) Can you tell us about your experience accessing mental health services?
 - What helped make this service accessible? Was there anything that made accessing these services difficult? What would make your experience and access to mental health services easier?
- 5) What qualities would you find helpful in a mental health provider?
 - Was it important to find a service provider that shared the same culture, gender, sexual orientation, faith, language or other value? What would you like to see a mental health provider?

The following questions ask about **interaction with health providers**.

- 6) Did you (or someone you know) receive any explanations about your/their mental status in a way you/they could understand? If not, what would be helpful to you in improving this?
- 7) Are your service care providers and staff willing to listen carefully to you and answer all your questions? Do the service care providers respect your beliefs about your mental health?
- 8) Do you experience any mistreatment or unfair treatment when you interact with your provider?
 - Do you feel that there is prejudice against you or negative attitude about you? If so, what makes you feel that way? What do you suggest to prevent this from happening?
- 9) Do your mental health and medical providers coordinate your care?
 - If they do, do you think it is helpful. What do you suggest can improve this process?
- 10) How is the (your) referral typically done?
 - Does the service provider help you get the services you need in the community? Do they help you navigate the system? What needs improving?

CONCLUSION

- 11) Is there anything we haven't discussed that would improve your experience and your access to mental health services in the community?

Quantitative Questionnaire

(AT EVENTS OR ONLINE)

It is important to hear from community members about their perception, understanding and experiences in relation to mental health and in accessing/receiving mental health care.

At Ottawa Public Health, we are working with the community to identify strategies to improve residents overall mental health. We hope to use what you tell us today to contribute to the improvement of services and increase service providers understanding of challenges faced by members of the ACB community.

Your input and ideas are important to us and we appreciate the time you are taking to discuss this issue.

- 1) How would you rate your overall mental health?
 - a. Excellent
 - b. Somewhat good
 - c. Average
 - d. Somewhat poor
 - e. Poor
 - f. Do not know
 - g. Prefer not to answer

- 2) How would you rate your stress level on most days? On most days, I feel:
 - a. Extremely stressed
 - b. Quite a bit stressed
 - c. Somewhat stressed
 - d. Not at all stressed
 - e. None of the above
 - f. Do not know
 - g. Prefer not to answer

- 3) In the past 12 months, have you experienced any prejudice or unfair treatment in any aspect of your life?
 - a. Yes
 - b. No
 - c. Do not know
 - d. Prefer not to answer

- 4) How would you rate your level of connection to others in your community?
 - a. Very strongly connected
 - b. Strongly connected
 - c. Somewhat connected
 - d. Not at all connected
 - e. Do not know
 - f. Prefer not to answer

- 5) How knowledgeable are you about mental health related issues?
 - a. Very knowledgeable
 - b. Knowledgeable
 - c. Neutral
 - d. Not knowledgeable
 - e. Not knowledgeable at all
 - f. Do not know
 - g. Prefer not to answer

- 6) What comes to mind when you hear that someone has mental illness?
 - a. Worried or sad
 - b. Fear
 - c. Hopeful
 - d. All of the above
 - e. None of the above
 - f. Do not know
 - g. Prefer not to answer

- 7) In your opinion, mental illness can be caused by:
 - a. Genetics: someone in your family has the illness
 - b. Difficult experiences and environmental stressors
 - c. A Curse or punishment for wrongdoing
 - d. All of the above
 - e. A and B
 - f. Do not know
 - g. Prefer not to answer

- 8) Most people feel that taking treatment for a mental health problem is a sign of personal failure.
- a. Strongly agree
 - b. Agree
 - c. Neither agree nor disagree
 - d. Disagree
 - e. Strongly disagree
 - f. Do not know
 - g. Prefer not to answer
- 9) Most people think less of a person who has a mental health problem.
- a. Strongly agree
 - b. Agree
 - c. Neither agree nor disagree
 - d. Disagree
 - e. Strongly disagree
 - f. Do not know
 - g. Prefer not to answer
- 10) If you need help with your mental health, how comfortable would you be to share this with your family or friends?
- a. Very comfortable
 - b. Comfortable
 - c. Somewhat comfortable
 - d. Not at all comfortable
 - e. Do not know
 - f. Prefer not to answer
 - g. Not applicable
- 11) What would prevent you from sharing your mental health needs with a friend or family?
- a. Don't want to be judged
 - b. Don't want to appear weak
 - c. Lack of trust
 - d. Fear
 - e. All of the above
 - f. Not applicable Do not know
 - g. Prefer not to answer
 - h. Not applicable

