

Improving mental health services

- in the -
**Jane and Finch
community**

Research with the Afro-Caribbean, Latin American, Somali, Tamil and Vietnamese communities



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The cover photo is of the “BeLovEd Movement Mural” at 25 San Romanoway (northeast corner of Jane Street & Finch Avenue). The theme of the mural is “Be Inspired, Love Yourself. Educate others.”

Mural artists: Gilda Monreal & Elisa Monreal.
Mural partners: Black Creek Community Health Centre, San Romanoway Revitalization Association, Greenwin Incorporated & the City of Toronto.
Photographer: Ornella Roman Miller.

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Contents

Acknowledgments	vi
About the North West Community Mental Health Network	viii
Introduction	1
Background	2
Project goal	7
Methodology	8
Limitations	9
Findings	10
Recommendations	25
Appendix	28

Acknowledgments

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Jane/Finch
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About the North West Community Mental Health Network

The North West Community Mental Health Network (NWCMMH) consists of representatives from organizations that provide mental health services to residents in the broader Jane and Finch community of Toronto. The purpose of the network is to collaborate and partner with others by responding to mental health issues identified by the network and by residents and service providers in the community.

NWCMMH member organizations

Across Boundaries
Black Creek Community Health Centre
Black Creek Local Immigration Partnership
Central Community Care Access Centre
Centre for Addiction and Mental Health
COTA Health
Family Association for Mental Health Everywhere
Humber River Regional Hospital
Jamaican Canadian Association

Jane/Finch Community and Family Centre
LOFT Community Services
St. Elizabeth Health Care
Toronto Police Service
Toronto Public Health
Y Connect
York University Psychology Clinic
YWCA Toronto





Introduction

The part of Toronto broadly identified as Jane and Finch is one of the city's most diverse and vibrant communities, culturally and linguistically rich and comprising countless, tightly-knit support networks. Many of the area's residents have a strong commitment to and pride in their community. Community members have developed over 30 grassroots organizations, including social, legal, educational, religious/spiritual, artistic, cultural and health services.

These many assets of the Jane and Finch area serve as vital supports to residents, many of whom face significant stress related to unemployment, low income, immigration and other risk factors for poor physical and mental health. These day-to-day challenges can result in high levels of anxiety, depression and other mental health issues for community members. Among the different kinds of supports in Jane and Finch, however, there are few mental health services. Moreover, many of the mental health services that exist do not adequately reflect the diversity of the community in terms of people's culture, language or both. This gap in services can be a barrier to community members' ability and desire to access needed supports.

To try to bridge this gap, LOFT Community Services came together with other members of the North West Community Mental Health Network (NWCMMH), a group of agencies and organizations serving the Jane and Finch area. The NWCMMH proposed a project to try to find out what different community members thought about mental health, what kinds of experiences they had had with mental health services in the community, and how they thought these mental health services could be improved, especially in ways to make them more culturally appropriate and accessible. The NWCMMH received funding for this project from the Community Research Capacity Enhancement Program at the Centre for Addiction and Mental Health (CAMH).

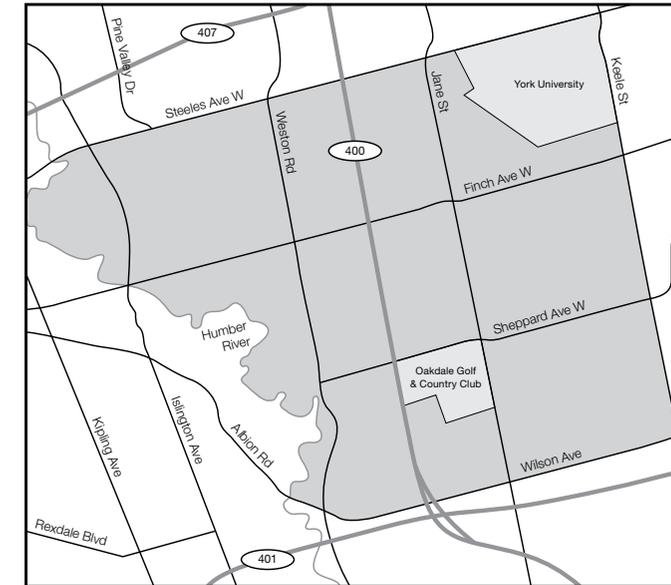
To pursue these questions, focus groups were conducted with members of five different racialized ethno-linguistic groups—Afro-Caribbean, Latin American, Somali, Tamil and Vietnamese—and another focus group was conducted with people providing mental health services in the community. Community members participating in the focus groups were encouraged to share what mental health meant to them, what supports they believed to be most helpful, and what changes they would like to see in existing services. This report documents what we heard, and recommends a number of key ways to make mental health services more culturally appropriate and accessible to people living in the Jane and Finch area.

