

STRIVING FOR BEST PRACTICES AND EQUITABLE MENTAL HEALTH CARE ACCESS FOR RACIALISED COMMUNITIES IN TORONTO



Research Report

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1.0 ACKNOWLEDGEMENTS

This consultation with various stakeholders in the form of educational workshops would not have been possible without the dedication, commitment and support of many people who in their daily work and/or lives struggle with the issue of racism and mental health, a topic which still today is little discussed.

This is an alphabetical list of organizations and agencies who participated in this study. While most participants in the second and third workshop attended the session as official representatives of their organizations, some participated as individuals rather than on behalf of the organization that employed them. Below are the participants who gave their consent to having the name of their organization listed.

Service Providers Workshop

Across Boundaries
Canadian Mental Health Association
Doorsteps Neighborhood Services
Griffin Centre
Midaynta Community Services
St. Stephen's Community House
Toronto Community Care Access Centre
Toronto Youth Job Corps
Turning Point Youth Services

To the many mental consumer survivors who will remain anonymous in this study but who did share their personal experiences and asked to be given the opportunity to participate in any future research that affects their lives.

Policy-Makers, Funders, Senior Management, Researchers/Educators Workshop

Canadian Mental Health Association
Community & Social Services, Social Policy
Development Division, Community Services Branch
Department of Canadian Heritage
Griffin Centre
Mark Garneau Collegiate Institute
Ministry of Health & Long-Term Care, Community Health
Division, Addiction & Mental Health
Ministry of Health & Long-Term Care, Population Health
Policy & Planning & Women's Health Branch, Mental
Health Policy Unit
Mood Disorders Association of Ontario (Toronto
Services)
Ontario Trillium Foundation
Oolagen Community Services
Psychiatric Patient Advocate Office
School of Social Work, York University
Toronto Community Foundation
Toronto Public Health, Mental Health
Toronto Public Health, Urban Health Issues

On behalf of the people who participated in this project, including the Race-Based Discrimination & Mental Health Working Group, we can only hope that the recommendations and conclusions documented in this report will be used as further evidence that 'race' needs to be recognized as a key social determinant of health.

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2.0 INTRODUCTION

Mental health plays a fundamental role in the well-being of individuals and is widely recognized as a significant factor in overall health status. The higher risk of mental health issues faced by racialised communities¹ trying to access mental health, counseling and other services is less acknowledged. Gee (2002) for example reports on an American study on the effects of racism that shows that discrimination at individual as well as institutional levels has negative impacts on the health status of racialised minorities. Similarly, Nazroo (2003) also asserts that the underlying racism of social and economic inequalities plays an important role in differential health outcomes for racialised communities.

¹For the purpose of this report, the usage of the term racialised communities refers to communities of colour only, thereby excluding 'white' communities who can also be racialised through the process of racialisation.

The World Health Organization (WHO) has defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Indeed, many researchers acknowledge that mental health is inextricably linked to physical health. For example, stress has been found to be a critical factor in risk of death from heart disease (Dunn, 2002). In particular, newcomers

- *The 20 poorest ethno-racial groups in the CMA are non-European*
- *Groups with highest proportion of persons below the Low Income Cut-off (LICO) include larger proportions of recent immigrants*
- *Economic disadvantage is racialised*
Ornstein, 2006

arriving in Canada experience high levels of stress and risk of mental health problems such as depression and anxiety, due to barriers and challenges encountered during the immigration and settlement process and in accessing services. This is significant as, according to 2001 Census data, 42.8 percent of Toronto’s population are considered members of racialised communities, and 49.9 percent have been born outside of Canada (Statistics Canada, 2001). Research shows that new immigrants to Canada experience a drop in socio-economic status, as well as racism, isolation

and traumatic experiences before migration (Canadian Mental Health Association, 2000; Hyman, 2001). Mental health issues also affect individuals from racialised communities who have lived in Canada for a number of years and are not considered new immigrants, because they still experience systemic racism and barriers in access to mental health care. In fact, such communities face a higher risk of mental health issues due to lack of access to and availability of culturally appropriate mental health services.

Since the mental health of racialised communities are often mediated by factors such as gender, age, socioeconomic status, and culture, it was determined that a collaborative discussion amongst various stakeholders is needed to capture the complexity of factors that intersect and determine the overall health and well-being of consumer survivors from racialised communities. Indeed, very little research of this kind has been done in Canada.

3.0 BACKGROUND

3.1 Purpose of Stakeholder Consultation

The objective of this study was to explore barriers and opportunities faced by service providers in the provision of appropriate mental health services to racialised communities; to explore the extent to which a holistic approach is being used in the assessment and intervention work with racialised communities; and to identify best practices to be used by service providers in providing culturally competent and equitable services that can benefit racialised communities in the Toronto area.

As part of this study, the working group held a series of workshops with consumer survivors from racialised communities, service providers, policy makers, funders, senior management, educators and researchers in the Spring of 2006 to identify specific gaps, challenges, recommendations and ultimately guiding principles that may help define (prospective) best practices and equitable mental health care access for racialised communities in Toronto, and inform priority areas for future research and action.

Innovating Research, Strengthening Communities Forum

In November 2004, the *Racialised Groups and Health Status* initiative hosted a forum on community-based research with a range of stakeholders. At this forum, the working group on race-based discrimination and mental health held a workshop to discuss people’s experiences with mental health services and how issues of racism may impede an individuals’ ability to participate in society. Evidence of the limited access and equity of mental health services for racialised groups in Toronto was discussed. The feedback from the forum emphasized the need for culturally appropriate and holistic interventions that account for both personal and societal factors. These discussions and stakeholders’ input formed the impetus for this research.

The workshop series provided an opportunity to build on existing networks of collaboration and initiate dialogue among participants. Such dialogue was deemed important for raising awareness of the divergent pressures that each group faces at both the individual and institutional levels. One of the outcomes of this

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**Please note that this alphabetical list consists of past and present members, all of whom have been instrumental in this study.*

series of workshops has been information sharing, and the identification of recommendations for the creation of equitable mental health care access for racialised communities.

The resulting discussions have been documented and presented as findings in this report in participants' own words, along with an extensive literature review that contextualizes these findings. By drawing linkages between participants' experiences, the literature, and input from the Race Base Discrimination & Mental Health Working Group, it is hoped that this report can also be useful to mental health service providers, researchers, funders, and policy makers in creating new assessment and intervention tools that can meet the specific service needs of racialised communities.

4.0 SUMMARY OF MAIN FINDINGS

1. Racialised community members' encounters with the mental health system when seeking and obtaining services are almost exclusively negative, both in terms of access to and quality of services received.
2. Eurocentric practice models and values exclude racialised communities from receiving quality mental health services in a timely and appropriate manner, often exacerbating the risk to their health and well-being.
3. Experiences of race-based discrimination are often dismissed and discounted when the individual is a consumer survivor. Consumer survivors from racialised communities feel isolated, alienated, and silenced by the high and frequent prescription of medication, when they would rather be listened to and heard.
4. Structural barriers to appropriate and equitable mental health care services access for racialised communities consist primarily of the predominance of the Eurocentric medical model as the basis for mainstream mental health practice, organizational resistance to change, racism in the form of race-based discrimination, sexism, stigma associated with mental illness, and funding limitations.
5. Consumer survivors from racialised communities felt misunderstood, alienated and stigmatized, expressing helplessness, hopelessness, fear, confusion, isolation, and regret at having sought mental health services in the first place, particularly with regards to psychiatric and hospital-based services.
6. Service providers feel unsupported by upper management to challenge organization's current practice and service delivery models in order to provide appropriate services to individuals from racialised communities.

7. In spite of growing awareness around racism as a determinant of health, service providers feel they do not have the tools to incorporate and actually use this knowledge to assess and provide appropriate services to consumer survivors from racialised communities. Risking to become marginalized within their place of employment, some service providers use their professional and personal experience and creativity as a basis for responding to the service needs of a particular client.
8. Barriers faced by service providers included encountering institutional resistance, race-based discrimination, lack of resources, lack of institutional support, and other restrictions due to a strict adherence to organizational policies.
9. Anti-racism policies and practices seem to exist on a rhetorical level as they are not always enforced or reflected in organizations' practices on the ground. Superficial adoption of cultural competency or anti-racism efforts often lead to tokenism as service providers from racialised communities singularly take on the role of the anti-racism educator or trainer at their organization.
10. Inconsistencies and lack of consensus in the field with regards to the conceptual definition of 'health', 'mental health' and 'racism' prevent funders from funding services that are (on the community level and rhetorically) known to be effective/appropriate for racialised communities. As a result these services are underfunded and remain marginal, alternative programs.
11. All groups were concerned with the question of accountability, but disagreed on who should be held accountable for the provision of appropriate mental health care services to racialised communities. Collaboration and collective effort is needed to address this issue.

5.0 SUMMARY OF MAIN RECOMMENDATIONS

1. Create accountability tools in the form of funding conditions that hold service providing organization accountable for the proper implementation of anti-racism policies beyond superficial cooption of anti-racist terminology, such that equitable access to inclusive services for racialised communities can be ensured.
2. Shift the theoretical and value base of mainstream and institutional mental health service providing organization's whose practice models are based on the medical model, by changing the curriculum of professionals in training and shifting conceptual definitions of key concepts that guide strategic frameworks of management.
3. Create a solid base of empirical research findings that document the linkages between racism/race-based discrimination and mental health, expose exclusive and discriminatory mental health practices, inform evidence-based practice, and legitimize 'alternative' services.
4. Create and implement an assessment tool that incorporates and connects knowledge of racism and race-based discrimination to mental health and overall well-being of consumer survivors from racialised communities.
5. Create spaces and opportunities where racialised communities can regularly come together to discuss their experiences and concerns, in an effort to break the isolation and stigma associated with being a consumer survivor from a racialised community.

6.0 LITERATURE REVIEW

Findings from studies investigating the health status of minority groups have documented disparities in health among and within various racialised communities (AAMCHC, 2005; Brown, 2003; Choi, 2002; Gore & Aseltine, 2003; Nazroo, 2003; Wu et al., 2003). They point to a significant relationship between

discrimination and mental health issues such as depression, anxiety, and stress for some groups albeit from many differing knowledge perspectives (e.g. Gee, 2002; Harrell et al., 2003). The majority of the literature in this area consists of American-based research reports with quantitative data that reveal concrete health patterns for African American, Black, and Asian American groups. Some of these hypothesize socioeconomic status and poverty as central to possible explanations for differential health outcomes. Gore and Aseltine (2003), for example, followed a diverse, urban sample of young adults in the United States over a period of two years and found that Blacks and Hispanics experienced higher depressed moods, compared to Whites and Asian Americans independent of socioeconomic factors. They conclude that this pattern is in part reflective of their increasingly disadvantaged transition into adulthood given their poorer prospects for educational advancement. Choi (2002) found that African American adolescents were more prone to be diagnosed with schizophrenia, while their Asian American counterparts had lower depression rates than other racialised communities. Other studies concern themselves with the ways in which *perceived* racism affects health, often focusing on individual-level forms of discrimination and perception and coping as mediating factors (Brown, 2001; Noh & Kaspar, 2003). In a Canadian-based quantitative study with Korean immigrants Noh and Kaspar (2003), for example, used depression as a single health outcome. Their results indicated that active, problem-focused coping styles effectively reduced the impacts of discrimination on depression, while more passive, emotion-focused coping strategies was associated with higher levels of depression and resulted in debilitating effects on mental health (Noh & Kaspar, 2003).

However, the role and adverse effects of structural racism and racial stratification on the mental health, as opposed to physical health, of racialised communities remain largely unexplored and neglected in research (Brown, 2003; Fernando, 2002; Karlsen & Nazroo, 2002a; Krieger, 2000 & 2003). Considering their findings that East and Southeast Asians, Chinese, South Asians, and black Canadians demonstrated better mental health outcomes than English Canadians, while Jewish Canadians' mental health is poorer than English Canadians', Wu and colleagues (2003) conclude that socioeconomic, social resources, and interaction hypotheses cannot fully account for racial or ethnic variations found in mental health. Peters (2004) also concludes that the disproportionately higher prevalence of hypertension and high blood pressure among African Americans can not be attributed to economic factors alone, as the hypertension levels of other racialised communities, such as Hispanics, Asian Americans, Native, are comparable to those of Whites.

Some of the more recent research reports contextualize findings, employing structural and multilevel analyses of racism as a direct and indirect determinant of health, rather than just another stressor (Brown, 2003; Gee, 2002; Harrell et al., 2003; Karlsen & Nazroo, 2002b; Nazroo, 2003). With the growing understanding that social structures impact mental health (Brown, 2003; Nazroo, 2003; WHiWH, 2003), they link individual-level mental health outcomes to macro-level social processes and structural factors (e.g., Karlsen & Nazroo, 2002a; Williams & Collins, 1995). Some of this literature argues for the deconstruction and re-conceptualization of some mental health problems as coping mechanisms that are strategically adopted by racialised communities when faced with adverse, systemic forces (Fernando, 2002 & 2003; Noh & Kaspar, 2003). The confusing of coping strategies, they argue, with psychopathologies may partly be attributed to "ignorance of cultural contexts" and "racist attitudes that invalidate the authenticity of some form of behaviour or thinking" (Fernando, 2002, p. 69).

Increasingly, study findings support the contention that racism and its various manifestations have various independent detrimental effects on health (Gee, 2002; Harrell et al., 2003; Karlsen & Nazroo, 2002b; Krieger, 2003; Nazroo, 2003). After controlling for acculturation, sex, age, social support, income, health insurance, employment status, education, neighbourhood poverty, and housing value, a study with Chinese Americans found a clear association between individual and institutional forms of racial discrimination and health status (Gee, 2002). Karlsen and Nazroo (2002a) similarly describe how interpersonal racist victimization and racial discrimination can have direct effects via negative physical and psychological consequences, while institutional racism results in social exclusion and economic disadvantage and subsequently affects health indirectly. Social and economic inequalities, underpinned by racism, play a fundamental role in racialised communities' inequalities in health (Nazroo, 2003). Using data from the Fourth National Survey of Ethnic Minorities, Karlsen and Nazroo (2002b), for example, found that experiences of racism - as opposed to ethnic identity - are directly related to health outcomes,

regardless of which health indicators were employed. A review of 20 studies in the American public health literature has found that the most common outcome of self-reported racism is depression and psychological distress, with the second most common outcome consisting of hypertension or high blood pressure (Krieger, 2000).

However, the number of studies explicitly documenting how discrimination can harm and affect health remains very small (Krieger, 2000). There is a significant gap in the literature in terms of structurally-oriented analyses of mental health that takes into account the role, influence, and effects of racism and race-based discrimination in the lives of racialised communities. Part of the issue is that there is a lack of consensus regarding the mediating factors between race/ethnicity, social class and health status (Beiser et al., 2002; Harrell et al., 2003; Nickens, 1995). The extent and severity of adverse effects on mental health; inter- and intra-group differences; the role of gender as opposed to 'race'; the influence of 'class' versus 'race' or racism; the causal link between racism and health; the conceptualization of racism; the measurement of racism and its manifestations; and the specific processes whereby race-based discrimination exerts detrimental effects on mental health are also not well understood (Brown, 2001; Coburn, 2004; Krieger, 2003; Meyer, 2003; Nickens, 1995). On the other hand it is evident that 'race' matters in that racialised minority persons tend to be at a greater health and mental health risk due to various experiences of discrimination (Harrell et al., 2003; Karlsen & Nazroo, 2002a; Nazroo, 2003; Noh & Kaspar, 2003; Wu et al., 2003). And yet, there is little literature that attempts to explain the nature of this relationship. Some hypothesize different causal pathways and processes whereby racism impacts mental health. In a Toronto study of ethnic seniors, Sadavoy and colleagues (2004), for example, focus on barriers to access as key in the association between race-based discrimination and mental health. Similarly, Snowden (2003) locates biases in clinicians' assessment practices as responsible for inadequate and inaccessible mental health care, which in turn places the mental health of racialised communities who seek services further at risk. The different explanations provided seem to relate in part to inconsistencies in the conceptual definitions and operationalization of key concepts such as racism and discrimination. Overall, this area of research is filled with much debate and inconsistent findings. In addition, Canadian-based research in this area remains scarce, with the majority of supportive empirical data coming from the United States presenting limited generalizability for the Canadian context.

7.0 RESEARCH METHODOLOGY AND CONCEPTUAL FRAMEWORK

7.1 Critical Social Research and Anti-Racism

This project has approached the concept of mental health from a holistic viewpoint and defines mental health as more than the absence of illness or disease. Race-based discrimination and mental health is on racialised minority communities, and an anti-racism lens serves as the analytical framework used in this study. It privileges an understanding of the dynamics and tensions involved in any discussion on equity and access, and allows for a critical examination of the ways in which structural and institutional racism in mental health operate in the lived experiences of racialised minority communities. Using an anti-racism framework, to explore the roles and practices of systems, policies, institutions and organisations gives voice to understanding how structures impact marginalized communities who have been historically silenced.