12) If you or someone you know needed mental health services, where would you access those services? Select all that apply

- a. Hospital
- b. Community Health Centres
- c. Private clinics
- d. Faith-based centres
- e. Home
- f. None of the above
- g. Do not know
- h. Prefer not to answer

13) Have you tried to access mental health services for yourself or a loved one?

- a. Yes
- b. No

14) How would you rate the care you have received from mental health services?

- a. Excellent
- b. Very good
- c. Good
- d. Fair
- e. Poor
- f. Very poor
- g. Do not know
- h. Prefer not to answer
- i. Not applicable

15) What did you find most challenging?

- a. Wait times
- b. Inconvenient location of services
- c. Language barrier
- d. Cost of service
- e. Service provider doesn't understand my needs
- f. All of the above
- g. None of the above
- h. Other:
- i. Do not know
- j. Prefer not to answer
- k. Not applicable

16) In your opinion, what would make your experience and access to mental health services easier?

- a. Access to service provider who can speak my language
- b. Access to service provider who understands my needs
- c. Culturally sensitive staff
- d. Proximity to the facility
- e. Affordable services
- f. Easy access to support services
- g. All of the above
- h. None of the above
- i. Others:
- j. Do not know
- k. Prefer not to answer
- l. Not applicable

17) Were you treated well by your healthcare providers and others on staff?

- a. Yes, definitely
- b. Yes, to some extent
- c. No
- d. Do not know
- e. Prefer not to answer

18) Was your condition and your treatment explained to you in a way you could understand?

- a. Yes, definitely
- b. Yes, to some extent
- c. No
- d. Do not know
- e. Prefer not to answer

19) Do your health care providers tell you what you could do to improve your mental health? Do you get instructions for follow-up care?

- a. Yes, definitely
- b. Yes, to some extent
- c. No
- d. Do not know
- e. Prefer not to answer

20) Do you feel that there is any prejudice against you or negative attitude about you when you interact with your health care provider?

- a. Yes, definitely
- b. Yes, to some extent
- c. No
- d. Do not know
- e. Prefer not to answer

21) If yes, what made you feel that way?

- a. Comments made to me
- b. Feeling unwelcomed
- c. Dismissive behavior
- d. Assumptions
- e. All of the above
- f. Other _____
- g. Do not know
- h. Prefer not to answer
- i. Not applicable

22) Do the service care providers respect your beliefs about your mental health?

- a. Yes, definitely
- b. Yes, to some extent
- c. No
- d. Do not know
- e. Prefer not to answer
- f. Not applicable

23) Do you have any last comments you would like to share about your experience and strategies to improve the mental health of African, Caribbean and Black communities?

Thank you for completing this survey. Your responses will be used to describe the experiences of ACB residents living in Ottawa in relation to mental health and provide recommendations to improve access to mental health services.

Socio-Demographic Questionnaire

Some of the questions in this survey are very personal. Please remember that the answers that you give are completely confidential. We are asking everyone who participates in this survey the same questions.

Factors such as culture, gender, education, income, employment and social and physical environments play an important role in one's mental health. Therefore, the next few questions are important for this questionnaire.

Please be assured that all the information you provide in the following section are strictly confidential.