Background

The area of Toronto broadly defined as and referred to here as Jane and Finch runs from Wilson Avenue in the south to Steeles Avenue in the north, and from the Humber River in the west to Keele Street in the east.

According to 2006 Census data,¹ 63% of people living in this area self-identified as a “visible minority,” compared to 47% for Toronto as a whole. At the time, there were approximately 86,000 immigrants living in the Jane and Finch area, representing roughly 60% of the community’s 141,980 residents, a higher percentage of immigrants than the rest of the city (50%). The main immigrant groups in the area were South Asian (18%), European (mainly Italian) (13.4%), South American (8%) and Caribbean (7%).

¹ Statistics Canada, Census 2006. Retrieved from www.toronto.ca/wards2000/pdf/2006.



■ Jane and Finch community

There is evidence that the socio-economic conditions of this geographic area are detrimental to the well-being of its inhabitants. Residents of the area presented higher levels of unemployment (9%) and low income (52.8%) than did the rest of the city (7.6% and 41%, respectively). Gaps are increasing between the resources needed to achieve a healthy community and those available, putting a lot of stress on families and community agencies. Poverty and various forms of discrimination, including racism, have been identified as negatively affecting the quality of life of the community’s families, and as significant risk factors for poor physical and mental health.^{2,3,4}

² United Way of Greater Toronto and the Canadian Council on Social Development. (2004). *Poverty by Postal Code. The Geography of Neighbourhood Poverty*. City of Toronto 1981–2001. Toronto: Author.

³ United Way Toronto. (2011). *Poverty by Postal Code 2. Vertical Poverty*. Toronto: Author.

⁴ Wilson, M. R., Landolt, P., Shakya, Y. B., Galabuzi, G-E., Zahoorunissa, Z., Pham, D., . . . Joly, M-P. (2011). *Working Rough, Living Poor: Employment and Income Insecurities Faced by Racialized Groups in the Black Creek Area and Their Impacts on Health*. Toronto: Access Alliance Multicultural Health and Community Services. Retrieved from <http://accessalliance.ca/content/launch-working-rough-living-poor-report>.



The relationship between poverty and mental health difficulties is complex. Poverty involves more than income deprivation. It can also be related to exclusion from meaningful employment, appropriate and affordable housing, safe neighbourhoods with public amenities (libraries, parks, schools, etc.), health care, other essential goods and services, social networks and basic human rights. All of these forms of exclusion contribute to high levels of stress, anxiety, sadness and depression for many community members.



For newcomers, the settlement process itself can be a significant stressor. Language barriers, barriers to entering the labour market, adjustment to Canadian society, insufficient income, high costs of living, and various forms of discrimination are the everyday challenges for many newcomer families.

Within the newcomer population there are several groups that experience higher rates of mental health issues. They include racialized newcomers, women (particularly women who are survivors of human trafficking, abuse, and/or torture and war); lesbian, gay, bisexual, transgender, transsexual and queer newcomers; middle-aged and senior newcomers; those coming from Central and South America, Africa and the Middle East; and refugees and newcomers without legal status.⁵

Other issues that negatively affect Jane and Finch residents' mental health include addictions, violence, environmental conditions and community stigmatization.⁶

⁵ Shakya, Y. B., Khanlou, N. & Gonsalves, T. (2011, Summer). Determinants of mental health for newcomer youth: Policy and service implications. *Canadian Issues / Thèmes Canadiens*, 101.

⁶ Richardson, C. (2008). "Canada's Toughest Neighbourhood": Surveillance, Myth and Orientalism in Jane-Finch. Unpublished master's thesis, Brock University, St. Catharines.

However, the Jane and Finch community is well known for its high levels of resilience in the face of these adversities. Community members often find strength in the area's rich cultural diversity; in forming supportive networks of trust and cohesion and in sharing knowledge and resources; in collectively taking action for the community's benefit; and in many forms of community engagement. As mentioned, community members have developed over 30 grassroots organizations, based on principles of solidarity, equity and human rights.

One in five people in Canada has a mental health concern at some point in their life, but only about 30 per cent of those people seek help.⁷ In many cases, people do not realize that they have a mental health concern, or do not have appropriate information about available services. In other cases the stigma associated with mental health difficulties is a huge barrier, discouraging people from accessing services or programs.