Through an anti-racist analytical lens, racialisation is seen to discursively and socially mark, define, and construct certain individuals as representatives of a particular 'race' or 'racial' group based on a set of criteria, such as skin colour, facial features, and other phenotypic characteristics. Racialisation classifies and categorizes communities in differential and unequal ways (Galabuzi, 2001), thereby enabling and reinforcing a system of racial stratification where certain groups of people are faced with barriers to access to equitable participation in society. While recognizing the intersectionality of oppressions based on gender, class, age, sexuality, dis/ability, and 'race' (Dei, 2000) that influence the health and well-being of communities and individuals, an anti-racism framework uses 'race' and racism as entry points to an analysis of race-based discrimination and mental health as it pertains to consumer survivors from racialised minority communities without denying that all consumer survivors – due to the legacy of western psychiatry and institutionalization practices – can be marginalized.

As such, the methodological framework of this study consists of a critical social research methodology that is complimentary to anti-racism analysis as it proposes to explore social processes and practices that lie beneath the surface level of social phenomena (Harvey, 1990). From this viewpoint, asking 'how' not 'why' is key when exploring the structural relationship behind race-based discrimination and mental health in their theoretical context (rather than in isolation) (Harvey, 1990).

7.2 Data Collection and Design

Qualitative data was collected from the discussions held in the three workshops. The comments were recorded manually by a note taker and digitally by an audio recorder. The conversations were then transcribed, coded, and analyzed.

Trustworthiness of findings, that is the extent to which findings can be trusted (Patton, 2002), is often questioned in qualitative research projects that seek to obtain qualitatively rich information, which tends to be collected from non-probability and non-representative samples. To address this concern, this study combined a qualitative method (i.e.: workshops) with a quantitative method (i.e.: facesheets collecting demographic data) of collecting data in order to add weight and establish validity to the findings.

In addition, participants were invited to participate in a member checking process, where participants were given an opportunity to provide feedback on the researchers' interpretations and to confirm or disconfirm the findings of the workshop they participated in. The member checking process with consumer survivors who participated in the first workshop consisted of a two-hour session, where participants read, reviewed, asked questions about, and discussed the findings and interpretations. All four participants who had expressed an interest in participating in member checking confirmed the findings and interpretations of the first workshop. For practical purposes, member checking with service providers as well as policy makers, funders, senior management, educators, and researchers in other workshops was done electronically over email and facsimile. Eight service providers from the second workshop expressed an interest in participating in member checking, however three provided their feedback, all confirming the findings and interpretations. Of the eleven participants from the last workshop who wanted to participate in member checking, two participant provided feedback, both confirming the findings.

Workshops were designed to be interactive and educational, involving participants in such a way so as to maximize educational and mutual consciousness-raising opportunities. This method allowed participants to draw analytical linkages and become more involved in the analysis of their experiences and other topics of discussion. In this sense, workshops are events that generate discussion where participants share insights and opinions. While there was a set of discussion questions, they only served as starting points and guides for the discussion parts of the workshops.

Uniquely, each workshop built on the knowledge gained from - and concerns raised in previous workshops. As a result, the content of the workshop with decision-makers was based to a great extent on the findings from the service providers' workshop, which in turn relied in part on the shared experiences and comments of consumer survivors from the first workshop. Overall, each workshop was designed with the following interactive components: 1) discussion in small groups and subsequently in larger group to engage participants in an exploration of the topic; 2) presentation of anti-racism and an analysis of participants' experiences through this lens; and 3) conclusion and summary, including an exploration of proposed recommendations.

With this format in mind, the common thread and focal point from workshop to workshop was the experience of race-based discrimination by consumer survivors from racialised communities in the context of their everyday lives and when accessing the mental health care system.

7.3 Recruitment and Sample

Participation in this study was of voluntary nature. The first workshop with consumer survivors used purposeful and convenient sampling, which targeted individuals who were likely to provide the greatest insight into the research question. This technique has been described as attracting 'information-rich cases' that meets the needs of a particular study (Coyne, 1997; Devers et al., 2000). The selection of such 'typical', information-rich cases tends to be affected by the resources available for a study and other restrictions, the conceptual framework, the research interest, and some practical necessities (Coyne, 1997). As a result, the sample frame for the consumer survivor workshop was expected to be relatively small, consisting of about 8 to 12 individuals. In correspondence to the central research question and guiding anti-racism framework, the selection of cases was further restricted to members from racialised communities above the age of eighteen. However, potential participants were not selected directly but recruited through service providers who knew of consumer survivors.

Removing barriers and maximizing the chances to participation was an important principle throughout this study, as racialised communities often face barriers to equitable access to services as well as participation in research endeavors and workshops. Concerned with maximizing access to marginalized individuals and reducing some potential barriers, rather than creating generalisable findings, service providing organizations were chosen according to geographical location, catchment area, whether they served racialised communities, and what services and programs they offered. Given the high concentration of well-established and funded mental health services in the central Toronto area, the geographical location of these played a key role in sampling. Using information from the 211Toronto.ca, a web-based information system that provides information on community, social, health, and governmental services, various organizations were identified. These sources created the final sampling frame that drew from many different corners of the GTA. In an effort to diversify the sample and recruitment source, these organizations were then ranked in order of preference according to a variety of criteria: 1) variety of languages (service provision); 2) ethno-racial composition of the area served (e.g. high concentration of Tamil adults); and 3) type of programs offered.

In addition, we used a snowball method, where interested individuals informed their acquaintances who may also have been interested in participating and met the criteria for participation. For the purposes of this study and this particular workshop participation was limited to adult consumer survivors from racialised communities.

Honoraria were provided to participants in an effort to reimburse them for their time and to cover any costs that they may have incurred in order to participate. Warm lunch was also provided. While we expected to be able to meet our sampling frame goal of eight to twelve participants, the quick, positive and eager response from the community was overwhelming. Unfortunately, given the resource and capacity related limitations, no more than fifteen individuals were able to participate despite greater interest from the community. Eleven of these individuals reported that they found out about the study through a community organization or program, while two heard about it through a family member or friend, one through the community, and another one directly through a member of the working group.

7.4 Participants in the Mental Health Consumer Survivors' Workshop

In the first workshop, there were a total of 15 consumer survivors who participated to discuss how race-based discrimination affects them on a day-to-day basis, and when seeking and/or receiving mental health services. All participants self-identified either as current or former users of mental health services, and/or as having or having had a mental illness or mental health issue at some point in their lives.

Participants were asked to fill out an anonymous face-sheet that collected demographic data to determine the demographic profile of this group (Appendix L).

Based on 9 of the responses, workshop participants were using housing and residential services, psychiatric out-patient services, community-based mental health services, hospitals, Ontario Disability Support Program (ODSP), and mentoring. The following chart illustrates the demographic profile of participants in more detail.

Code Name	Gender	Year of Imm.	Self-identification
F1	F	N/A`	A person of colour
F2	F	1976	Part of a visible minority, a person of colour, African
F3	F	1974	A person of colour
F4	F	N/A	A person of colour, Afro-Arab
F5	F	2002	N/A
F6	F	N/A	Part of a visible minority
F7	F	1985	Racial minority
F8	F	2003	A person of colour, African
F9	F	1997	N/A
M1	M	1974	Part of a visible minority, Chinese/Canadian
M2	M	N/A	A person of colour
M3	M	1986	Part of a visible minority, a person of colour, racial minority, not white, Arab
M4	M	N/A	Black community
M5	M	N/A	Part of a visible minority, a person of colour, not white
M6	M	2004	N/A

7.5 Participants in the Service Providers' Workshop

Potential participants for the workshop with Service Providers were mainly identified using 211.Toronto.ca. After potential participants were identified, they were contacted with a letter of introduction and invitation per email or fax that provided information about the study and what their participation would involve (Appendix A). Six of the participants indicated that they found out about the study by being directly contacted and invited to participate, while two found out about it through their supervisor or manager, and one heard about it indirectly through a community organization.

As part of the recruitment criteria, all participants for this workshop consisted of individuals who work with mental health consumer survivors as part of their service provision, which may or may not be considered official mental health services. Despite extensive outreach the turnout for the second workshop was the lowest compared to the first and third workshop for this project. Of the 84 individual service providers that were contacted directly as part of the recruitment strategy, 19 respondents regretted that they would not be able to make it to the workshop due to time conflict and other reasons; although they asked to be kept in the loop and expressed they would like to be involved in a future workshop or similar capacity. In the end, a total of nine service providers participated in the workshop. With frontline work experience in housing, mental health, social work, community development, youth work and counseling, participants' professional backgrounds were relatively varied. The chart below provides more demographic detail of the group that participated in the service providers' workshop.

Code Name	Gender	Employment	Year of Imm.	Self-identification
F1	F	Case Manager	2000	Indian, South Asian
F2	F	Counsellor	N/A	Canadian, Irish/Scottish
F3	F	Coordinator	2000	European
F4	F	Counsellor, Social Worker	N/A	White, Ashkenazi, Jewish
F5	F	Program Director	N/A	Canadian, Irish extraction
F6	F	Social Worker	N/A	Jamaican-Canadian
M1	M	Social Worker	N/A	Black
M2	M	Housing Counsellor	1990	Somali
M3	M	Community Development Worker	N/A	Caucasian, Buddhist community

7.6 Participants in Policy Makers, Funders, Senior Management, Educators/Researchers Workshop

The third and final workshop was intended for those in institutionally higher positions with relatively more decision-making power. Potential participants who were sought for this workshop were individuals deemed to be representatives in the areas of mental health research and education, policy-making, funding bodies, and senior management. With this aim in mind, we applied a combined sampling technique of reputational case selection, where participants were identified and chosen on the basis of expertise, as well as purposive selection, where individuals' professional experience involves making decisions that affect mental health service provision and racialised communities. Specifically, individuals were identified using the 211.toronto.ca website and internet directory of the Ontario Government (www.infogo.gov.on.ca) that lists various governmental departments, their mission and staff. For the networking-based recruitment strategy, working group members who are professionally immersed in the mental health field, provided their contacts. Service providing organizations were also contacted to invite those in senior management positions to participate in the workshop. Overall, ten participants found out about the study by being directly contacted, while four were informed about it through a community organization, and one by a colleague.

The response and demonstrated interest in participating in this workshop was overwhelmingly positive, and unfortunately outweighed the maximum number of participants that we were able to accommodate. In the end, a total of 16 individuals attended and participated in this workshop.

Code Name	Gender	Employment	Year of Imm.	Self-identification
F1	F	Supervisor	1967	Afro-Caribbean, Guyanese community
F2	F	Program Manager	N/A	English/Scottish heritage
F3	F	Policy	N/A	Caucasian, Canadian
F4	F	Funder, Manager	N/A	White, Canadian
F5	F	Manager	1977	Filipino
F6	F	Associate Professor	1993	Chinese
F7	F	Policy Analyst	N/A	White Anglo-Saxon Protestant
F8	F	School-based Social Worker	N/A	Canadian – Scottish, Welsh, British
F9	F	Clinical Director	1973	Jewish
F10	F	Cross-cultural Coordinator	N/A	South Asian, specifically Indian Muslim
F11	F	Consultant	1982	Asian
F12	F	Funder	N/A	Chinese Canadian
M1	M	Multiculturalism Program Officer	N/A	Ukrainian-Canadian
M2	M	Program Director, hospital	1977	African Canadian
M3	M	Multiculturalism Program Officer	1968	Sierra Leonean-Maliago, Black

* missing data = 01

8.0 LIMITATIONS OF THE STUDY

There are three limitations to this study. First, the meaningful participation of marginalized communities was sought out but was limited due to resource limitations. Funds are required to pay for their time and participation as well as therapeutic support that would allow them to drop in and out of participating in the study. Future research that aims to involve consumer survivors needs to build-in the provision of adequate support systems, accommodation, time, funds and compensation for their meaningful participation from the inception of the study. Secondly, the results of this study are not generalizable to the general population. And thirdly, consumer survivors were mainly recruited through gatekeepers and, therefore, the voluntary nature of the participation of racialised communities created a self-selection bias.

9.0 FINDINGS

9.1 Workshop I – Mental Health Consumer Survivors

A number of dominant themes and patterns emerged from the discussions. These themes and topics of discussion are presented below along with excerpts from participants. Participants mainly spoke about recent negative experiences that they had with mental health or psychiatric services in hospitals and service providers. This led to a number of conversations about availability, access, and quality of services, which in turn led to discussions that raised questions about the use of power, the provision of 'help', representation and diversity issues, as well as self-determination, respect and dignity.

Encounters with the Mental Health System

Participants who shared their personal experiences during the workshop spoke almost exclusively about recent negative experiences they have had with their therapists or psychiatric services in hospitals. As the following excerpts illustrate, these experiences concerned either the actual quality of the services or the interpersonal relationship and interaction with professionals such as nurses, psychiatrists and therapists.

Participants spent a significant amount of time sharing their concerns about the lack of quality, one-on-one time spent with treatment providing mental health professionals. When describing the services they received, some participants said:

I don't know, I find that most of the services are like rush-rush. They don't take the time to diagnose you or, you know, [...] 'Oh I have another patient' [...]. They kick you out really fast. (F3)

For me, if I go to a psychiatrist I spend like 5 minutes in there. All they ask me is, how is your medication doing [...] And then I go. That means, for me, they're not doing much, you know. My mother can do the same. (M2)

When you go to a doctor, you're there for 5 minutes and he writes a prescription for you and out you go. There's no time to discuss the way the problems, the ups and downs, even the side effects of the medication. It's like ok there is a prescription for the side effects and they go away and out. You're just in a rush, and you're in and out as quick as they can get you out. (M1)

This impression of being rushed was common among respondents. Specifically, more than three participants emphasized how discouraged they were by the distance between themselves and their doctors, psychiatrists, and nurses, explaining that they understand the need for medications but would like their treatment to go beyond the prescriptions to include quality, one-on-one time and attention with their therapist and other service providers.

Speaking for myself, and from my own personal experience, it seems that some of the nurses or workers are almost afraid of the patient. When [patients] come in, [the nurses] will lock themselves into the nurses' station. The only time they come out is when it's medication time. And they never came out to say 'hi, how are you doing? How is your medication? Are you feeling ok?' I think more time should be spent, less on the emphasis spent on medication and therapy, and more on quality time spend with in-patients. (M1)

They just group you guys together and they just leave you there. Give you your meds and just leave you there. That's how they handle you, you know. Just give you the meds basically and make sure you're behaving yourself, keeping the peace. (M5)

Interestingly, however, respondents felt that the more time doctors spent individually with them, the more time they spent in an institutional care setting. When speaking about receiving treatment at the hospital's psychiatric ward, many respondents spoke about feelings of being trapped or locked in a situation that they could not escape from, even if they had initially, voluntarily sought the advice, assistance, treatment or service that later caused this 'entrapment'. As one participant expressed:

When you're in there [the mental hospital], and you want to come out, basically you can't do anything. And they think that they're helping you. For me, for example, when I get locked in the hospital and I know I didn't do anything wrong, they lock me up when I get upset. And they tell me I'm not taking my medication. So what I do is, I'm just more quiet. And sometimes that's the only way to get out of that predicament. (M2)

Other than their dissatisfaction with the emphasis on medicating, participants' concerns about medicating practices included the dosage, the lack of accompanying information provided, and the lack of follow-up and monitoring of side effects.

A lot of medication. And, they don't give you enough information. You end up with health problems. (M1)

And you all end up taking the same medication. And [...] it's not the same - all of you don't NEED the same [dosage of] medication. Some people need a heavy dose of medication, and they react the same way. Some other people get a heavy dose of medication and all they do is sleep. They sleep the whole day. When they're in the hospital, as soon as they get in, they get some food, they fall asleep. You wake up, they give you some food, you fall asleep. And that's the medication. And if you don't tell the doctor that - but I had to tell my doctor at one time, this is what was happened to me, and they didn't even realize. They just figured everything was going well because I wasn't getting upset anymore, or I wasn't complaining. It wasn't until I started complaining, I said look my whole day is wasted I'm not doing anything. All I'm doing is eat and sleep. And they said ok we'll change the medication. But I was like taking the medication like everybody else was. (M2)

As a result, participants expressed that they found themselves disappointed, discouraged, and even regretful and fearful of seeking such services again. This finding was echoed by another respondent whose experience when seeking treatment for her mental illness actually caused her additional distress with family members who were her support system. She explained,

The first time I was hospitalized - I come from a Muslim background [...] - When my uncle, who is the head of the family, realized that I was in a psychiatric ward where there were men as well, he flipped! There was no way he could have been supportive. It was absolutely inappropriate for me to be in a ward with men. And sitting in a common area with men, because I had to be wearing the, you know, the hospital clothes. [...] And, part for me, being ill and I'm worried about my Muslim background and that I'm not following [the rules]. All that was going through [my head] was 'oh I'm going against the will of god by being with these men...' They couldn't get that. And I kept begging them 'please! You need to! I'm being ruined!' [...] You know what they did? They just doped me up so I could sleep it off. And every time I woke up [I said] 'Oh my god! You have to get me out of here!' So they finally locked me away in a separate ward, or whatever, where I felt better because I wasn't mixed in with the men. But they didn't get it. And then they didn't want to listen to my family, who kept saying 'You have to get her out of here. She can't be here, she can't be doing this'. But they totally didn't get it. Didn't get it. And that's the whole thing about cultural (inaudible). And being ill at the time, I I didn't know how to explain it the way I can explain it right now. (F2)

She also added,

And also, the other thing that I think that would help me is also having [...] the system be more respectful to my cultural needs. And I don't - the system, especially the hospitals, they're not! They're not respectful of my cultural needs. (F2)

Others shared similar experiences.