- 1) Which of the following best describe your ethno-racial identity? (Check ALL that apply.)
 - ☐ Black African
 - ☐ Black Caribbean
 - ☐ Black Canadian
 - ☐ Black American
 - ☐ Black Latin American
 - ☐ The options do not apply to me. I identify as (please specify):

- 2) How old are you now?
 - ☐ 16-19 years old
 - ☐ 20-29 years old
 - ☐ 30-39 years old
 - ☐ 40-49 years old
 - ☐ 50-59 years old
 - ☐ 60-64 years old

- 3) Can you speak English or French well enough to have a conversation? If "Yes" check all that apply
 - ☐ English
 - ☐ French
 - ☐ Neither
 - ☐ Do not know
 - ☐ Prefer not to answer

4) What other languages would you feel most comfortable speaking with your health care provider?

- ☐ I prefer to speak: _____
- ☐ American Sign Language
- ☐ Amharic
- ☐ Arabic
- ☐ Creole
- ☐ Somali
- ☐ Swahili
- ☐ Do not know
- ☐ Prefer not to answer

5) Were you born in Canada?

- ☐ Yes
- ☐ No, I arrived in _____ (write year)
- ☐ Do not know
- ☐ Prefer not to answer

6) Do you live with any of the following? Check ALL that apply

- ☐ Addictions
- ☐ Environmental sensitivities (e.g. sensitive to scents)
- ☐ Hearing or vision loss
- ☐ Intellectual disability
- ☐ Learning disability
- ☐ Mental health issues
- ☐ Physical disability
- ☐ Other (please specify):
- ☐ None
- ☐ Do not know
- ☐ Prefer not to answer

7) What type of housing or with whom do you live with? Check ONE best option only.

- ☐ Boarding home
- ☐ Correctional facility
- ☐ Group home
- ☐ Homeless/on street
- ☐ Owned home/condo
- ☐ Rented home/apartment
- ☐ Retirement residence
- ☐ Shelter/hostel
- ☐ Supportive housing
- ☐ With friends
- ☐ With family (e.g. parents, children)
- ☐ Other (please specify):
- ☐ Do not know
- ☐ Prefer not to answer

8) What is your gender identity? Check ONE option only

- ☐ Female
- ☐ Gender Fluid
- ☐ Intersex
- ☐ Male
- ☐ Non-Binary (genderqueer)
- ☐ Questioning
- ☐ Transgender Female/Trans Woman – MTF
- ☐ Transgender Male/Trans Man – FTM
- ☐ Two-Spirit
- ☐ I identify as:
- ☐ Do not know
- ☐ Prefer not to answer
- ☐ Not applicable

9) What is your sexual orientation? Check ONE option only

- ☐ Asexual
- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual/Straight
- ☐ Lesbian
- ☐ Pansexual
- ☐ Queer
- ☐ Questioning
- ☐ Two-Spirit
- ☐ I identify as:
- ☐ Do not know
- ☐ Prefer not to answer
- ☐ Not applicable

10) What is your CURRENT relationship or marital status? (Check ALL that apply to current relationship or marital status)

- ☐ Single
- ☐ Married
- ☐ In a relationship with a steady partner (living together)
- ☐ In a relationship with a steady partner (not living together)
- ☐ Widowed
- ☐ Separated/Divorced
- ☐ Other (specify):
- ☐ Do not know
- ☐ Prefer not to answer

11) What, if any, is your CURRENT faith or religion? (Check ONE only)

- ☐ None
- ☐ Muslim
- ☐ Christian
- ☐ African traditional
- ☐ The options do not include my religion (please specify):
- ☐ Do not know
- ☐ Prefer not to answer

12) What is the highest level of education or training that you have completed? (Check ONE only)

- ☐ No formal schooling
- ☐ Less than high school
- ☐ Some high school
- ☐ Completed high school
- ☐ Some college, CEGEP, vocational school, trade school, or apprenticeship training
- ☐ Completed college, CEGEP, vocational school, trade school, or apprenticeship training
- ☐ Some university
- ☐ Completed university certificate or diploma e.g. Certificate in Project Management, Human Resources, etc.
- ☐ Completed undergraduate university degree (for example B.A., B.Sc., B.Ed.)
- ☐ Completed graduate or professional university degree (for example M.A., PhD, M.D., LL. B)
- ☐ Other (specify):
- ☐ Do not know
- ☐ Prefer not to answer