Addressing issues of mental health requires focusing on both the psychological and social determinants of health. This means supporting individuals and families living with mental health challenges through appropriate and accessible services and programs. But it also means making changes on broader social and political levels in order to achieve the more equitable and inclusive society that is required to truly support the physical and mental health of all communities, including Jane and Finch.

⁷ Centre for Addiction and Mental Health. Looking for Mental Health Services. What Do You Need to Know? Retrieved from www.camh.net/About_Addiction_Mental_Health/Mental_Health_Information/looking_menthealth_services.html.

Project goal

As stated earlier, the main objectives of the research were to learn what different community groups thought about mental health, what kinds of experiences they had had with mental health services in the community, and how they thought these mental health services could be improved, especially in ways to make them more culturally appropriate and accessible. Ultimately, this project was aimed at improving mental health services to better meet the needs of the Jane and Finch community.



Improving
mental health services
to better meet the needs of the Jane and Finch community



Methodology

Focus groups were conducted with adult members (25 years of age and older) of five different large racialized ethno-linguistic groups in the Jane and Finch community: Afro-Caribbean, Latin American, Somali, Tamil and Vietnamese. Each focus group comprised seven to 16 participants who were recruited through the member organizations and agencies of the NWCMHN. Participants in these five focus groups were all asked the same seven questions (see Appendix) translated into the respective languages of the different groups. Another focus group, asked a different set of questions (see Appendix), was conducted with 10 mental health service providers from the community. Each focus group was between 60 and 90 minutes in duration, was conducted in the official language of the group, and was audio recorded for analysis. Additionally, someone who was fluent in both the language of the focus group and in English (where relevant) acted as a recorder at each focus group, observing and taking notes on the discussion. After each focus group, the facilitator also made notes on her impressions of the discussion. After both the facilitator and the recorder had organized their notes, they both listened to the recording of the focus group to check for congruency and/or omissions, each working toward a comprehensive presentation in English of the participants' answers to the various questions.

The facilitator and the recorder from each focus group then met with the research team to discuss their respective summaries, which were qualitatively analyzed for themes. The themes identified across the different focus groups are presented below, as well as a list of recommendations, stemming from these themes, to improve mental health service delivery in the Jane and Finch community.

Limitations

With sufficient funding only to conduct one focus group with each of the selected groups, the main limitation of this study is its relatively small number of participants. With an average of 10 participants per focus group, we acknowledge that participants' perspectives cannot be assumed to adequately represent the broader racialized ethno-linguistic groups with which these participants identify.

Another limitation concerns the challenges of conducting research across different languages. Because the facilitator and recorder of each focus group had to translate their records of the discussion into English, there were undoubtedly ethno-linguistically specific meanings lost in this translation.

The great majority of the participants in the focus groups were women, resulting in a significant underrepresentation of men's perspectives. While many of the participants' experiences—such as difficulty finding service in their language, or transportation issues—did not seem to be sex or gender specific, the research still unfortunately lacks a balanced account of both men's and women's viewpoints and experiences.



Findings

Community focus groups

Findings reported below represent key issues that emerged from focus group discussions with members of the Afro-Caribbean, Latin American, Somali, Tamil and Vietnamese communities residing in the Jane and Finch area.

Access challenges

Focus group participants identified a variety of ways in which they or other members of their linguistic and/or cultural community, residing in the Jane and Finch area, experienced challenges in accessing mental health services. Many of these challenges represent access issues commonly faced by many marginalized groups, but some are unique to or exacerbated for members of the Jane and Finch area. These challenges in accessing services were organized into seven themes, related to issues of: (1) discrimination; (2) language; (3) cultural misunderstandings; (4) time constraints; (5) transportation; (6) economics/finances; (7) lack of awareness and understanding.



(1) Discrimination

Participants across all the focus groups cited various forms of discrimination as posing major challenges to community members' accessing mental health services. Foremost among these was a) the social stigma across many cultures surrounding mental health issues, which participants said discouraged community members from talking about mental health and illness and from accessing services. In addition, participants stated that other forms of discrimination also created barriers to their accessing services, including b) racism and c) the stigma associated with being a resident of the Jane and Finch community. Moreover, participants indicated that these different forms of discrimination and stereotyping often function simultaneously, compounding the difficulties people face in accessing services for mental health issues. The various types of issues that focus group participants described with respect to stigma and discrimination are outlined below.

(a) *Social stigmatization of mental health issues*

Social and cultural perceptions and beliefs that stigmatize mental health issues may deter individuals from seeking out mental health services. In some communities, mental illness can impact the perception of the family as a whole and not just of the person with the illness. A family may feel shame when one member has a mental illness, which may lead to keeping the problem hidden and within the family. Furthermore, not sharing with others leads to isolation and a sense that they are the only ones experiencing this type of issue. There is also a sense that mental illness may be seen as a weakness or something to just get over:

“Back home there is a shake-it-off-and-go attitude.”