[...] the psychiatrist were not of colour or come from diversity and that caused problem, because their cultural understanding of you is not there. [...] An appointment on a religious holiday, he won't change it. (M1)

I found that they, sometimes they give too much information so quickly. I don't understand. Not so good language, my language is not so good. Process that amount of information. English is so fast, and when I said 'I didn't understand that part', they think that (inaudible) and I think that (inaudible) uncomfortable. (F6)

F6: I was applying for some kind of (inaudible), but before that some psychologists screened me and she wasn't nice to me. So, I wanted to go to head but I just gave up. I didn't want to go, I was afraid of another negative experience. [...] She was just asking my name, what kind of symptoms, that kind of stuff. And it was depression, I was worried I was having depression. Especially with the mental illness. If I needed shelter or something I... but if you're suffering a mental illness and if you're receiving such a.... treatment, you're getting worse even, so I...

Facilitator: So, you first wanted to go get other tests and then you decided no.

F6: No. it was not worth, I did not think it was worth.[...] I lost trust in service.

While the specifics of their stories differed from one participant to another, the commonalities of their stories stand out significantly. What was repeated in the discussions was the lack of being understood by service providers. Workshop participants expressed a desire to be heard and listened to, rather than simply medicated, which they interpreted as a denial of their autonomy and a dismissal of their individual circumstances. While some attributed this experience to the service providers' ethno-cultural background, while others did not hypothesize any particular explanations for this.

Structural Barriers

According to the stories of respondents, their negative experiences with the mental health system and service providers were often shaped by structural barriers that prevented or limited their access to quality care. Based on these accounts, such barriers consisted of Eurocentricism, race-based discrimination, sexism, and various outcomes of health care budget cuts and subsequent funding restrictions.

When speaking about their personal experiences, participants described aspects of the mental health system that reflect the Eurocentric nature of the medical model upon which mainstream, institutional mental health services tend to be based. Drawing a linkage between practice models and social location, the following quotations illustrate what some respondents believed prevented their personal experiences from being positive.

I would like to see more people that look like me in the system, working within the system. More people that are living with a mental health issue and are coping quite well working within the system, not just someone who went to school to learn about it. And when I say more people like me, I mean more people of colour not just the male, white, female.[...]. That'd help me. (F2)

I also think they should work on, more with the family. If there is a situation where you get there [hospital] and you're family is around instead of...I think they should have the family involved, because that way[...] you'll listen more to your family, than to a stranger, you know. And I know that they have to be trained and all that, but I'm not just talking about giving medication. I'm also talking about just talking to you, same thing a psychiatrist would do. [...] But I think they should try and make it more family-oriented. ... I think if they did that, I think it would progress a lot better. (M2)

What the last quotation touches on is the tendency to exclude the family unit from treatment for individuals. Three other participants also agreed that service provision did not consider their ethno-cultural background and thus often caused difficulties for them. However, as this participant explains, lack of diversity or representation among staff may not be the only issue:

I think, for me, [need] person of colour, but then again, if they're privileged by class, and if their education is based on the same system, that doesn't mean that having persons that look like me means that they get it, you know. So it has to be a solid, a balance of so many things. Re-defining what this mental health [means], the international standards of mental health are so vague. They

don't include, you know, the spiritual. They don't include community. One thing I never found in the mental health system was the aspect of political identity and all that comes with that: race, and class and just even the recognition of who you were. If you were Arabic, African, Muslim, you know. And all that comes with that. (F4)

According to this respondent, the components that are not typically considered by service providers in their practice are the spiritual, community, race, class, and ethnicity – aspects that tend to be neglected from a Eurocentric perspective.

A few respondents saw their difficulties in obtaining proper services as a result of being racially discriminated against.

M1: I applied for transportation allowance. My friend, he applied transportation allowance. We have the same number of [...] from different [...]. And he get \$100, I get \$70.

F7: Why was it different?

M1: Because he was white.

M1: Another experience I had is when I got sick, I couldn't find a hospital that would [...] It wasn't like a mental issue. But I had a social worker with me and she was advocating for me, like for months.

Facilitator: Because they didn't believe that you needed the help or what?

M1: No it was just that, well you know: 'ok this guy, he looks like he's on drugs' or something.[...] so I get sicker because of that. Finally I ended up in the hospital.

F3: And then when I see a white woman, a white patient come on, you know, the doctor would take time and stuff like that. And she's been in there how long you know. And I've been in there, for what, 10 minutes and its like 'ok, move along'. And it feels like...

Facilitator: So you feel like, that much of a resistance.

F3: Yeah.

Others spoke more generally about exclusionary practices that they perceived to be predominant when seeking services or treatment.

The system, especially the hospitals, they're not. They're not respectful of my cultural needs. Like, I go to the hospital and they say 'well you HAVE to use your support system'. I don't have any family! My family lives in this [denial] that I have clinical depression. They say that it's a white people's disease and that I'm just sucked into the whole white thing because I've lived here for too long. [...] That this is not what, you know, happens in our culture. So when they say to me I have to use my supports, I have to use my family, I must bring in my family - ok, I don't have that. So what else? I just don't feel respected. Like does it leave room for someone who is in my shoes? (F2)

Because when I go there, I don't get the same services. I wait one hour, sometimes an hour, and everybody is going in except me. And the worker, he would just get rid of you. He would just say, [...] I have to do this. Ok Fine! (M1)

And now it's even worse now, because in the hospitals they won't give you a bed but (inaudible) even if you're in crisis. They won't give you a bed. (M1)

Reproducing Stigma and Marginality

M1: I know someone who end up in the computer, in the police computer system, just because he was sick and –

Facilitator: They called him an ambulance, yeah.

M1: Yeah. And so now every time the police stop him, they know his mental risk, they know his address.

Right now I feel so self-conscious being a woman, an African woman living with mental illness, trying to get back into the system. 'Cause I honestly feel that part of the reason why I'm not in a job is because (inaudible) ... Because I just don't see enough, I don't know - and I think, I know part of the reason is, people just don't come out, they don't talk about it. In our community anyways. I can only speak about the Caribbean-African community, where I come from and have a lot of friends. So, lifting the stigma for that, I think, would be more helpful. (F2)

Many of the participants' shared experiences illustrating their feeling of being stigmatized and/or marginalized as typical of being a mental health consumer survivor. While this may not be necessarily 'race'-specific, the consumer survivors in this workshop spoke about the 'racial' or ethno-specific dimensions of their experience(s). As the following quotations suggest, participants described labelling, categorization, and stereotyping as a form of streamlining that reduced their individuality. This further reinforced their feelings of discouragement, hopelessness, and frustrations.

Some participants, for example, were concerned that once they started taking medication, any of their behaviours were seen as indicative of their mental health state. As a consequence, when an individual expressed frustration, it would often be interpreted as symptomatic of the mental illness. This went hand in hand with practices that further labelled and categorized consumer survivors 'who are otherwise already marginalized due to 'race', gender, sexual orientation, age, etc.

Well other than for the categories, for the lowest one, they clump. So there's one special club for (inaudible), and another one special one for schizophrenic. And another for (inaudible). They clump everybody by the nature of their illnesses, rather than their individuality, or as M2 said, the level of their illness. Some people are not really that sick and some people are extremely ill but you're all put onto one floor because that is the diagnosis you were given. (M1)

Being labelled and stereotyped by service providers attributed to their sense of alienation and distance, which resulted in many feeling discouraged from seeking services again. Some participants verbalised a certain level of mistrust and questioned the expertise and training of mental health professionals.

When they're trying to help people, they should be careful how they put you - how they situate people. Like when I first went to a mental hospital, I didn't feel like I belonged there. Now, I'm not saying that I didn't or don't have an illness. But I don't think my illness was as bad as some of the people that I was around. And being around them, made me think that I was in the same situation as them. And it took a while for me to realize that, ok I'm sick but, I'm still... Like I'm not trying to say that ...but some are worse cases than others, but when you go to a mental hospital, like sometimes, you have some people like, I've had this one person they start crying to me, telling me what's happening and, when I'm listening to them, I'm like, am I supposed to be here though? I'm not in the same position as them and it kind of, it doesn't help your situation when they do that to you. They have to be careful how they situate you if they're gonna help you, help you properly. Don't just classify you and put you in a certain, you know, in a certain category and then deal with you and everybody in that category. 'Cause like you said, everybody's situation is different. There's different levels of your illness. (M2)

I think what would be more positive would be better training for the caregivers and health care professionals. Especially for in-patient, in hospitals. Speaking for myself, and from my own personal experience, it seems that, some of the nurses or workers are almost afraid of the patient. When they [the patient(s)] come in, they [the nurses] will lock themselves into the nurses' station. Only time they come out is when it's medication time. And they never came out to say 'hi, how are you doing? How is your medication? Are you feeling ok?' I think more time should be spend, less on the emphasis spent on medication and therapy, and more on quality time spend with in-patients. (M1)

Reactions: Coping and Resistance

As M2 said, I don't feel so isolated and alone, and the other people's experiences and problems, and the way to deal with them is also inspiring to me. (M1)

Overall, participants expressed that they felt misunderstood and alienated as a consequence of their experiences with mental health service providers and, generally speaking, with the mental health system. For many, these experiences were accompanied by feelings of loneliness, confusion, self-consciousness, fear, helplessness and hopelessness.

Right now I feel so self-conscious being a woman, an African woman living with mental illness, trying to get back into the system. (F2)

It's frightening to be an in-patient in the mental hospital. When you see everybody [...] You feel even more isolated, even more depressed, even more victimized. (M1)

Well I'm just glad I came, because I know now I don't feel alone anymore. I just know how a lot of people feel about the system, you know. I thought I was just being ignorant. I realized it's not just me alone. I feel a lot better now. (M2)

However, this is not to say that participants felt entirely powerless. Throughout the duration of the workshop many participants provided feedback, encouragement, and advice to one another, illustrating their own coping strategies.

Then you should report it. Simple as that. The social worker doesn't have the knowledge, [...] Next time it happens, and you're with your social worker, just go report it, talk the security in the hospital or head office in the hospital or something. Tell them your situation. (M2)

I just got some information, ideas how to (inaudible) in a situation like that. Also, just sharing this information allows me to be an assertive person. So I know my rights and (inaudible). (M4)

While some advocated on behalf of themselves and others, some participants seemed to defend their experiences as generic, as opposed to examples of 'race'-based discrimination, normalizing their own and others' experiences and often times dismissing them as common or insignificant.

It's rude, but at the same time it's like, on the sake of the [police] officer too eh. I can't imagine this guy taking off his shoes and then somebody come with a shot gun shoot him or something, you know. 'Cause there's many people at the house, or he has his shoes off. [...]. So, when they do those things, coming to your house keeping their shoes on or talk aggressive, you know, I don't really condone the talk aggressive, but it's part of life. (M2)

Looking Ahead: Seeking Understanding, Demanding Respect

I learned that, people suffer from lack of respect and understanding more than their mental illness. (F6)

When asked about any recommendations and suggestions for mental health service providers and those in decision-making positions, participants shared an array of ideas. In summary, participants stated that:

- more information is needed
- more help is needed
- service providers need to be more honest and stop discriminating
- more and better training is needed, especially for those who work with psychiatric in-patients
- practitioners need to place the emphasis on humanity and to spend more quality time with patients
- the family needs to be involved in service provision and treatment/therapy
- more representation is needed among service providers (i.e.: consumer survivors of colour),
- the stigma against mental illness needs to be lifted in various communities
- more public awareness campaigns with inclusive and representative imagery and messages are needed
- more funding for one-on-one programs are needed
- self-determination in treatment needs to be respected and increased, and

- other types of treatment/healing need to be acknowledged and permitted

9.2 Workshop II – Service Providers

Approximately one month following the workshop with mental health consumer survivors, another workshop was held with service providers who work with consumer survivors of colour in their day-to-day practice. The main purpose of this workshop was to explore the barriers and opportunities experienced by service providers in the delivery of appropriate, anti-racist services to consumer survivors of colour. Participants were also asked to share their suggestions for addressing some of these challenges.

While the focal point of the workshop focused on the challenges faced by service providers, a number of specific concerns arose during the three hours of this workshop. These included the lack of appropriate practice models, organizational support, assessment tools and know-how to help incorporate anti-racist knowledge into service provision, and raised questions about the extent of organizationally imposed constraints vis a vis the role of the individual service provider. These as well as other main findings are reviewed in more detail below.

Conceptualizing ‘the problem’

Some of the comments and case scenarios from the first workshop that spoke to the experiences of consumer survivors of colour were used to stimulate discussion at the beginning of the workshop. Facilitators guided this discussion by asking participants to share their thoughts and reactions to the presented quotations first in small groups. While participants seemed equally concerned about consumer survivors’ negative experiences, not everyone agreed in their interpretation of ‘what went wrong’ or what the problem is. In their articulations, some spoke of the barriers and realities faced by individuals from racialised communities, whereas others pointed to/spoke to the marginalized existence of all consumer survivors regardless of ethno-racial background.

I think that the experience is very familiar to me. And I think that some of them are common to all people who seek help for a psychiatric premise, regardless of their ethnic background or their color or their ethnicity. Some of it is just simply the way that people are treated in a psychiatric system regardless. (F5)

The extent to which participants drew analytical linkages between the case examples and racism also varied from person to person. As the quotations below insinuate, some respondents linked their interpretations to the issue of barriers to access experienced by persons from disadvantaged social locations, such as racialised communities.

Yeah, there is a lot of obstacles in society, in regards to persons of colour. (M1)

With clients that I work with, they have so many secret barriers to cross. The workers that they work with would allow them to get things, so what would that mean for me as the client? ‘I need the support the person is giving me but maybe I’m experiencing racism with them’. That power is so huge, you know. Am I feeling powerful enough then to complain? Is there an anti-racism policy because I need help accessing services, I need information, I need whatever it is. And how it is that people will navigate that kind of situation. (F6)

And yet others participated in the discussion by focusing on individual-level racism as it may play out and affect an individual who is seeking services.

In the context of shared housing, if somebody is making racist remarks to someone else, you, just in terms of the Landlord-tenant Act, you probably can’t...you probably have to show a pattern of severe and persistent harassment to evict them. And I think in my spirits and also of most clients they know that eviction is such a drastic punishment that people will say “I don’t want you to throw him out, I just want him to stop saying those things to me”. Whereas if the same client takes a slug at somebody then people are much more likely to want to say “I can’t live with that person anymore, I want you to

evict that person." Because people are afraid of them in a different way and as a landlord you have the capacity to do that. You can't go to the landlord-tenant tribunal and say, you know "Joe made a racist remark to so and so once because... and therefore we want to evict him". You can go and say "Joe punched her in the face and we want to evict him." So there is certain, there are differences to a degree that is just the reality the people respond to those things and what your capacity is in that case. (F5)

Some of the responses, however, suggested that structural/systemic racism and its manifestation lie at the core of racialised communities' negative experiences with mental health services or the mental health system. Reflecting on their work experience with youth of colour, service providers commented that,

I had to take a youth to the hospital to be admitted. And he was totally ok with it and agreeable. But then they were like 'you gotta take your clothes off and put on this hospital gown'. And it was just so horrible to have to watch and try to explain to him why it is. I know why it is but I really don't agree with it. So I'm trying to calm him down and I'm not calm about it. It is just so horrible [...]. Right away they kind of asked him 'what kind of drugs have you been using?' And then they had him take a urine test. I don't know whether this is standard practice [...] And then they just kind of assumed right away that his symptoms were drug abuse and not a part of a longer mental health issue. Even though I was standing there saying 'hello, I have been following this family for a while and this is not just drugs!' [...] I think the thing with the kind of racism that I encounter in the mental health system is so subtle that often you go home and you're like, 'wait a minute, should I - what just happened?' You know what I mean? So that was one of those situations. (F6)

A lot of the youth that they see in the homeless system and a lot of them have mental health problems, they're coming into the system through the criminal justice system if they're from a racialised community. Their access to mental health is often through criminal justice system and the shelter system. And, so they're even more, sort of like, in the system. (F4)

I think one of the issues that it really comes down to in the main case study is that the people who that person is having an interaction with on a daily basis in the hospital are very unlikely to be of a similar background or to have any particular understanding of what that background is. [...] I would doubt that there, in the whole staff of the hospital, would be many people in that position who would come from a similar background and have an understanding what the issue for this woman is really, that is making her uncomfortable at that moment [...]. I don't think there are a lot of qualified medical practitioners throughout the system who are reflective of our overall community, of Toronto. (F5)

I think there is also a misconception that within communities of color, families are always tight-knit and supportive, and everybody takes care of everybody else. I think that can be just as much of a misconception [...]. You know there's a bit of a stereotype there around what the family unit is and what it means to be. (F5)

Family lack of support, it is seen as the patient's fault. There are no culturally appropriate support systems. (M)

For some the main issue spoke to cultural appropriateness, and for others it had to do with representation and diversity. The differential interpretations and view points among participants with regards to their analysis of race/racism and mental health points to the conceptual discrepancies that exist not only at the frontline and in the field, but also among scholars and academics. In this workshop, conceptualizing 'the problem' depended on how 'race' and racism, and what it means to be a person of colour in this society were conceptualized by each individual participant.

Back in the large group, the discussion quickly turned towards a critique of the medical model as the basis for institutional and mainstream mental health services. Participants agreed with each other about the inadequacies of the medical model for consumer survivors and particularly those from diverse ethno-racial backgrounds.