13) Over the past six months, what has been your employment status? (Check ALL that apply)

- ☐ Employed or Self-employed full time
- ☐ Employed or Self-employed part time
- ☐ Volunteering
- ☐ Unemployed and looking for work
- ☐ A full or part time student
- ☐ Not working due to disabilities
- ☐ Looking after children or other family members
- ☐ Retired
- ☐ Other (please specify):
- ☐ Do not know
- ☐ Prefer not to answer

14) What was your total family income before taxes last year? Check ONE option only.

- ☐ \$0 - \$29,999
- ☐ \$30,000 - \$59,999
- ☐ \$60,000 - \$89,999
- ☐ \$90,000 - \$119,999
- ☐ \$120,000 - \$149,999
- ☐ \$150,000 or more
- ☐ Do not know
- ☐ Prefer not to answer

15) How many people does this income support? Indicate number OR check ONE box.

- ☐ _____ people
- ☐ Do not know
- ☐ Prefer not to answer

APPENDIX 3: QUANTITATIVE SURVEY TABLES

The tables below show the frequencies for each question included in the survey.

Q1. How would you rate your overall mental health?

n=	100
	%
Top Box (Excellent/Somewhat good)	72
Excellent	43
Somewhat good	29
Average	18
Somewhat poor	4
Poor	3
Bottom Box (Somewhat poor/Poor)	7
Do not know	1
Prefer not to answer	2

Q2. How would you rate your stress level on most days? On most days, I feel:

n=	100
	%
Top Box (Extremely/Quite a bit stressed)	23
Extremely stressed	3
Quite a bit stressed	20
Somewhat stressed	52
Not at all stressed	18
Bottom Box (Somewhat/Not at all stressed)	70
Do not know	3
Prefer not to answer	2
None of the above	2

Q3. In the past 12 months, have you experienced any prejudice or unfair treatment in any aspect of your life?

n=	100
	%
Yes	47
No	40
Do not know	11
Prefer not to answer	2

Q4. How would you rate your level of connection to others in your community?

n=	100
	%
Top Box (Very strongly/Strongly connected)	48
Very strongly connected	15
Strongly connected	33
Somewhat connected	39
Not at all connected	8
Bottom Box (Somewhat/Not at all connected)	47
Do not know	3
Prefer not to answer	2

Q5. How knowledgeable are you about mental health related issues?

n=	100
	%
Top Box (Very/Knowledgeable)	59
Very knowledgeable	15
Knowledgeable	44
Neutral	30
Not knowledgeable	6
Not knowledgeable at all	1
Bottom Box (Not/Not at all knowledgeable)	7
Do not know	3
Prefer not to answer	1

Q6. What comes to mind when you hear that someone has mental illness?

n=	100
	%
Worried or sad	51
Fear	3
Hopeful	13
All of the above	23
None of the above	6
Do not know	3
Prefer not to answer	1

Q7. In your opinion, mental illness can be caused by:

n=	100
	%
Genetics: someone in your family has the illness	5
Difficult experiences and environmental stressors	27
A curse or punishment for wrongdoing	1
All of the above	24
A and B	40
Do not know	1
Prefer not to answer	2

Q8. Most people feel that taking treatment for a mental health problem is a sign of personal failure.

n=	100
	%
Top Box (Strongly agree/Agree)	40
Strongly agree	13
Agree	27
Neither agree nor disagree	8
Disagree	25
Strongly disagree	23
Bottom Box (Disagree/Strongly disagree)	48
Do not know	3
Prefer not to answer	1

Q9. Most people think less of a person who has a mental health problem.

n=	100
	%
Top Box (Strongly agree/Agree)	66
Strongly agree	15
Agree	51
Neither agree nor disagree	12
Disagree	12
Strongly disagree	6
Bottom Box (Disagree/Strongly disagree)	18
Do not know	2
Prefer not to answer	1
Not applicable	1