It also could be a reflection of just the medical practitioners. [...] And without even taking the time to explore what issues might be upsetting this woman. Is it just because she is 'crazy' and that's why she is here, so give her her medication. [...] It looks to me like they just made an assumption that the family was backward or whatever. 'Why are they so upset? She needs this help, we're doing the best for her'. Rather than looking into what they had to say. (F2)

I think, you know, one of the things that we talked about initially was just this idea of a medical model and how that's a barrier in general to health and in particular to people who are that much more against this place from the western kind of medical model approach. (F4)

I think that it's very much still very much seen as a medical issue. People are, reciprocating to what you were saying - they are ignoring all the other factors involved. They are taking a medical approach like you know "you have this, according to this". I think it's still, especially in hospitals, it's a common fashion. (F3)

It's important to have a staff that is openly listening and I think with the medical model that is not an encouraged attribute. [...] There's tons of nurses and doctors on each floor, but there's maybe one social worker and then maybe they're part-time. And there's one, someone who's trained more in psycho-social [...] and they're looking at the whole picture. And that kind of person is [...] not as available as they used to be, and I think that's a huge component. (F3)

A lot of it has to do with medication. About how we see mental health, [and the] focus on medication. It is a very medical model; it's not helpful. (F)

Medication is seen as the 'end all', instead of talking to the person. (M)

The staff couldn't get it (collectively). It means, systemic indifference of this institution. Their responsibility is to isolate and medicate. (M)

Similar to the findings from consumer survivors in the first workshop, the most mentioned perceived limitations and shortcomings of the medical model and hospital-based mental health services consisted of its Eurocentric orientation and lack of holistic approach, labelling and categorization tendencies, and its reliance on medication.

Since none of the service providers actually practiced in a hospital setting, it might not be surprising that a large amount of time was spent critically discussing mental health services that are based on the medical model and its limitations. Rather than dismiss these accounts as simply biased, it should be noted that the beginning of this workshop started with a discussion which was stimulated with quotes and accounts by consumer survivors who participated in the first workshop. While this is not to say that other mental health services are non-discriminatory by default, consumer survivors' traumatic experiences that were disclosed, occurred primarily in hospital settings or psychiatric services, which in turn were based on the medical model.

Professional Experiences and Own Practice

When facilitators inquired about participants' own work with individuals from racialised communities, respondents described difficulties they faced at a professional level in an attempt to deconstruct how they themselves are implicated in the experiences of consumer survivors. Questions on representation as well as power and privilege surfaced when participants articulated what they perceived as key to providing appropriate and equitable services. When asked how they navigated around issues of difference, some of the respondents expressed the following.

I think I feel privileged right. There's less prejudice against me. You know, I'm aware of that. [...] When we asked one of the questions, "what kind of role would you like to play if you could choose your role in the world?" Some of the kids, well one kid said that she wants to be a white woman because she saw that white women had the most privileged status right. I feel comfortable, but I'm

aware that I have a comfortable position. I'm quite aware of that. And another thing is that being a woman, certainly there are some obstacles. (F2)

The fact that I'm white, I'm conscious that with clients who aren't white, people of colour - what I'm thinking is I want them to know that I'm aware of the barriers, or that I'd like to think that I'm aware of the barriers that they face. That I'm not overlooking the fact that there is racism. So, I'm trying to be conscious of that and let them know that. (F2)

I work primarily with youth on probation and primarily young men, many of whom are of colour, many Black young men. So we have a really, really long conversation about what it means for us to be sitting in a room together, and that can last over many sessions. And I keep opening it up, but I say right from the beginning that I'm gonna mess up. And that I really hope that they call me on it and that I will mess up. [...] It has to do with power differential between each race but so we talk about the fact that they are on probation and they have to see me. That they're Black and I'm white, that they're young and I'm not as young as they are. [...] It's a really long process and I really wanna make sure that we talk about it as long as we need to and if that means that's the entire intervention then I think it's worth while. [...] I don't think it's a bad intervention I think that it is what it is. But I'm sure if I was a Black man or if I was someone else that I'm not, then I'm sure that the intervention would be different. Maybe we wouldn't be having the same conversation. Maybe we would, but I think because of the lot of different reasons we talk about the differences of power and how that's not gonna be easy. And we talked about what those are and different ways in which I might judge them. And how maybe they see me, too, as a white woman or as a woman with short hair or as a woman who's from downtown or whatever. I don't tell them I'm Jewish but it comes up sometimes. (F4)

I think that being white for me right now holds an enormous amount of responsibility to confront other people. Particularly white people in power on racism, and that's heavy a lot of the time. (F4)

Non-white service providers also spoke about the influence of the colour of their skin or ethno-racial/ethno-cultural background on their service provision and relationship with the client population. For these respondents being non-white introduced certain advantages but also disadvantages in their work. They too described a kind of distance between themselves and some clients due to privilege extended to them by virtue of higher socioeconomic status and educational level.

Sometimes if I'm doing a service with someone who is of the same culture as me, I'm not legitimate. Even though I have the same school credentials as that colleague. [...] On the other hand, sometimes I feel like because of my education, it's like now I don't know the culture anymore. It's like I'm removed. I don't know if that makes any sense. I don't know. (F6)

So now that I have a certain level of education, I'm 'aligned with white people'. So then I loose a piece of being able to interact with my culture. (F6)

The responses illustrate the complexity and intersectionality of structural disadvantage and sites of oppression that influences the client-worker relationship and shapes the lives of individuals from racialised communities. Despite this realization, participants expressed that these elements, which speak to positionality and social location, were not explicitly or not at all considered in their organization's practice. Instead, participants often take the initiative and attempt to somehow incorporate this knowledge into their own work.

Personally, I take [racism] into account. I talk to the young people about the different ways they feel discriminated against and how they thrive. But if there is a policy, I'm not aware of it. Because of the law there is probably a policy. But if you look at the agency and who fills what role, there are questions about how the policy is being played out. (F)

It's part of the intake assessment definitely. What I try to do is I try to give them opening in the sense that, because it's just one of a category of these barriers right and I try to make them feel more comfortable. I think I'm accomplishing that, I'm not 100% sure, by saying "you know there are different

kind of discrimination or racism..." - I think it says discrimination not specifically racism. And I try to talk about ageism issues because they're young. It's a little bit leading just to give them that time to think about it and process it. And we do talk about it, I think. And in the life-skills program, we do. Try to give them opportunity to talk about even being stopped by the police on every day basis, that kinda thing. (F2)

Management was kinda like "you need to do like you either need to do solution focused or cognitive behavioural stuff and that's it!" Period. "There is no other therapeutic intervention you should be using." [...] So this was kinda really difficult. But I kind of sensed for my client, in terms of her cultural background and some of the issues that she was dealing with, that those interventions were not appropriate. So just having to be able to kind of think out of the box and use other types of therapy that maybe aren't like evidence based. So, it was like mixing the narrative with some of her own personal values and that kind of thing. So I had to make up my own kind of therapeutic model that makes sense for her and I was certainly told that that was not gonna be appropriate. That the only thing that was gonna work was that if it's depression it's cognitive behavioural therapy and that's pretty much it. So to me that was a really good example of when my gut was telling me that wasn't going to make any sense because that's the way that that kind of therapy is created, [it] does not make sense for this woman and her culture. (F6)

Some participants explained that, despite wanting to incorporate anti-racism knowledge into their every-day practice, they were not certain on how to go about that and often relied instead on their own imagination and insight to provide better services. Overall, participants agreed that their intake or assessment practices and procedures did not allow for an exploration of how experiences of race-based discrimination/racism may have affected their client. When explored further, participants mentioned several key barriers, constraints and challenges that they were struggling with in their work.

Barriers, Constraints & Challenges

A growing frustration I suppose at this particular moment, historical moment or temporary moment, is arising from the fact of increasing levels of dismissedness and denial that seems to be ever more openly expressed in Canadian society to the privilege, to the oppression, to the exclusion experienced by the racialised community. We seem to be encountering that more and more in different moments, in different contexts in different places, and... I guess in some moments feeling a little bit overly challenged or overwhelmed by that. (M3)

Participants expressed that they were frustrated about a number of things with regards to the provision of equitable and appropriate services, including lack of managerial support, organizational resistance and collective denial of oppression and racism, lack of resources related to funding formulae and restrictions.

Participants explained that in many ways funding policies and practices create the barriers that they experience as frontline service providers.

What ideas get air-time depends on where the money is. (F)

It's depending on how much the funders buy into it right. And how much they believe in this tool. (F2)

Many described how evidence-based practice and service delivery models have gained credibility and are now preferred, if not demanded by upper management in order to meet funding requirements. From participants' point of view, this expectation does not allow them to provide 'alternative' mental health services which they deem more appropriate in certain cases, as they are not considered evidence-based.

Is it counterproductive to make people feel better, to be flexible, break the rules, be creative? It's the systemic piece that speaks to broader issues. My workplace is big with few funding streams. Issue: Some of what we're seeing around evidence-based practices. Having to show evidence is the trend, the emphasis is limiting. To put it mildly, the fear that you won't get funding if you're not evidence based. It doesn't capture the systemic piece. How do we create tools and measures? Need measures

to get the funding. [It is a] self-fulfilling prophecy. [...] Trying to find funding for this is difficult. Hard to measure how effective narrative therapy is. (F)

So one of the challenges for me in my work is this direction towards evidence based practice. And this fear that if you are not using an evidence-based practice that you won't get funding for the program you are doing. However, evidence based practices, the measures to prove that you are doing something in a way that's evidence based are very narrow and don't account for the systemic pieces. And then M3 added that it becomes a vicious circle in terms of getting this funding for evidence based practices. You're not prov, but you're keeping out the possibility of other kinds of - the example for me is around the use of something called cognitive behavioral therapy so it's very easily measured but at the same time you're not looking at the way too much let's say racism impacts anger which impacts your physical health. There's no way to account for that. Or different kinds of therapy like narrative therapy, you know it's hard to measure how well more progressive types of interventions and M3 talking about holistic interventions like acupuncture or areodetic medicine how that's not as easily measured and how we don't have tools for that. (F4)

The challenge for these service providers lies in finding supportive evidence such as statistics and other documentation to defend their practice. As the respondent below suggests, the underlying issue is that the notion of racism/race-based discrimination itself and its linkage to mental health as a determinant of health has yet to gain wider organizational and institutional acceptance.

I need evidence to say that poverty is hurting people and that racism is hurting people and those kinds of things. So when we go back and say, "yes, our interventions have worked but our interventions are much more expensive and take longer", it's because we're not just dealing with anger, we're actually dealing with the system that is funding us. (F4)

Linked to the notion of organizational resistance, participants emphasized that having to work strictly within the policies and procedures of the agency/organization constituted another major barrier for them.

I think that it needs to be top down, I think there has to be some will from the...I mean there are a lot of people I think working independently in agencies who are really interested in implementing certain kinds of frameworks of working, but if you don't have the organizational or institutional support it's hard. And there has to be permission to talk...like you were saying, you have to struggle with it. But I think to struggle with it you need permission to talk about it and that's why in terms of working with youth when these issues come up, we talk about it. I don't shut down those conversations because I think they have to struggle them out and we have to struggle them out together and not just say "no that's not ok to say that", because it's much more complicated than that. And, so the idea is to have permission to talk about it, but they have permission to talk about it with me in a room if I'm doing a group but it's harder for me to have permission to talk about it within the agency, or within other sort of systems. (F4)

The greatest challenge, I think is, I work so hard with my clients in order to give them a sense of hope. [...] It's like me trying to fight against constant negative input. [...]. I constantly feel like, you know, it's just one step forward and then five steps backward 'cause I'm not getting a lot of help. [...] So for me, it's a challenge to kind of keep hope going and keep people focused on their dreams when there's so many barriers and so much negative influence and ways that they could kind of, you know, get into stuff that they don't want to get into. But it's all around them right. So sometimes they get into stuff in order to survive so you know it's very tricky. (F6)

According to participants, lack of support from management creates a dilemma for frontline service providers who are responsible for delivering appropriate services to a client but cannot determine appropriate services, particularly if these do not fall explicitly within the agency's internal policies and procedures. Taken together, these barriers blocked participants in their work but, to a degree, also challenged and motivated them to press for social change.

Lack of resources such as funds and time were also mentioned as a barrier in enabling what participants from the first workshop described as spending quality one-on-one time with workers. This barrier also surfaced when participants discussed to what extent anti-racism policies and anti-racist practice is existent at their organizations/agencies.

Anti-Racism

I find it hard to imagine that there's a social service agency in Toronto in 2006 that doesn't have an anti-racism policy. (F5)

We do have a policy of anti-racism, [but it's] difficult to know whether the policy works. There is no money. (M)

While participants overall affirmed that anti-oppression or anti-racism policies do exist at their agency and other mental health service providing agencies, they are not necessarily enforced or integrated at every organizational level or reflected in all of the agency's practices. Participants perceived that this had to do with a certain level of discomfort and subsequent reluctance their ability to translate anti-racist/oppressive policies into practice.

I think that [anti-racism] challenges organizations, the power structures within the organizations in a really core way. Because a lot of the organizations that I've worked for, social service organizations, beyond a certain level are white. So the board is white, the executive directors are white and all senior management is white, and most middle management is white. So, they don't want to look at it, it's a little too touchy. (F4)

I think sometimes my ideas about how the work has been [or] should have been done in terms of what I see at the front line level is very different from my manager's point of view. So, having to really battle to kind of make it known that some of the interventions I'm using weren't legitimate. So, I think that sometimes it can be very tricky when the whole organization isn't on the same page with the anti-racism framework. (F6)

Participants linked this discomfort to the climate of political correctness and the positionality/social location of senior management, who were in turn under pressure from funders. Based on this interpretation, participants, such as F4 below, explained that conditional funding, proper resources as well as direction and support have to be provided from individuals in upper decision-making level positions in order for anti-racism/oppression to fully exist.

It's not invited, it's not invited. And, so I really think it needs to be top down. Like I we were saying it has to come from a funding level because it won't be of interest to many decision makers unless it is attached to money, unfortunately. And, I think that that's a lot of what we are seeing in social services because it is a direct threat to power. I mean, it's really clear it's interesting I mean there's all kinds of policy changes happening in different organizations around becoming more sensitive, but around race and racism it's always a little bit harder or a lot harder to address that. (F4)

Care and effective oversight, monitoring and evaluation has to be matched with adequate resourcing. The proposition is having resource capacity to be able to deliver on the policies' commitment. [...] Many of the funders got strong rhetorical commitments to anti-racist and anti-oppression funding on that basis as a condition of making available funds. But after that state of commitment what kind of follow up is there in terms of budget allocation for organization X or program Y? How much of that is specifically given for building capacity within the organization to deliver on those policies' commitments? Because often it's lip service. (M3)

Even when the agency, as a whole, and management claim to be working from an anti-oppressive/discriminatory/racist perspective, participants found that often this did not occur at the frontlines and only became rhetoric at the agency, much to the frustration of participants.

The anti-racism approach has to be kept alive, not just one or two trainings but revisiting and in different ways. (F4)

Some participants pointed out that this rhetoric can run a risk of encouraging tokenism and reactionary practices at the organization.

Even if someone was assigned or there was money for that role, probably not, but if some of that ...I'm just thinking about how you would begin that kind of process to make it pro-active instead of reactive. (F2)

Yeah, and unfortunately that person is usually a person of colour you know. I find that people are usually like, if someone brings it up they are like "oh yeah, I never thought of that". Which is cool, but then if you're the person that constantly brings it up then that's not cool, after all you are like "people come on, am I the only person that can see that this is an issue?" And then from the other side of it too, I think that there's people...there might be people in the room that do see it but then they think, "well I'm white, so should I say something?" You know, and then I think...so that's another issue as well or like, or you get told... (F6)

I think that [it's] ultimately important for organizations to realize that... [...] And I don't care what training you've had or how many anti-racism programs you've been to, until they really kind of realize that and just not see anti-racism policies as like being a reaction. I feel like it's really reactive and it's also preventative. It should be preventative but in a way that it actually works. You wait until I come to your office with a complaint before anything happens, you don't talk about the little conversations that are had in the meetings or little comments that are made so... None of that stuff is really talked about until somebody says something. And I think the reality in my kind of day-to-day working environment is noone is going to full out call me with a racial slur, that's not really going to happen, we all know it. (F6)

Overall participants seemed frustrated that they were not always able to do something, particularly with management who already claimed to be anti-oppressive. Again, the question of accountability with regards to the implementation and integration of anti-oppressive/racist principles surfaced.

And then I guess some of the other things that we talked about that stand out for me are around anti-racist and anti-oppression policies in our workplaces and if they exist, how are agencies held accountable to whether they are actually being carried out? (F4)

Needs and Recommendations

What participants perceived as potential solutions to these dilemmas and recommendations for addressing the issues that relate to racism/race-based discrimination and mental health were largely two-fold. On the one hand participants proposed changes at the front-line levels of practice and on the other hand, shifts at the policy level that would influence the work of senior management and decision-making.

Reflecting on their own frontline work and having discussed the lack of know-how and proper intake or assessment tools, participants saw a need for incorporating anti-racism practices into assessment forms and procedures.