Q10. If you need help with your mental health, how comfortable would you be to share this with your family or friends?

n=	100
	%
Top Box (Very comfortable/Comfortable)	45
Very comfortable	20
Comfortable	25
Somewhat comfortable	27
Not at all comfortable	27
Bottom Box (Somewhat/Not at all comfortable)	54
Do not know	0
Prefer not to answer	1
Not applicable	0

Q11. What would prevent you from sharing your mental health needs with a friend or family?

n=	100
	%
Don't want to be judged	37
Don't want to appear weak	25
Lack of trust	13
Fear	7
All of the above	28
Do not know	6
Prefer not to answer	2
Not applicable	8

Q12. If you or someone you know needed mental health services, where would you access those services? Select all that apply

n=	100
	%
Hospital	55
Community Health Centres	50
Private clinics	29
Faith-based centres	33
Home	15
None of the above	1
Do not know	7
Prefer not to answer	2
Not applicable	<1

Q13. Have you tried to access mental health services for yourself or a loved one?

	n=	100
		%
Yes		35
No		62
Do not know		2
Prefer not to answer		1
Not applicable		0

Q14. How would you rate the care you have received from mental health services?

	n=	100
		%
Top Box (Excellent/Very good/Good)		26
Excellent		8
Very good		6
Good		12
Fair		12
Poor		6
Very poor		2
Bottom Box (Fair/Poor/Very poor)		20
Do not know		21
Prefer not to answer		3
Not applicable		30

Q15. What did you find most challenging?

	n=	100
		%
Wait times		19
Inconvenient location of services		9
Language barrier		2
Cost of service		19
Service provider doesn't understand my needs		18
All of the above		8
Do not know		17
Prefer not to answer		2
Not applicable		29
Other, please specify		0
None of the above		5

Q16. In your opinion, what would make your experience and access to mental health services easier?

n=	100
	%
Access to service provider who can speak my language	13
Access to service provider who understands my needs	38
Culturally sensitive staff	36
Proximity to the facility	19
Affordable services	36
Easy access to support services	30
Do not know	6
Prefer not to answer	2
All of the above	17
Not applicable	9
Other, please specify	<1
None of the above	1

Q17. Were you treated well by your providers and others on staff?

n=	100
	%
Yes, definitely	24
Yes, to some extent	23
No	3
Do not know	29
Prefer not to answer	8
Not applicable	13

Q18. Was your condition and your treatment explained to you in a way you could understand?

n=	100
	%
Yes, definitely	16
Yes, to some extent	22
No	4
Do not know	35
Prefer not to answer	8
Not applicable	15

Q19. Do your providers tell you what you could do to improve your mental health? Do you get instructions for follow-up care?

n=	100
	%
Yes, definitely	14
Yes, to some extent	23
No	10
Do not know	34
Prefer not to answer	6
Not applicable	13

Q20. Do you feel that there is any prejudice against you or negative attitude about you when you interact with your provider?

n=	100
	%
Yes, definitely	5
Yes, to some extent	12
No	33
Do not know	31
Prefer not to answer	6
Not applicable	13

Q21. If yes, what made you feel that way?

n=	100
	%
Comments made to me	6
Feeling unwelcomed	6
Dismissive behavior	9
Assumptions	9
Do not know	12
Prefer not to answer	5
All of the above	3
Not applicable	59
Other, please specify	2

Q22. Do the service providers respect your beliefs about your mental health?

	n=	100
		%
Yes, definitely		18
Yes, to some extent		20
No		5
Do not know		21
Prefer not to answer		4
Not applicable		32

APPENDIX 4: GLOSSARY OF TERMS

ACB: African, Caribbean and Black communities; Black; refers to all people of African descent.

Anti-Black Racism: Discrimination, prejudice, stereotyping, attitudes or beliefs that is directed at people of African descent and their communities, rooted in their unique history and experiences of slavery and colonization (Centennial College, 2020).

Anti-Oppressive Practice: Identifying strategies to construct power in a way that will address systemic inequities and inequalities operating at the individual, societal, organizational or institutional level, in a way that will limit or oppose oppressive strategies (Yee et al, 2006).

Capacity Building: Refers to the process where individuals and people from the ACB communities possess the knowledge and resources, retain skills and abilities that can create an empowering environment for transformation.

Cultural Competence: The ability of an individual, group, institution/organization to understand, communicate with and effectively interact with people across cultures (ACB cultures) by being aware of their own world views, developing positive attitudes towards cultural difference, improving communication skills and gaining knowledge of different cultures (CREVAWC, 2017).

Culturally Naïve: Refers to when individuals, groups or organizations do not acknowledge the importance of culture and have not made efforts to educate themselves on the importance of being culturally aware to drive better performance.

Cultural sensitivity: Refers to self-awareness of the cultural similarities and differences that exist with people in the communities without assigning them a value – whether positive or negative, right or wrong, better or worse (Dabbah, 2020).

Diversity: Refers to understanding that everyone is unique, recognizing and respecting those individual differences. These can be along the spectra of race, age, gender, ethnicity, sexual orientation, socio-economic status, religious and political affiliations, physical abilities and so on. It is important to note that while people from ACB communities do share some commonalities, they are not a homogenous group.

Health Equity: Refers to the concept of every individual having their fair opportunities to achieve their optimal health status by reducing or eliminating barriers that are unfair and unjust (PHO, 2020).

Microaggression: Refers to the daily verbal, nonverbal, environmental and institutionalized insults, slights or snubs that communicates negative, derogatory or traumatic messages to the target persons or group based on their skin colour and race. This could either be intentional or unintentional (Singleton, 2013).

Shared Identity: Refers to social/ethnic similarities where individuals can identify and recognize shared beliefs along the dimensions of race, cultural affinity, language, religion, geographic roots and sense of history (Fox, 2001).

Social Inclusion: Refers to the process of improving the conditions that will enable individuals and groups from the ACB communities to positively take part in society. For example, improving the abilities and opportunities for disadvantaged neighbourhoods would allow them to properly integrate into the society.

APPENDIX 5: ANTI-RACISM AND CULTURAL SAFETY TRAINING RESOURCES

- **OHRC eLearning – Ontario Human Rights Commission**

The OHRC eLearning site provides all Ontarians the opportunity to learn about their human rights and responsibilities. The OHRC's eLearning program is informative and engaging and participants can learn on their own time and at their own pace. Topics include racism, racial discrimination and human rights.

<http://www.ohrc.on.ca/en/learning/learning>

- **Education and Training – Canadian Race Relations Foundation**

The CRRF is committed to providing support for transformative education and training initiatives in the pursuit of eradicating all forms of racial discrimination in Canada.

Education and training initiatives focus on capacity building for organizations to create just, equitable and inclusive environments. The Foundation's work has crossed diverse segments of Canadian society and inspired learners to value diversity, communicate across differences, and transform injustice so that all members can achieve success and reach their full potential.

<https://www.crrf-fcrr.ca/en/programs/education-and-training>

- **Canada Beyond 150 - Learning about Racism**

The CRRF has developed an exclusive, free on-line program that has brought together a "faculty" of subject matter experts to create a curriculum and a set of reading materials.

Learners, drawn from multiple sectors, will read provided material and participate in courses led by faculty members who are experts in the topic of discussion.

Interested in taking the program or coordinating learning for your team?

Please email CRRF at s.priyatharsan@crrf-fcrr.ca with your 1) Full Name 2) Preferred Email and 3) Professional Background to enrol in the course.

<https://www.crrf-fcrr.ca/en/canada-beyond-150/learning-about-racism>

- **CRRF Webinar Series – Canadian Race Relations Foundation**

The Canadian Race Relations Foundation regularly hosts webinars on a variety of topics related to racism, race relations, and multiculturalism in Canada. Past webinar information, including video recordings, can be found below.

<https://www.crrf-fcrr.ca/en/programs/webinars>

- **Podcasts – Race, Health & Happiness**

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