I mean I just wanted to change something on the intake assessment. What I feel could be good is just add one thing to a column or the information piece that you can share whatever information is relevant and significant to your diagnosis which may not be very medical or very maybe health-based. Anything related to your culture, to your values, to your upbringing, to your family that you think we should be aware of these things - that might open up a bit a little bit, that might create a little positive feeling in the person that may make them feel comfortable. [...] Many times very good professionals are totally ignorant about these issues and if the psychiatrist is astute enough he can request putting someone for extra charge or make it a little flexible to the needs of the clients. If that part is included in the process, in first interaction that might smoothen the process. (F1)

[I'm] thinking of changing assessment tools so we can bring in anti-racism / anti-oppression. (M)

Considering the push towards evidence-based practice, participants also suggested investing in research endeavours that would support the development of a tool that could help service providers with identifying systemic issues that may affect their clients' health. In further discussing the possibility of change at the practice level, some respondents spoke about the need for holistic practice, where knowledge about racism/race-based discrimination and mental health would be integrated rather than provided as an add-on to existing practices.

We've got to generate those numbers, [...] into creating a service model which can be more holistic, more and more fully integrated. (M3)

Should we make the assumption that it is an issue for everyone, for every person of colour? What if you start with that assumption then, it has some impact on people's lives. (F2)

I think [...] it's about weaving it into everything that you get, it's not about "today, the anti-racism day". You know, it's like "we're having conversations about our clients", you know it just weaves into your conversations/meetings that you have every week, or whatever it is. (F6)

As the comments below suggest, these practice-level needs also require shifts in conceptual frameworks at higher management and policy levels.

Policies need to take into account the kind of overlapping of barriers that clients face. (F6)

Those two, sort of identifying and understanding racism to be a key social determinant of health. In terms of using that language as well. [...] The LHIN process needs to recruit a knowledge of racism as a fundamental foundation of social determinant of health. [...] Certainly resourcing the anti-racism, anti-oppression service framework through the LHIN process [is also needed]. (M3)

I mean in creating an integrated system of support so that people don't fall through the cracks. [...] I can say that I'm doing anger management but the kids are saying to people that they need a job. Or what they really wanted is a job and they actually need the job and I think that that would actually really help. [...] So, it's actually about getting rid of silos and about funding things in an integrated way and in a way that is relevant to the community and locally. (F4)

To help ensure that equitable services are provided, participants suggested the development of a tool or mechanism to monitor and assess the implementation of anti-oppressive/racism policies which organizations claim to have integrated. Participants saw this kind of policing as regrettable but on some level necessary to overcome the barrier of organizational resistance and rhetorical anti-oppressive/racist policies. To this end, some participants suggested to have conditions attached to funding while others recommended having an external evaluation or monitoring body with the responsibility to hold organizations accountable.

Tools could measure whether policy is working. Institution is self-policing. There should be external measures, external entity where people could complain. (M)

Some of the other things that we talked about that stand out for me are around anti-racist and anti-oppression policies in our workplaces and if they exist, how are agencies held accountable to whether they are actually being carried out? [...] it's useful to have an independent sort of way, or some way they should be held accountable. Then we also talked about funding. This idea that funding should be conditional based upon I guess agency policies or maybe the programs - if the program takes into account anti-racist and anti-oppression approaches. So there should be some conditionality on funding and accountability in terms of how that money would be used in a program. How that program would be implemented. (F4)

Where a tool is critically needed is that funders...it's inconsistent what policies they have on paper (granting to meet regulations) and what gets implemented. A tool that would provide getting accountability. A measurement or audit tool. (M)

In addition to policy enforcement and the development of assessment tools, two participants also suggested investing in collaborative and partnership work to build capacity and provide more appropriate and equitable services to racialised communities. One participant explained,

Work such as this, analysis such as this and maybe the effort of joining up with others can be critical to us being more effectively able to intervene into that process. Whether it'd be LHINs or going back to what M2 was saying earlier, about having some kind of a common point of reference for ensuring the integrity of [an] anti-racism initiative. A constant [range] of programming service, it's something akin to having the province re-establish an anti-racism secretariat. Something that has sort of cross-ministerial responsibilities to possibly do monitoring, to do evaluation. But, first and foremost a better resource and work that needs to be done. But that brings us to that enhanced effective capacity. (M3)

9.3 Workshop III – Policy-Makers, Funders, Senior Management, Educators/Researchers

The focal point of this third and final workshop on mental health and race-based discrimination was on the response of those in senior decision-making level positions with regards to the contributions and preliminary findings of previous workshops, with mental health consumer survivors and service providers.

While participants affirmed and confirmed the disclosed experiences of workshop I and II participants, and even added/shared other accounts of mental health and race-based discrimination, the focus of ensuing discussions was predominantly on practice model and organizational-level issues, rather than the individual experiences of consumer survivors of colour. One of the central concerns for participants in this workshop, was the gap or disconnect between understanding/knowing 'what is going wrong' and 'what can we do' (what can be done), which lead to questions about 'where to go from here' (moving forward). These questions reflected the main challenges faced by participants, as they discussed racism, mental health and anti-racism in relation to the development, implementation, and evaluation of policies and programs that affect the experiences of mental health consumer survivors and the delivery of appropriate anti-racism services by service providers in the field.

Making Linkages: Racism/Race-Based Discrimination and Mental Health

Overall, participants conveyed an understanding of current issues and anti-racist work as they discussed the verbatim quotes and cases taken from the two previous workshops. In other words, they presented information that did not seem to particularly surprise participants. In fact, those who spoke, expressed their commitment to the need to address the issues reflected in the materials from the first and second workshops. Based on participants' comments and discussions, the way in which 'the problem' was interpreted and defined, also dictated what a particular participant identified as gaps, needs, and possible solutions. Given this pattern, the following quotations illustrate some of the participants' analysis and interpretations as the group discussion moved towards examining ways to address what mental health consumer survivors and service providers talked about.

Racism can actually cause mental illness itself, but once you have the illness and are in the system, racism determines access, etcetera. The course of your experience in the mental health care system will be directed by race, gender, sex, etcetera. More likely to get there and to get stuck. (F7)

I'm seeing it as James Baldwin, a famous African American writer once said, to be black and conscious is to live in permanent state of depression. To be aware of what your blackness means in American society, actually drives you crazy. It'll take your mind. I think it's more than the awareness it's also the impact. The accumulative impact of your experiences [of] being a person of colour. In a society where white supremacy and racism are integral to that society, failing in terms of things like prospects for your life, future prospects for future feelings of self-worthiness, [...] and self respect and

the human being everyday having to negotiate their humanness all the time in terms of how others might perceive your assumptions or [...] your work and so on, to more apparent things like politics, that [is] significant you know. Particular ways that because of who you are racially, your experience in the educational system, everyday racism, actually books about everyday racism and [...] taking the train, stopping at a stop, at a street light, and the kind of looks you get in the elevator, someone who is of mainstream culture, some of their reactions. I think it's all those things put together that can have an impact on your stress level, your depression, your feelings of marginalization in a nation, your mental illness. [...]. So I think it's a whole bunch of, a confluence of things, in my mind, that have to do with how you are located in society, how you are perceived [...]. And your spirit and your body and your mind negotiate those things, every day of your life. And for some people the results are significantly damaging. Their coping skill, support mechanisms, and sense of self and so on, are not strong. (M2)

According to participants, the racialised identity of the consumer survivor as 'a person of colour' first and foremost mediates any experience in the world on a day-to-day basis, shaping and influencing his or her mental health, and subsequently the experience with the mental health system. Racism not only affects mental health directly by causing mental illness in terms of determining the overall health and well-being of a person, but also racism plays a key role in their lives on an everyday basis,

There was research that talked about that kind of labelling. And who is getting access to certain services is very, you know, gender based, race mediated. (F4)

F4: I think [...] what's happening is as you're going through the system because there is stereotyping that mediates what kind of access and services [...].

F3: Right yeah. So you're more likely to get in there in the first place and more likely to get stuck in there

The media does not help. We are struggling right now with families, as soon as you say Jane and Finch you have a "No" and [we] are hoping that with time, that will go away and you can become credible in the community and people can see the agency and the work that we're doing in a positive way rather than a Jane and Finch community agency. I think that, we see a lot of racism, the kids tell us, and so we hear [...]. (F1)

Racism in the form of race-based discrimination continues to affect the person once involved with mental health services and/or the mental health care system. As the quotes suggest, racism not only determines access to services but also the length of time spent in a given mental health institution, including incidents of misdiagnosis, and mistreatment. The issue of access to appropriate services and treatment was mentioned the most as participants conceptualized what happens to individuals of colour who encounter the mental health system. Specifically, participants saw the practice of labelling and stereotyping, and the stigma attached to mental illness as exacerbating access issues faced by consumer survivors of colour.

Some participants pointed out that the concept of mental health itself is flawed and discriminatory because of its Eurocentric historical roots and practice model. This in turn encouraged discussion on the mental health system itself, where participants drew linkages between funding and programming, and the experiences of consumer survivors of colour.

Once you get ill and already in the system, some more likely to get medicated. Sometimes just need a lunch program, not psycho-therapy but don't get funded for it. Therefore, problem is how they define 'mental health' within the mental health care system. So, how is it systematically organized doesn't allow for [this type of response]. (F6)

What is Being Done

Guided by workshop facilitators, the focus of the discussion shifted from an outward perspective on interpretations and analyses of consumer survivors' experiences to inward experiences on participants' own practices and programming. When asked what they or their organization may be doing in an attempt

to address some of the issues raised, many participants described some of their organizations' current projects and initiatives. Some of these consisted of supporting, developing or adopting 'alternative mental health practice models such as narrative therapy and community-capacity building efforts.

My program, [...] which is a minister health program, that is in the Jane and Finch community and around surrounding places. And we are approaching it very much on a community-based, community building. I firmly believe that you can't help the youth and send them back into the same place. That we have to help both, the individuals and the families, and the community. And so the group of workers that guides them [...] really have embraced the community and in fact have become very protective of it because you have to get in there to know the agencies [...] live agencies, not just partnerships there, and to build capacity in that community. We have two clients that we have to save: the community and we have the individual and the youth. And we decided to go to high schools, all the high schools, all the TDSB high schools. So the workers all are running groups, running workshops, and just being there [...]. Now we have a summer program, and we're hoping to support some of those youths from the schools. Because what happens is that they are vulnerable during the school year, and we just let them go in the summer. So our plan is to [...] connect, and hold on to [them] in the summer, whether it be some type of recreation, whether we help them with employment, but support them, rather than leaving them until September and then, you know. (F1)

Others spoke about funding and/or participating in community-based partnership research initiatives in the area of mental health and racism.

[We] work with communities around supporting and advancing initiatives that are related to racism and mental health. So we have strong [...] partnerships with [mental health agencies] and so on. Because we strongly believe that this is a priority and true partnerships and joint projects is something that we want to pursue. We also have some research funded by Department of Canadian heritage looking at access issues, difficulties and challenges people are going to have in the area of mental health. [That is] useful for us in terms of program planning, training and so on. (M2)

Few of the participants spoke about attempts to challenge established discourses around mental health and influence organizational practice models. To change the system, they wanted to change how staff perceive and define 'mental health', through, for example, incorporating holistic notions of mental health into health promotion work.

At Toronto Public Health [...] something that I've been impressed with is the fact that they have [...] to integrate mental health into health promotion in general. And this is an exceptional thing that they're looking at, and along with this comes the training, that policy development and the training that X has been putting into practice [...]. We don't use the medical model approach, and the nurses that are, the staff that is on the front line, in dealing with the community and dealing with individuals in the community are in general not taught in a medical model approach. They're taught to look at their [...] social picture in the individual they are meeting with. And the strategies that they're given to work in the communities they're working in now is very narrative and again, very non-medical model. So, it's like picking away at things, one level at a time. (F2)

I guess what we wanted to do was to have an [access] framework sort of where everybody's practice from the medical office of health, from the person who answers the phone to [...] introduce these standards. So our medical office of health announced approval of this framework. [They] said this is the Toronto Public Health practice framework founded on diversity acts and (inaudible) so it's not ghettoized and it's something else, right. It is the core of how we, Toronto Public Health, should be practicing. So, anti-racism, diversity, it's in the core. It's Public Health's practice. [...] It took us a long way to get there, but then again it's lacking all those little things. One day we'll get there. (F5)

As the quotes suggest, many of them are 'alternative' and marginal projects, in that they are exceptional rather than a part of the mainstream, regularly running programs, core policies, or funding projects. In this sense, even 'what is being done' at upper decision-making levels in the field appears marginal and scarce.

It may also be worth noting that many of these descriptions seemed to be offered in an attempt to show linkages between the conceptualization of 'the problem' and that their organizations are in fact not only aware, but also actively attempting to address this 'problem' (i.e.: issues such as race-based discrimination and mental health). However, when asked whether racism and/or race-based discrimination were actually regularly factored into their core funding, policy, and/or programming decisions, participants were not able to confirm this. Instead, many affirmed that while inclusiveness and anti-racism values were part of the discourse at their work place, they perceived many gaps and challenges that may be slowing down or preventing 'what is being done'.

Gaps and Barriers

Throughout the workshop, participants identified a series of gaps that, in their view, needed to be bridged in order to move forward and ultimately address race-based discrimination and mental health, and the experiences of consumer survivors of colour.

Perhaps due to the demographic make up of the sample, such as the comparatively low number of participants in funding positions, the most discussed gaps and needs were related to funding issues. Those working in positions of senior management, in particular, described the need to provide core funding for programs and services that are effective or proactive but currently under-funded or non-existent.

Once you get ill and you have already [been] in the system, and some people are more likely to get medicated while some others are likely to get access to drugs such as (inaudible) therapy. Now my experience with some [is] they don't need psychotherapy. They may just need a lunch program. So then, being in the mental health system (inaudible) this is not our mandate. So they don't get funding for a lunch program for the mental health and (inaudible) survivors, because this is not our mandate. [...] And that is what is seen as the problem. As the systemic problem on how we [define] mental health too narrow. That if you are working within mental health you go to the Ministry of Health or whatever and then that is their mandate and that is the kind of project or service that they will fund. Other than that it's not. (F6)

'Funders Network on Racism & Poverty' network – [there is] increasing concerns among funders, concern that out of touch about what it is that organizations are actually doing. (F12)

Stop pilot-project funding – need core funding. (F7)

Many of their frustrations seemed to relate back to the conceptual gap in the field, where mental health has not been holistically defined and/or operationalized.

I guess what everybody is trying today is that, the strong statement that racism is the determinant of health. If everybody accepts that racism is the determinant of health then, it will [...] but right now, it's sort of being said but not being said. So if there was a policy statement that says that then on we go, but we still have to get there. (F1)

As a funder, how can I convince myself that 'good' practice is happening across the board? Do I need a report card? How do we know what DOES happen out there? (M1)

From a funder's point of view, the gaps and needs in terms of addressing racism and mental health are much more practical at the core. As the following quote suggests, inconsistencies surrounding mental health as well as racism/race-based discrimination problematize the evaluation and measurement involved in funding decisions. According to this participant, more empirical work is necessary in order to support and promote initiatives that address racism/race-based discrimination and mental health.

From Ministry policy perspective, through Ontario Mental Health Foundation all new investments are being evaluated in Ontario - CIHR will do the same on the federal level. But before we can say what it is that we would want people doing, we need to figure out what are the indicators. (F7)

Obligated to build something or do something new ("value added"). It's always a dilemma when making decisions on what to fund - e.g. some projects on the topic of 'access', seems like have been done before but difficult to ask the applicant to prove that it hasn't been done. Prevent 're-inventing the wheel'. (M2)

The issue of representation in terms of involving frontline service providers in funding decision-making is another gap that was identified and affirmed by many other participants.

Problem is that funders sit down with Executive Directors who are often the problem themselves - why not talk with workers? Need many voices. (F11)

When discussing the need for accountability attached to funding decisions, some participants emphasized that these do not occur in a vacuum, but rather require political will and commitment to addressing racism and mental health. According to the respondents, these are either lacking or not evident in a meaningful way, such that making particular funding or policy decisions without the political support become difficult or impossible.

MPP's [political will] is also important because [you] can't go around setting up accountabilities without it being part of their political commitment. Therefore have to get it onto their agenda. At this point [you] could look at access, look at research on who needs access to what [...], collecting data on 'race' to start with. There has to be a push. (F7)

I just think today [...] anti-racism is offered as just an add-on and it's not something that funders are committed for us to do. We have to find a way for us to put it in, and so I think it is about money and commitment and, like many items, work or collaborate together or to have an approach to support anti-racism. (F8)

With LHINs, they're the operational arm of the Ministry, [but] it's still the Ministry that needs to set the strategic plan. Some basic decisions need to be made before. (F7)

Despite research on racism as a determinant of health, and more support on the frontlines to incorporate the notion of mental health as an integral part of health itself, participants in this workshop, as with service providers in the last workshop, described how racism is actually rarely treated as a determinant of mental health in the area of funding and policy. Echoing the comments of service providers, participants in this workshop seemed frustrated that even when anti-racism is part of a funding requirement, it is often not fully translated 'on the ground' (i.e.: at the organizational level).

Many participants expressed their frustrations, emphasizing that the issues surrounding consumer survivors of colour with respect to racism and mental health are not new and yet not much seems to be changing.

As the quotes below illustrate, some of the participants spoke about barriers that are created through funders' and policy-makers' preference for Evidence Based Practice. A few participants also spoke about the difficulty of shaking belief systems that influence the practice of upper decision-makers, such as the belief in meritocracy among white, privileged middle-aged men in executive positions.

That's the other problem, a lot of the evidence based practice is really individualized so we're never really able to show the evidence that is [(inaudible) that people just (inaudible) what happens to another colour (inaudible) to find their way into the research (inaudible)]. So, it's really a catch-22. When you're in it... (inaudible) it becomes very popular as a resource (inaudible)... (F?)

Talking about the front line people not wanting to recognize their own racism: I think I have to recognize, from a policy-maker sort of frame, taking it upstairs and looking at it at a minister and deputy minister kind of level. As a minister, you have a very privileged position [...] or people at that level. It's not even [about] willingness, there's a very strong sort of individualistic "I got here because I worked hard and anybody that works hard can get here- kind of idea. So when you talk about systemic barriers, what they're hearing is excuses for not doing well. And that is, it's a very sort of 'to the bone' kind of mindset. It becomes very difficult to even start the conversation because it is all about individual and individual treatments and diagnosis and it's part of the philosophy of the culture. So, even getting to the place where you can get the conversation about that's what's happening to a person on the front line, there's huge psychological barriers. (F7)

Challenges

Unbelievable that [we are] still talking about racism, marginalization, voiceless, etcetera. (M1)

One of the most challenging things for us is [to] actually get people to accept that racism is real and is a problem. I'm talking mostly conditions where it's a social discomfort and silence and denial. And the training that we do, we have a level 2 training where we work with condition around issues of cultural competence. [...] There's a challenge around [...] talking about assumptions and stereotypes that might inform the way they [clinicians] interact with certain clients and the clinical decisions they make around diagnosis and treatment and some of the implications of those decisions. It's very, very difficult. Racism is the hardest thing for us to talk about [in] mental health. (M2)

Apart from concrete barriers and gaps that need to be overcome in order to move forward towards equitable mental health care access for racialised communities, participants shared their professional experiences with a number of challenges that they are faced with. These challenges can be described as conceptual and/or methodological difficulties that participants are currently struggling with in their own work. One of these challenges relates to social location and involves reflexive practice. Participants distinguished between the need for professionals to accept racism as a determinant of health, and accepting that racism may exist structurally and internally in the organization. With this acknowledgement comes the challenge of examining oneself as being implicated in racist practices and processes that may affect individuals from racialised communities.

We have to work with the youth and we cannot walk away from the whole thing. (inaudible) affecting a lot of youth of colour and from that there's a whole chain reaction: out of school, nowhere to go, unemployed (inaudible) and then we run the whole (inaudible). So I think the whole school be racist. It's like somehow the whole thing from here generates to (inaudible), like social workers too. They don't want to believe that social workers, because of their work with kids and health, can be racist. But you know what, they come up in the same system, and they can be racist, and it's something that nobody wants to talk about. Nobody wants to say that the power and the privilege you have plays a central part in your therapy, and how do you handle that, you know. (F1)

What comes next, once accept that 'race' place a role? I.e. have to look at all aspects of the organization, etcetera. (F9)

One of the things really as a manager, as a funder manager, I think that we are going to have to continue to do is challenge the assumptions of others that we work with because again, working in all those years in the system is very discouraging to me, that in 30 years [...] in Toronto it's still as difficult. Sometimes I think well, should we just wait for the next generation, when people have come up? You know, compared to 20 years ago there is more diversity in this group than there would have been twenty years ago. Anyways, that was sort of just my own discouragement. It comes with challenging the system there are many places that do have anti-racist policies, diversity, equity but there's a self protectiveness and also maybe it's a self righteousness that nobody feels that they...you know, even when you raise the topic even when you say it in a place that you feel it. In a health organization you should be able to talk about it. It's extremely difficult, so I believe what we need to do as managers or people that have a belief in this is to continue to find a way to challenge within the

organizations that we work in. [...] People really need to examine themselves, whether it takes the community to do that. (F4)

According to some participants, even when racism is fully acknowledged, the implementation and maintenance of anti-racism as a framework, practice, values, and knowledge are still a challenge at the frontlines.

I think, there's something that I've discovered about keeping anti-racism alive in a neighbourhood. I think it is very easy to apply, and everybody knows what's politically correct everybody knows to say this...it's so easy to implicate, to co-operate. So, to me it speaks about, do you have diversity? Do you have people that can keep that alive? Because if you don't, then who is holding it? Some...who are the people who are going to hold this idea, and keep it going because I feel the mainstream because they don't have to deal with and interact with the people of colour or racialised people. They go home and it's easy for them to come back next week and forget. So, it's like, how you keep it alive. I mean, it's good we go to the workshop and we come back, da da da da da like everything, it's just so much wrong. (F1)

When discussing an evaluation of anti-racist practices and policies, the issue of political commitment as well as questions around accountability arose. This theme emerged throughout the workshop, particularly when participants voiced their frustrations with regards to existing equitable and anti-racist programming, policies, and funding that are not enforced due to uncertainty about who is to be held responsible. This question was a challenge as well as a barrier for participants who felt that their roles and capacities in their work were limited to developing or implementing, but not enforcing or evaluating.

When you talk about writing policy, I have (inaudible). But the moment 'mental health' comes up the response generally is "well that's Health's problem, we're dealing with this problem". So my role is continually to try to bring the links back between mental health and homelessness and try to build policy around [that]. But it's very, very difficult because many of the people who work with me don't have any background, they see it purely from the diagnosis framework and a serious framework as opposed to something [...] overall and then shut down, push it away. So it's definitely a challenge. (F3)

I think there's a [...] who defines what mental health care is, you know what I mean? [...] people get trapped in whatever the categories are that were established so long ago. (F9)

Policy Recommendations

Towards the end of the three hour workshop, participants were asked to brainstorm and discuss who they think needs to be on board to create the changes that they see necessary to address the question of equitable mental health care access for racialised communities. While the questions asked about institutional change are due to the vocational background of participants in this workshop, the responses ranged from specific recommendations to more generic suggestions and visions.

Almost all of the participants expressed a need for shifts in conceptual and strategic frameworks that currently dominate and guide the work of policy-makers, funders, and senior managers in the mental health field.

Need to talk to and involve healers in these discussions. Racism has to be seen as a determinant of health. (M3)

Shift definition of mental health into/within 'health promotion' Equity in/and LHINs, because have disregarded access and equity work, taking a non-adversarial approach: Want to talk with you about ideas that can be helpful to you. (M3)

Apart from acknowledging racism as a determinant of health, taking social determinants of health into account, and including 'mental health' into the concept of 'health promotion, participants expressed that

racism and mental health as an issue needs more attention at the political front and where decision-makers are from privileged backgrounds. As one participant stated, change

Require[s] alarm, urgency strategy outside of the normal work. For example, [get a] senior, white male at top level [to] become spokesperson on racism and mental health. Accreditation, measurements obligate, opportunity mechanisms... [We] need a provincial anti-racism mental health strategy that would hold people in the field accountable. (M2)

Others suggested that race and equity be incorporated into accreditation measures, while another participant explained that the definition of 'healthy community' needs to be specified and understood as a construct with cultural dimensions for accreditation purposes and report cards.

Some of the solutions proposed by participants suggested institutional-level changes. Because of the medical background of most institutionally-based mental health care service providers, many of the participants' suggestions referred back to medical schools and curriculum contents. Some of the more prevalent and generic suggestions included 'infiltrating' the curriculum to include education about racism and mental health, and training in equitable, anti-racist practice. Another participant explained that most health promotion strategies in stigmatized communities are too generic and seldom anti-racist, and called for a more active role of Colleges and their practice standards, such that mainstream clinical institutions can be held accountable. One participant specifically suggested having a dissemination presentation to the Ralph Massey Interdisciplinary Education Committee, which has advisory power at the University of Toronto Medical School.

Major drivers of policy need to be brought into the circle. For example, Associations. (F4)

As another funder: About report cards, for example regarding children, I recommend that funders help build community-capacity, rather than just see the goal in the end. Continue to fund the infrastructure and capacity so they can see that it takes time to change and also for funders to work with people with the writing of the proposal, because that is difficult. (F4)

Other institutional-level solutions, included setting standards at the Ministry level through the Strategic Policy Framework because these changes require political will and so-called 'buy-in' from the MPP, and thus, a mandate from government. Similarly, a participant suggested implementing a provincial anti-racist mental health strategy by government and funders in making relevant policy and programming decisions.

At the organizational level, participants suggested that funders involve more frontline staff and less senior managers when seeking input and insight. The provision of anti-racism training to mental health service providers as well as boards of education, teachers and trustees. Organizational change was another recommendation as a step towards addressing racism and mental health.

I believe what we need to do as managers, or people that have a belief in this, is to continue to find a way to challenge within the organizations that we work in. [...] People really need to examine themselves [...]. (F4)

It occurs to me that there needs to be some focus on day-to-day practice in terms of educating service providers [...]. Educating the service providers on the issues of racism: racism in the system because of the way that people practice from day to day. So, changing policies is an important piece of the puzzle but it's not the centre piece, we really need to change how people carry out the services and what their understanding of the multi-cultural sensitive specific groups [is]. (M4)

Need anti-oppression framework for every staff at TDSB, because that's where kids start. (F8)

One participant expressed that bringing racism and mental health related concerns to the forefront of a LHINS' or political agenda requires an advocate at the highest level of influence and power. According to this participant, a senior white man would be ideal for such a position. Others discussed that the support of the Physician's Association could also be beneficial as the association is quite influential.

A number of suggestions related to representation in research (i.e.: involve alternative healers as participants, focus on youth as subjects), and research findings. There was a consensus among participants that longitudinal data and studies are needed to show what happens to individuals who are from racialised communities in their day-to-day lives and when navigating the system in order that the impact of racism over time can be documented.

Need more longitudinal research. What happens to people of colour as they navigate the system? [We need this information] so that we can say definitely how racism is impacting people's mental health. Because most info right now is from the UK and the USA. Especially with regards to youth. (M2)

I think it's [...] building policy, policy sketch, and experience working with children and what we began to look at, moving away from having to have a diagnosis and what helps keep people mentally healthy, and there's a lot more work being done now on resiliency. What is it about one person that has all these strikes against them, and another person, what is it? So rather than trying to eradicate all the things that cause problems, can we build on things that help you [...] that [...] from adversity? Which is really, I mean there are some amazing stories out there. So I will believe that, you know, in all health and mental health, to focus on what are some of the things that help people [...] if there are many things that will against racism, being one of them. And you know, resilient people, the hallmark of resilient people is that you believe that tomorrow is going to be better than today, that there is hope for the future. And I think that we have done a lot of work for children in the homeless shelters in the Scarborough community, and really in the end we can't take away all of the strikes against them at this point, but what we can do to build on what they have. So I would say racism and then the connection there, is yet a huge strike against people who are already having a difficulty in [...]. (F2)

There was also a call for empirical research to help determine and identify 'good practice' indicators and accountability measures to support and assist funders.

Re report card: we should measure what is a 'healthy' community - definition would come from epidemiological research - so that it would become an accountability measure In terms of quality of life – some report cards are already there i.e.: social determinants of health. (F4)

Develop an experimental research model [about] what factors would mean. Indicators that measure what we already know is out there. (M1)

10.0 DISCUSSION

According to the respondents who participated in the workshops, the mental health care system generally fails to appropriately meet the needs of racialised communities due to barriers to access such as race-based discrimination.

For consumer survivors from the first workshop, race-based discrimination and experiences of racism in their everyday lives comprise a major obstacle to gaining equitable access to mental health services that they seek out. Their experiences are shaped by a multitude of structural dimensions such as gender, socioeconomic status, dis/ability, and age that intersect and combine with a variety of institutional barriers of which access to equitable and appropriate mental health care is a central piece. In other words, the stigma associated with having a mental illness, is exacerbated for those from racialised communities who seek mental health services as they are marginalized on the account of being a consumer survivor as well as a person of colour.

When faced with inter-personal and institutional barriers, consumer survivors attempted various strategies in order to cope. These attempts included seeking the assistance of an advocate such as a social worker, speaking up at various events such as workshops, and actively resisting service providers by denying medication and demanding a change in prescribed treatment. However, the 'power over' exercised by professionals in charge of determining clinical diagnosis and treatment combined with the dominance of

Eurocentricism that they encountered particularly in the context of institutional, psychiatric services further silenced and excluded them. Participants illustrated that remaining resilient and vocal about their needs and rights requires not only a conscious effort, but also personal power and perseverance when faced with a mental health care system that seems to render them silent and powerless through its every day practices (e.g.: via over-medicating, medicating all the same/categorizing, stripping of individuality, dismissal due to labelling and stereotyping).

The notion of inclusivity, and lack thereof, was raised in relation to the perceived lack of diversity among service providers. Participants attributed this to the mental health care system's inability to truly comprehend the experience of racism and thus consider this knowledge when attempting to help an individual from a racialised community. As two of the respondents clarified, they would like to see consumer survivors who 'have made it' and are of colour among mental health service providers in the hopes of being understood. Although the issue of representation was raised in relatively subtle ways, respondents seemed to agree that the quest for diversity and representation has to incorporate dimensions beyond 'race' in order for service providers to be truly representative and able to identify and advocate on the behalf of racialised communities. This notion resonates with some of the literature that cautions how assuring diversity among staff can easily turn into superficial level tokenism that fails to address the underlying issue of racism and exclusion. It is important to acknowledge how a person's social location via gender, class, age, dis/ability, and sexual orientation shapes access to equal participation in society.

Participants in the service provider workshop however seemed to identify restrictions arising from funding requirements and institutional policies that affect programming, as the biggest source of constraint, in their practice with mental health consumer survivors from racialised communities. In addition, many of the service providers were not able to conceptualize how they could be able to practice from an anti-racist (anti-oppressive) practice framework when they are faced with barriers such as organizational resistance to change internally.

At the same time, when asked how they would account for the experiences of racialised communities during assessment or intake procedures, participants seemed to have difficulty, conceptually, to envision an assessment tool that would go beyond individual-level experiences of racism/race-based discrimination such as verbal or physical abuse. This became particularly evident when participants discussed the challenges in their own practice and brainstorming potential solutions that could meet their needs as professionals. These analytical gaps may point to what consumer survivors who participated in the first workshop perceived as a need for the inclusion of anti-racist analysis in the curriculum and training of mental health service providers.

Service providers also felt that more backing from various levels of policy makers and funders may help enforce anti-racist policies that some service providing organization have adopted superficially but have not implemented. Service providers expressed a need for resources in their organizations that focuses solely on these changes.

Policy makers, funders, and other participants from the last workshop suggested a need for a system of checks and balances that would hold service providing organizations accountable for the provision of equitable services to racialised communities, but acknowledged that such a system may not serve the purpose if it is received by the community as just another intrusive measure that threatens to withhold funding. These participants recognized and conceptualized the problem as expressed by consumer survivors in the first workshop, but were more at a loss of what to do to remedy this situation. Most of the participants agreed that a conceptual shift at decision-making levels is needed to influence practice models and service provision at the frontlines.

Participants from all three workshops were simultaneously eager to move towards positive change in the mental health care system with regards to access to quality care for racialised communities, and almost equally expressed a sense of helplessness in terms of tangible steps that could be taken to move collectively in this direction. All in all, participants expressed a dissatisfaction and disbelief in mental health practices that continue to be based on the medical model. Reflecting participants' own professional

experiences that are rooted in community-based or otherwise non-mainstream mental health services, such mental health services appear to be the root causes of consumer survivors' negative experiences with the mental health care system.

11.0 GLOSSARY

Anti-racism refers to an active and consistent practice and process of change to eliminate individual, institutional and systemic racism and the oppression and injustice caused by racism (Canadian Race Relations Foundation, 2005).

Consumer Survivors was a politically correct term coined by the mental health community to refer to deinstitutionalized mental health patients who used mental health services. According to Crossley (2004) 'survivor' conveys a sense of activity, independence, strength and courage and "both breaks the direct link to illness, challenging psychiatric categorization, and allows for the diverse range of adverse situations that 'survivors' have survived." (p.169). This report approaches this term as an open and flexible concept, acknowledging its dependence on sociopolitical context, time, and person. Individuals may be choosing this term for a variety of reasons, such as conveying that they have had a mental illness or mental health problem in the past, that they no longer experience a mental health problem because they have 'survived' it, that they are currently experiencing mental health problems or a mental illness and are using ('consuming') services because of it, or that they have successfully 'survived' the mental health care system.

Discrimination refers to 'the process by which a member, or members, of a socially defined group is, or are, treated differently (especially unfairly) because of his/her/their membership of that group' (Jary & Jary, 1995).

Health is the 'state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity' (WHO, <http://www.who.int/about/definition/en>). This study approaches health from a holistic view that understands how sociopolitical environment, access to power and privilege, and other structural realities impact and determine health outcomes for communities.

LHINs refers to 'Local Health Integration Networks' which were created by Ontario's Ministry of Health and Long-Term Care in an effort to address the issue of un-coordinated services in the health care system. Under the Local Health System Integration Act, LHINs are non-profit corporations that have the legislative power and authority to develop, fund, and coordinate local health systems to provide accessible health care. Among the services and programs that LHINs are responsible for are mental health and addictions agencies, community health centres, and hospitals.

Member Checking refers to a process where participants in a study verify what researchers have reported by reading and confirming researcher's findings as being true (Neuman, 2003). Also referred to as *member validation* or *participant verification*, member checking allows for higher authenticity and trustworthiness.

Mental Health is the 'state wherein the person is well adjusted' (WHO, <http://www.who.int/about/definition/en>). Integral to overall health status, a person's mental health is directly and indirectly affected by a variety of intersecting personal, institutional, and structural factors and dimensions. Experiences of race-based discrimination, for example, affect the well-being of racialised communities through many ways, some of which are explicitly obvious while others are not easily identified or named.

Mental Health Care System, for the purpose of this study and report, refers to the totality of policies, practices, service providing organizations, and services, including official mental health services (psychiatric, counseling, therapeutic) as well as others that provide services that address the mental health of an individual.

Newcomer refers to an individual who has been born outside of Canada and immigrated to Canada. For the purpose of this report, this definition includes groups of people who are not legally considered economic class immigrants, such as refugees, sponsored individuals, or individuals with less than full legal status.

Non-probability and **non-representative samples** are types of samples that are not representative of the general population because they are based on nonrandom sampling methods.

Nonrandom sample is a sample that has been created through a process other than a mathematically random process (Neuman, 2003). Nonrandom samples are not representative of the general population and yield findings that therefore not be generalized to the wider society.

Purposive case selection is a nonrandom sampling method where researchers identify and choose all possible individuals or 'cases' for their sample, particularly when the specific population is hard to reach (Neuman, 2003). Purposive sampling is determined by and reflects the purpose of the research.

Racialisation refers to the process whereby 'racial categories are constructed as different and unequal in ways that lead to social, economic and political impacts and health inequities' (Galabuzi, 2001). This process also constructs some individuals and communities as 'whites'.

Racialised Communities is a term that deconstructs the notion of 'race' by emphasizing instead the process of racialisation that constructs identities and racial stratifications. It is used to highlight how communities are discursively and socially constructed as primarily 'racial' through racialisation. Although the process of racialisation also constructs and racializes some people as 'white', the usage of the term 'racialised communities' in the context of this report reflects the Mental Health and Discrimination Working Group's preference to refer exclusively to 'communities of colour'.

Racialised Groups refers to non-dominant ethno-racial communities, who through the process of racialisation, experience race as a key factor in their identity and therefore experience differential treatment in relation to the dominant cultural group (i.e. white) (Galabuzi, 2001).

Racism refers to a system in which one group of people exercises power over another group on the basis of skin colour; an implicit or explicit set of beliefs, erroneous assumptions, and actions based on an ideology of the inherent superiority of one racial group over another, and evident in organizational or institutional structures and programs as well as in individual thought or behaviour patterns (Henry et al., 2000, p.410).

Reputational Case Selection is a nonrandom sampling method where researchers locate potential participants or 'cases' because of the known reputation of that individual. Behind this method is the assumption that "groups of influentials in a given field are interconnected: that members know each other, either personally or by reputation, so that if you ask them who the key people in the field are, they will know" (cited in Farquharson, 2003).

Snowball sampling is a nonrandom sampling method where researchers identify one individual as a potential participant ('sample case') and then identify other participants based on the first individual's interrelationships and networks, and repeat this process to create a sample (Neuman, 2003).

Trustworthiness refers to the extent to which a study's findings can be trusted (Patton, 2002). Multiple data collection methods as well as member checking help establish trustworthiness, which adds to the credibility of study findings (Patton, 2002).

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13.0 APPENDICES

Appendix A: Letter of Request – Service Providers

March 2006

Dear Colleague(s),

On behalf of the Mental Health and Discrimination Working Group, I would like to invite you to participate in a workshop that examines the barriers and opportunities faced by mental health service providers in the delivery of appropriate services to racialised communities. The workshop is part of a larger community-based research partnership project, entitled **Striving for Best Practices and Equitable Mental Health Care Access For Racialised Communities in Toronto** (funded by CIHR).

In the workshop, we would like to know the extent to which a holistic approach is being used in assessment and intervention work with racialised clients in mainstream (e.g. hospitals), ethno-specific (e.g. culturally based service providers) and alternative (e.g. feminist, anti-racist service providers) mental health agencies. Overall, we hope to identify barriers and opportunities so that service providers may provide appropriate services to racialised communities.

The working group mentioned above is comprised of Dr. June Yee (School of Social Work, Ryerson University), Martha Ocampo (Co-Director, Across Boundaries), H el ene Gr egoire (Research/Evaluation Coordinator, Access Alliance Multicultural CHC), Chris Rahim (Coordinator, Women's Counselling Referral & Education Centre), and Eliana Suarez (Social Worker, CMHA). These research partners have been involved in the design and development of the larger study and will continue to be involved throughout the project.

Your interest in this workshop is greatly appreciated. Your insights, experiences, and expertise are important for this study and may influence improvements in the mental health system such as access to appropriate services for racialised communities in the future.

This workshop is second in a series of workshops held with various stakeholders. This one will build on a previous workshop we held with 15 mental health consumer survivors on February 21st, 2006. Some of the participants' comments and case stories will be used as material for discussion for the service provider workshop. A third workshop will be held with a group of funders, policy-makers, and researchers towards the end of April 2006. The findings of this study will be disseminated through a variety of channels including a report that will be distributed to SPOs and other stakeholders, a community presentation, and other venues pending stakeholder input.

I would like to ask you to participate on March 15th from 12:30 pm to 4:00 pm, at Access Alliance Multicultural Community Health Centre (340 College St., Suite 500. At Augusta Ave.). Food will be catered and we will have lunch from 12:30 until 1:00 pm. However, as space is very limited I would like to ask you to pre-register with me as soon as possible.

If you have any further questions about this study please feel free to contact me at _____ or per email at sshahsia@ryerson.ca.

Thank you for your time and interest, and I look forward to hearing from you,
Sincerely,

Sara Shahsiah (BSW, MA)
Research Assistant
sshahsia@ryerson.ca _____

Ethics clearance from both the Ryerson University Ethics Review Board and the Ethics Review Committee at Access Alliance Multicultural Community Health Centre has been obtained.

**Appendix B:
Letter of Request – Policy-Makers, Funders, Senior Management, Researchers/ Educators**

April 2006

Dear Colleague,

On behalf of the Mental Health and Discrimination Working Group, I would like to invite you to participate in a workshop with policy-makers, funders, educators/researchers, and management who work in the mental health field. The workshop is part of a larger community-based research partnership project, entitled **Striving for Best Practices and Equitable Mental Health Care Access For Racialised Communities in Toronto** (funded by CIHR). The working group is comprised of the following research partners: Dr. June Yee (School of Social Work, Ryerson University), Martha Ocampo (Co-Director, Across Boundaries), H  l  ne Gr  goire (Research/Evaluation Coordinator, Access Alliance Multicultural CHC), Chris Rahim (Coordinator, Women’s Counselling Referral & Education Centre), and myself as the Research Assistant/Coordinator.

This workshop is the third and last one in a series of workshops held with various stakeholders. It will build on the findings of two previous workshops; one held with mental health consumer survivors in February, and another with mental health service providers in March. The first workshop focused on how racism affects participants’ on a daily basis and their interactions with the mental health system. Participants also created a list of recommendations and concerns for service providers. The workshop with service providers dealt with the barriers and opportunities participants felt they face in the delivery of appropriate mental health services to racialised communities using some of the findings from the first workshop. Some of the contributions and comments from previous workshops will also be used as discussion material in the workshop with you.

Apart from your responses to the findings from the first two workshops, in this workshop we would like to explore your response to the issue of racism and mental health in terms of policies and programs that may or may not respond to and/or address some of the concerns raised by consumer survivors and service providers. We would also like to hear from you about the barriers/opportunities that you may face in pushing forward towards an anti-racism/anti-oppressive policies and programs. Overall, we hope to identify avenues towards equitable mental health access for racialised communities in Toronto. The findings of this study will be disseminated through a variety of channels including a report that will be distributed to SPOs and other stakeholders, a community presentation, and other venues pending stakeholder input.

Your interest in this workshop is greatly appreciated. Your insights, experiences, and expertise are important for this study and may influence improvements in the mental health system such as access to appropriate services for racialised communities in the future.

I would like to ask you to participate on April 27th from 12:30 pm to 4:00 pm, at Access Alliance Multicultural Community Health Centre (340 College St., Suite 500. At Augusta Ave.). Food will be catered and we will have lunch from 12:30 until 1:00 pm. However, as space is very limited I would like to ask you to pre-register with me as soon as possible.

If you have any further questions about this study please feel free to contact me at (phone number) or per email at sshahsia@ryerson.ca.

I look forward to hearing from you,
Sincerely,

Sara Shahsiah (BSW, MA), Research Assistant

Ethics clearance from both the Ryerson University Ethics Review Board and the Ethics Review Committee at Access Alliance Multicultural Community Health Centre has been obtained.

Appendix C: Workshop Discussion Guide – Mental Health Consumer Survivors

Note: The following discussion questions serve as a guide only. The discussion questions have been created to respond to the following research questions:

- How does race-based discrimination affect mental health consumers/survivors in their every-day life?
- How does race-based discrimination affect mental health consumers/survivors in the mental health system?

Objective: To learn about consumer survivors' experiences with the mental health system and their mental health in relation to their day-to-day life experiences as individuals from racialised communities.

I. Experiences with the mental health system

(including services, service providers, institutions, policies)

- a. While seeking services, did you experience any problems in trying to get the services you wanted/need?
- b. What is/has been your experience with mental health services, programs, etc?
- c. Do you think your identity or who you are played a role in your experience?

II. Making connections: Mental health and racism → *responses to these questions will be derived through interactive workshop exercises*

- a. How did you first learn about your own mental health?
- b. What is mental health to you?
- c. How, if at all, do you think are discrimination and mental health linked?

III. Final Suggestions

- a. What would be the single most important change you would suggest to improve services to individuals (from racialised communities) who experience mental health related issues or problems?
- b. Any advice for current or future mental health consumers/survivors and/or their families?
- c. Is there anything else you would like to us to know?

Appendix D: Workshop Discussion Guide – Service Providers

Note: The following discussion questions serve as a guide only and may not be followed exactly due to the interactive nature of workshops. The responses and (preliminary) findings from Workshop I will be incorporated in these discussions.

I. Own practice

- a. What is the practice model at your workplace?
 - *Probes:* What is the practice approach? What do the working assumptions and/or policies look like? Are any equity policies/practices incorporated into the practices at your workplace? If so, how?
- b. How do you practice from that model?
 - *Probes:* How would you assess if someone had a mental health 'problem'? Does 'race' play a role in assessing whether someone has a mental health 'problem'? Do the assessment tools you use to make an assessment/diagnosis factor-in 'race'? Does it include experiences of racism/race-based discrimination?
 - *Probes:* In what way do you factor the role of racism/race-based discrimination in a client's mental health into your practice/service provision?

II. Self

- a. How do you as a person (of colour?) influence your practice?
 - *Probes:* Do you think assessments differ depending on who is assessing or who is being assessed? Does your identity have any affect? In which way does your 'race'/skin colour/ethnicity/etc affect your work?
- b. What is the single greatest challenge you face in working with/providing services to people from specific ethno-racial backgrounds?
 - *Probes:* What would you change about the work you are currently doing? The services you provide? The mental health system?
- c. What advice would you give to other service providers who
 - find themselves in a similar situation like you?
 - also work with mental health consumers from racialised communities?

Appendix E: Workshop Discussion Guide Policy-Makers, Funders, Senior Management, Researchers/Educators

Ask participants to speak from their own professional and person experience(s)...

III. Opening

- a. introduction of facilitator/note-taker, workshop purpose/objective
- b. review briefly larger study that this is part of
- c. introduction of participants (go-around)
- d. review of agenda

IV. Racism & Mental Health (using quotes)

- a. How does racism affect mental health and people's experiences with the mental health system?
- b. Do your policies and programs reflect this/respond to this?
 - o What do you have already in terms of programming/policies?
 - o Do they/can they address these concerns?
 - o What is your bigger plan/mission (what are you trying to accomplish) and how does 'race'/racism and mental health fit in there?

Education piece: What is Anti-Racism?

→ We think that anti-racism is a proper approach to this work and this is what mental health service providers from the second workshop have said...

→ Some discussion

V. Barriers & Recommendations: Experiences of Service Providers

*→ Present the barriers expressed by *WII* participants while contextualizing it in the anti-racism framework*

Small Group Discussion Questions

- What are your reactions, thoughts, concerns (re the barriers)?
- Why do you think these barriers exist?
- Is there any way we could remove them? Can we work together to do so? How?
- What do you think of the solutions that the service providers proposed?

Large Group Discussion Questions

→ take up discussion from small groups – esp. around their explanations of why these barriers exist

VI. Suggestions & Recommendations

- a. Who needs to be on board to create institutional change?
- b. How realistic do you think is it to (e.g.) monitor the implementation of anti-racism/anti-oppression policies at service providing organizations?

Appendix F: Consent form for Workshop Participation – Mental Health Consumer/ Survivors

Research Project Title: Striving for Best Practices and Equitable Mental Health Care Access
For Racialised Communities in Toronto

Principal Investigator: June Ying Yee, B.A., BSW, MSW, PhD;
Associate Professor, Ryerson University, School of Social Work
(416) 979-5000 ext. 6224 j2yee@ryerson.ca

Co-Applicants:

Axelle Janczur
Executive Director
Access Alliance Multicultural
Community Health Centre
(416) 324-0927 ext. 304

Hélène Grégoire
Research & Evaluation Coordinator
Access Alliance Multicultural
Community Health Centre
(416) 324-0927 ext. 286

Martha Ocampo
Co-Director, Programs & Services
Across Boundaries
(416) 416 787-3007

Chris Rahim
Resources/Self-Help Coordinator
Women's Counselling Referral
& Education Centre
(416) 534-7401

Stephanie Austin
Research Analyst
Bureau of Women's Health and
Gender Analysis, Health Canada
(613) 946-4096

Sara Shahsiah
Research Assistant
Ryerson University, School of
Work
sshahsia@ryerson.ca

You are being asked to participate in this workshop as part of a research study. Before you give your consent to being a volunteer, it is important that you read this information and ask as many questions as possible to make sure that you understand what you will be asked to do.

We are asking you to participate in a workshop that looks at your experiences with the mental health system as someone from a racialised community. This workshop is part of a larger study that looks at race-based discrimination and mental health. The study also explores the barriers and opportunities faced by health care providers in the delivery of mental health services to racialised communities in Toronto. We hope to identify what is needed so that service providers may provide appropriate services that are anti-racist to individuals from racialised communities, like yourself. The findings of the study will also be used for the development of future research proposals and projects by involved organizations.

In total, three workshops are held with: (1) mental health service providers; **(2) mental health consumer survivors**; and (3) researchers, funders and policy-makers who work in the field of mental health. About 5 to 12 individuals will participate in each of the workshops. You are invited to participate in this workshop because of your personal experience as a mental health consumer survivor.

In accordance with the Ryerson University Ethics Committee and Access Alliance Multicultural Community Health Centre Ethics Committee, this consent form is only a part of the process of informed consent. This consent form provides you with a basic idea of the research and what your participation will involve. We will make two copies of this form; one for you to keep and one for our own records. If you would like more information that is not provided on this form or if you have any other questions, please contact June Ying Yee, listed above. Please take the time to read this form carefully and to understand all the information stated in this form.

1. This research study is exploratory in nature. That means we would like to get your opinion and experiences about mental health services, and find out how these relate to you and the larger the mental health system. To gather this information as accurately as possible we would like to audiotape this workshop. There is a separate consent form asking you for your permission to do so.
2. You will be asked to participate for a total of 3 hours in each workshop. On-site childcare, lunch, and TTC tokens are provided. Also, you will be compensated for your time and voluntary participation with an honorarium of \$30.
3. Because of the personal nature of the questions, you might reflect on unpleasant memories or experiences while participating. If any of the discussion questions cause you discomfort or concern, you may refuse to

answer any question or stop participating in the workshop, either temporarily or permanently. While the facilitator of your workshop is a counselor who can provide you with immediate counseling, counsellors are also available to you on-site should you require assistance after the workshop.

4. We anticipate that you will benefit from participating in this study. Participating in the discussion will allow your point of view to be heard and represented. When hearing what other participants have to say, you might find it also helpful to reflect on your own experiences, thoughts and feelings in relation to mental health services. There are also some learning opportunities that might come out of the workshop exercises. While you will be asked to review the results of the analysis and interpretation of your responses (called member checking), there are also other opportunities for your voice to be heard by participating more meaningfully at a later stage of this study. The findings of this study will influence the development of another research project in the near future. If you would like to be involved in the shaping or another aspect please notify the facilitators or contact June Yee (see above).
5. We cannot guarantee complete confidentiality to you, because we cannot control what each participant will do or say outside of the workshop. But we try to ensure that the findings of this study are not personally identifiable and that access to identifiable information is restricted. Only the facilitators (Chris & May), the principal investigator (June Yee) and the research assistant (Sara Shahsiah) will have access to data that may identify you. This raw data will not be shared with anyone else and destroyed at the end of the study, May 2006. The research assistant will transcribe the audiotapes in a manner that protects your identity, by using false names or numbers in all materials. Research partners, such as working group members who are listed above, as well as consumer survivors who are involved in the next phase of the study may have access to the transcribed and analyzed materials which contain non-identifiable data. This data will be kept and may be used by research partners for future publications, projects, or presentations. All audio recordings and transcription material will be stored safely in a computer via a password and/or in a locked cabinet at June Yee's office at Ryerson University, School of Social Work.
6. There are no financial costs that will result for you by participating in this study. Your participation in this study will not affect the services that you currently receive from mental health agencies in any negative way.
7. The findings of this study will be used for publications and presentations. Anonymity of information given and used in any forthcoming publications or presentations is assured. To access the general results of the study when they are available, please contact June Yee.

Your signature on this form indicates that you have understood to your satisfaction the information about participating in this research study and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors or involved institutions from their legal and professional capabilities. You are free to withdraw from this study at any time. Your continued participation in this project is part of your informed consent and should you have any questions, feel free to ask by calling Dr. June Ying Yee, responsible for this study. A copy of this consent form has been given to you to keep for your records and reference. *Please contact the Ryerson University Research Ethics Board if you have any questions about your rights as a human subject and participant in this study.*

*Research Ethics Board
c/o Office of Research Services, Ryerson University
350 Victoria Street, Toronto, Ontario; M5B 2K3
(416) 979-5000 ext. 5042*

Name of Participant (please print)

Signature of Participant

Date

Signature of Facilitator

Date

Appendix G: Consent form for Workshop Participation – Service Providers

Research Project Title: Striving for Best Practices and Equitable Mental Health Care Access For Racialised Communities in Toronto

Principal Investigator: June Ying Yee, B.A., BSW, MSW, PhD
Associate Professor, Ryerson University, School of Social Work
(416) 979-5000 ext. 6224 j2yee@ryerson.ca

Co-Applicants:

Axelle Janczur Executive Director Access Alliance Multicultural Mental Community Health Centre (416) 324-0927 ext. 304	Hélène Grégoire Research & Evaluation Coordinator Access Alliance Multicultural Community Health Centre (416) 324-0927 ext. 286	Martha Ocampo Co-Director, Programs & Services Across Boundaries, Ethno-Racial Mental Health Centre (416) 416 787-3007
Chris Rahim Resources/Self-Help Coordinator Women's Counselling Referral & Education Centre (416) 534-7401	Stephanie Austin Research Analyst Bureau of Women's Health and Gender Analysis, Health Canada (613) 946-4096	Sara Shahsiah Research Assistant Ryerson University, School of Social Work sshahsia@ryerson.ca

You are being asked to participate in a research study. Before you give your consent to being a volunteer, it is important that you read the following information and ask as many questions as possible to be sure you understand what you will be asked to do.

We are asking you to participate in a workshop that explores the barriers and opportunities that you face as service providers in the delivery of appropriate mental health services to racialised communities in the GTA. This workshop is part of a larger study that looks at race-based discrimination and mental health. We would like to know the extent to which you use a holistic approach in your work in mainstream (e.g. hospitals), ethno-specific (e.g. culturally based service providers) or alternative (e.g. feminist, anti-racist service providers) agencies. We hope to identify what is needed so that service providers may provide appropriate services to individuals from racialised communities. The findings of the study will be disseminated in various ways and used for the development of future research proposals and projects.

In total, three workshops are being held with the following groups: (1) mental health consumer survivors; (2) **mental health service providers**; and (3) researchers, funders and policy-makers. You are invited to participate in this workshop given your work experience as a mental health service provider.

In accordance with the Ryerson University Ethics Committee and Access Alliance Multicultural Community Health Centre Ethics Committee, this consent form is only a part of the process of informed consent. This consent form is to provide you with a basic idea of the research and what your participation will involve. If you would like further information that is not provided on this form or if you have any further questions, please do not hesitate to contact the Principal Investigator, June Y. Yee (see above). Please take the time to read this form carefully and to understand all the information stated in this form.

8. This research study is exploratory in nature. The intent is to obtain your opinion and experiences about mental health services and racialised populations. To gather this information as accurately as possible we would like to audiotape this workshop. There is a separate consent form asking you for your permission to do so.
9. Each participant will be asked to participate for a total of 3 hours.
10. If any of the discussion questions cause you discomfort or concern, you may stop participation in the workshop, either temporarily or permanently without penalty. You can also refuse to answer any questions during the course of the workshop at anytime.

11. We anticipate that there are some benefits for participants in this study. For you, these may include the opportunity to reflect on your experiences, thoughts and feelings about your practice specifically and mental health services in general. The workshop may also provide an opportunity to network with other service providers. You may also benefit from the study's findings and the final report that will be made accessible to you. As a result of participating you may be more informed and supported in your practice.
12. We cannot guarantee complete confidentiality to you, because we cannot control what each participant will do or say outside of the workshop. However, steps are taken by the researchers to ensure that the findings of this study are not personally identifiable and that access to identifiable information is restricted. Only the facilitator (Martha Ocampo) and the research assistant (Sara Shahsiah) will have access to data that may identify you. This data will not be shared with anyone else and destroyed at the end of the study, May 2006. The research assistant will transcribe the audiotapes in a manner that protects your identity, by using pseudonyms or numbers in the transcription materials. Research partners, such as working group members who are listed above, as well as consumer survivors who are involved in a later phase of this study will have access to this anonymous data. All audio recordings and transcription material will be stored safely in a computer via a password and/or in a locked cabinet at June Yee's office at Ryerson University, School of Social Work. The anonymous data will be kept for present or future research purposes.
13. While participating organizations will be acknowledged in future publications and reports, your workshop participation and responses will not be identifiable to a specific organization. To clarify, while your organization may be listed in the final report, any quotes or general findings will be unidentified in the transcript, report, and any other materials.
14. There are no financial costs that will result on the part of the participant in this study. In no way does your participation in this study affect your employment at a related mental health agency.
15. You may have access to the general results of the study when they are available, by contacting June Yee or Sara Shahsiah.
16. The findings of this study will be used for publications and presentations. Participants can be assured of anonymity of information given and used in any forthcoming publications or presentations.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participating in this study and agree to participate. In no way does this waive your legal rights nor release the investigators, sponsors or involved institutions from their legal and professional capabilities. You are free to withdraw from this study anytime. Your continued participation in this project is part of your informed consent and should you have any questions, feel free to ask now or contact June Yee. A copy of this consent form has been given to you to keep for your records and reference.

If you have any questions regarding your rights as a human subject and participant in this study, you may contact the Ryerson University Research Ethics Board for more information.

Research Ethics Board
 c/o Office of Research Services, Ryerson University
 350 Victoria Street; Toronto, Ontario; M5B 2K3
 (416) 979-5000 ext. 5042

 Name of Participant (please print)

 Signature of Participant

 Date

 Signature of Facilitator/Research Assistant

 Date

Appendix H: Consent form for Workshop Participation Policy-Makers, Funders, Senior Management, Researchers/Educators

Research Project Title: Striving for Best Practices and Equitable Mental Health Care For Racialised Communities in Toronto

Principal Investigator: June Y. Yee (MSW, PhD)
Associate Professor, Ryerson University, School of Social Work
(416) 979-5000 ext. 6224 j2yee@ryerson.ca

Co-Applicants:

Axelle Janczur Executive Director Access Alliance Multicultural Community Health Centre (416) 324-0927 ext. 304	Hélène Grégoire Research & Evaluation Coordinator Access Alliance Multicultural Community Health Centre (416) 324-0927 ext. 286	Martha Ocampo Co-Director, Programs & Services Across Boundaries (416) 416 787-3007
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Chris Rahim Resources/Self-Help Coordinator Women's Counselling Referral & Education Centre (416) 534-7401	Stephanie Austin Research Analyst Bureau of Women's Health and Gender Analysis, Health Canada (613) 946-4096	Sara Shahsiah Research Assistant sshahsia@ryerson.ca
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You are being asked to participate in a research study. Before you give your consent to being a volunteer, it is important that you read the following information and ask as many questions as possible to be sure you understand what you will be asked to do.

We are asking you to participate in an exploratory workshop that is part of a larger study that looks at race-based discrimination and mental health. Specifically, this study examines the role of racism in mental health and the experiences of racialised individuals with the mental health system, as well as the barriers and opportunities that mental health care providers face in the delivery of appropriate mental health services to these communities in the Greater Toronto Area. From all these discussions, we hope to identify what is needed so that more appropriate services are provided to individuals from racialised communities. The findings of the study will also be used for the development of future research proposals and projects by involved research partners and organizations.

In total, 9 -15 individuals have been sought to participate in each of the three workshops with the following groups: (1) mental health service providers; (2) self-identified mental health consumer survivors; and **(3) Policy Makers, Funder, Senior Management who work in the field of mental health.** The first two workshops have already been held and have informed the overall design and content of the this (third and final) workshop.

You have been invited to participate in this particular workshop given your professional and personal insights and expertise as a researcher/educator, funder, and/or policy analyst/advisor who is involved in the mental health field. In the workshop with you, we would like to know your responses to the general findings of the first two workshops and the barriers and opportunities you face in your work in relation to mental health services and racialised communities.

In accordance with the Ryerson University Ethics Committee and Access Alliance Multicultural Community Health Centre Ethics Committee, this consent form is only a part of the process of informed consent. This consent form is to provide you with a basic idea of the research and what your participation will involve. Two copies are made of this form; one for you to keep and one for the study's records. If you would like further information that is not provided on this form or if you have any further questions, please do not hesitate to contact Sara Shahsiah or June Yee. Please take the time to read this form carefully to understand all the information provided.

17. This research study is **exploratory** in nature. We intent to obtain your insights, opinions and experiences about mental health services for racialised communities. To gather this information as accurately as possible we would like to audiotape this workshop. There is a separate consent form asking you for your permission to do so.

18. You will be asked to participate for a total of **3 hours** in this workshop.

19. You are free to ask any questions regarding the workshop before we begin. You may stop participating in the workshop, either temporarily or permanently without penalty. You can also refuse to answer any question(s) during the course of the workshop.
20. We anticipate that there are some **benefits** for participants in this study. For you, these may include the opportunity to reflect on your experiences and work within the mental health system when learning about the responses obtained from mental health service providers and consumer survivors. The workshop can also serve as a platform for discussion where your concerns can be voiced and represented. The workshop may also provide you with an opportunity to network with others who are also working towards appropriate mental health system responses for racialised communities. Study findings may further support you in your work.
21. We cannot guarantee complete **confidentiality** to you, because we cannot control what each participant will do or say outside of the workshop. However, steps are taken by the researchers to ensure that the findings of this study are not personally identifiable and that access to identifiable information is restricted. Only the facilitators, June Yee and Hélène Grégoire , and the research assistant, Sara Shahsiah, will have access to data that may identify you. This data will not be shared with anyone else and destroyed at the end of the study (August 2006). The research assistant will transcribe the audio recorded materials in a manner that protects your identity, by using pseudonyms or numbers in the transcription materials. Research partners, such as working group members who are listed above will have access to this anonymous data. This anonymous data will be kept for present or future research purposes. All audio recordings and transcription material will be stored safely in a computer via a password and/or in a locked cabinet at June Yee's office at Ryerson University, School of Social Work.
22. We would like to **recognize** all organizations who have participated in this study by appending a list of organizations in alphabetical order at the end of the report. This list will not specify names, job titles/positions, or any other information identifiable of you so as to protect your privacy, however if you have any concerns please notify any of the facilitators or the research assistant.
23. There are **no financial costs** that will result on the part of the participant in this study.
24. Before the findings will be reported in the final report, you will be contacted to confirm/disconfirm any interpretations/analysis of your contributions (**member checking**).
25. You may have **access** to the general results as well as the final report of the study when they are available. The findings of this study will be used for publications and presentations. Participants can be assured of anonymity of information given and used in any forthcoming publications or presentations.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in this research study and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors or involved institutions from their legal and professional capabilities. You are free to withdraw from this study anytime. Your continued participation in this project is part of your informed consent and should you have any questions, feel free to ask now or contact June Ying Yee. A copy of this consent form has been given to you to keep for your records and reference.

If you have any questions regarding your rights as a human subject and participant in this study, you may contact the Ryerson University Research Ethics Board for more information.

Research Ethics Board (416) 979-5000 ext. 5042
 c/o Office of Research Services, Ryerson University
 350 Victoria Street; Toronto, Ontario; M5B 2K3

 Your Name (please print)

 Your Signature

 Date

 Signature of Research Assistant/Facilitator

 Date

Appendix I: Consent for Audio Taping of Workshop – Mental Health Consumer Survivors

This audio recording is used to help us in remembering what participants have said. Noone else but Sara Shahsiah (Research Assistant) will have access to these recordings. Sara will use the recordings to take notes and will erase them at the end of the project (May 30, 2006). The notes from the tapes (transcripts) will not include your names or any other identifiable information, and kept only for research purposes. Other research partners, including Chris Rahim (Facilitator) will have access to these anonymous transcripts.

I hereby give permission for Chris Rahim and Sara Shahsiah to make an audio recording of this workshop.

Name of Participant (please print)

Signature of Participant

Date

Signature of Facilitator

Date

Appendix J: Consent for Audio Taping of Workshop – Service Providers

This audio recording is used to help us in remembering what participants have said. Noone else but Sara Shahsiah (Research Assistant) will have access to these recordings. Sara will use the recordings to take notes and will erase them at the end of the project (May 30, 2006). The notes from the tapes (transcripts) will not include your names or any other identifiable information, and kept only for research purposes. Other research partners, including today’s facilitators Martha Ocampo and H  l  ne Gr  goire will have access to these anonymous transcripts.

I hereby give permission for Martha Ocampo, H  l  ne Gr  goire and Sara Shahsiah to make an audio recording of this workshop.

Name of Participant (please print)

Signature of Participant

Date

Signature of Facilitator

Date

Appendix K: Consent for Audio Taping of Workshop Policy-Makers, Funders, Senior Management, Researchers/Educators

This audio recording is used to help us in remembering what participants have said. No one else but Sara will have access to the recordings. Sara will use the recordings to take notes and will erase it at the end of the project (May 30, 2006). The notes from the tapes (transcripts) will not include your names or any other identifiable information, and kept only for research purposes. Other research partners, including today's facilitators, H  l  ne Gr  goire and June Yee will have access to these anonymous transcripts.

I hereby give permission for H  l  ne Gr  goire , June Yee and Sara Shahsiah to make an audio recording of this workshop.

Name of Participant (please print)

Signature of Participant

Date

Signature of Facilitator

Date

Appendix L: Demographic Profile Face Sheet – Mental Health Consumer Survivors

The purpose of collecting this information is so that we, the researchers, may get a better sense of the background of all participants. Please circle the answers that best apply to you and fill in the blanks.

Date: _____

1. I am: male female

2. I am _____ years old.

3. Please circle:

- a. I am currently a service user/consumer
- b. I used to be a service user/survivor
- c. I am a family/friend of a service user/consumer survivor
- d. Other: _____

4. If you are currently using services, what agencies or types of service providers are you obtaining services from?

5. I consider myself

- a. part of a visible minority
- b. a person of Colour
- c. racial minority
- d. not white
- e. None of the above.

6. I self-identify as a member of _____ (e.g.: community/group)

7. If you immigrated to Canada please list the year when you came to Canada _____.

8. I found out about this study through

- a. A community organization, agency, program
- b. A friend or family member
- c. Other: _____.

9. If you would like to be contacted for the purpose of confirming and/or providing feedback about the results of this study, please provide us with your **name** and **contact number or email** in the space below.

Appendix M: Demographic Profile Face Sheet – Service Providers

The purpose of collecting this information is so that we, the researchers, may get a better sense of the background of all participants so that we may contextualize study findings. Please circle the answers that best apply to you and fill in the blanks.

Date: _____

10. Gender: _____

11. Age: _____

12. Position/role: _____

13. I have been working in this capacity since _____ (please specify year or number of years)

14. Self-identification:

- a. Ethno-cultural background: _____
- b. Community: _____

15. If you immigrated to Canada please list the year when you came to Canada: _____.

16. How did you find out about this workshop/study?

- a. Through a community organization, agency, program
- b. Through friend or family member
- c. Directly, through a member of the research team
- d. Other: _____.

17. If you would like to be contacted by one of the researchers for the purpose of confirming and providing feedback about the results of this study, please provide us with your **name** and **contact number or email** in the space below.

Thank you for participating!

Appendix N: Demographic Profile Face Sheet Policy-makers, Funders, Senior Management, Researchers/Educators

The purpose of collecting this information is so that we, the researchers, may get a better sense of the background of all participants. Please circle the answers that best apply to you and fill in the blanks.

Date: _____

18. Gender: _____

19. Age: _____

20. Position/role: _____

21. I have been working in this capacity since _____ (please specify year or number of years)

22. Self-identification:

- a. Ethno-cultural background: _____
- b. Community: _____

23. If you immigrated to Canada please list the year when you came to Canada: _____.

24. How did you find out about this workshop/study?

- a. Through a community organization, agency, program
- b. Through friend or family member
- c. Directly, through a member of the research team
- d. Other: _____.

25. If you would like to be contacted by one of the researchers for the purpose of confirming and providing feedback about the results of this study, please provide us with your **name** and **contact number or email** in the space below.

Thank you for participating!

Appendix O: Member Checking Feedback From

After reading the write-up of the findings, please provide your feedback and comments below. Please specify the exact page number, subheading and paragraph that should change in your opinion.

1. Overall, do you confirm the findings?

YES

NO

If you indicated NO please continue answering the questions below.

2. Specific changes to content:

3. Any other changes:

4. Any other concerns:

PLEASE SEND THIS FORM PER EMAIL TO SARA SHAHSIAH: sshahsia@ryerson.ca
OR PER FAX TO ATTN: JUNE YEE AT 416.979.5214

THANK YOU FOR YOUR TIME AND FEEDBACK!