-participant from the Afro-Caribbean community focus group

Participants expressed fear and concern regarding the consequences that a person with a mental illness may face. For example, they spoke about the fear of being ostracized by family and friends, and even of losing their jobs, if it became known they had a mental illness. Some also expressed a fear of the side-effects of medications and the possibility of becoming dependent on medications. Participants also reported the fear that medications could lead to a disease or disorder more serious than the issue they originally tried to address. A particular worry among parents was that accessing services could result in the involvement of the Children's Aid Society and the possibility of being considered unfit to raise their children.



(b) Racism

Some participants indicated that service providers make assumptions about them based on cultural and racial stereotypes. As noted within the Afro-Caribbean focus group, there is a sense that racialized individuals may not be taken seriously and that assumptions may be made that they are looking for “free” services. Some participants said they felt that members of their community are treated as a homogeneous group rather than as unique individuals seeking help.

(c) Discrimination based on neighbourhood

Some participants indicated that service providers make assumptions about them based on where they live geographically, and view them suspiciously or negatively because they reside in the Jane and Finch area.

(2) Language

Language was also identified as a key barrier to accessing services. Participants described difficulties in communicating their problems to service providers and finding the right words to use. In some languages, such as Somali, there is no term to translate the English term “mental health.” In one of the focus groups, participants indicated that they had gone to the expense of hiring their own interpreter to accompany them to appointments.

(3) Cultural misunderstandings

Related to language barriers is the issue of cultural misunderstanding. Participants spoke of service providers not understanding cultural dynamics, which hindered the quality of service that participants received. Individuals spoke about wanting service providers to understand them

as a whole person—understanding their history, context and how various components of their lives intersect—while treating them as individuals with unique needs and circumstances. Some community members noted that their experiences of family separation, resettlement, civil war, severe trauma, death and loss may have significant impacts on mental health that might not be appropriately considered or dealt with during treatment. Individuals spoke about being referred to a practitioner who spoke a different language because of assumptions that they spoke that language:

“I got referred by a GP to a health centre [where they spoke Chinese]. I think it was because I was Vietnamese. The GP assumed I spoke Chinese because I am Asian.”

-participant from the Vietnamese community focus group

Furthermore, as mentioned earlier, many participants did not think “mental health” was a term understood in their own culture. Nor is it something for which they felt they necessarily needed to seek services. People may take remedies such as homemade medicines, teas and other medications instead of accessing other kinds of services, including professional mental health services.

(4) Time constraints

Wait list times within the community were identified as a barrier. Participants also said that time limits imposed by some service providers, particularly physicians, were a barrier to speaking about sensitive issues related to mental health and illness. There was a belief that physicians are overly quick to write prescriptions, thus moving to treatment before adequately understanding the problem. Participants also expressed the view that physicians “want to diagnose you before you are ready to be diagnosed.” This tendency may be problematic, for example, in instances of somatization, where physicians may treat the physical pain without inquiring about the reason for the pain.

(5) Transportation

A key issue raised by many focus group participants was the need to travel outside the community to access service providers with relevant language and cultural competence. For certain cultural groups, doctors and other health care professionals who speak their language are located outside of the Jane and Finch area. Given the limitations of public transit in this area and the distances involved, many participants reported that time required to travel was very taxing on individuals and families. They also indicated that specialized services were usually located separately from one another, which also added to the time and distance required to travel from one service provider to the next. For example, individuals referred to a psychiatrist might have to travel from their social worker’s community office to a hospital location where the psychiatrist has an office. For parents with more than one child requiring specialized services, travel to various services is time consuming and is particularly challenging using public transportation.

(6) Economics/finances

Focus group participants spoke about the costs associated with accessing certain mental health services. They felt that there was not enough coverage under OHIP for these services. Participants spoke about the need to hire an interpreter when accessing health care services; this was an onerous expense but one that the person could not do without.

“We have to hire a translator when coming to see doctors or social workers who do not speak Vietnamese, but translation and interpretation services are expensive. People on OW or ODSP cannot afford this cost.”

-participant from Vietnamese community focus group

(7) Lack of awareness and understanding

Participants in most of the focus groups reported a lack of awareness about accessing mental health professionals, in part because of confusion about the differences between service providers—i.e., physicians, psychiatrists, psychologists and social workers. Eligibility for services varies across sectors, age groups and catchment areas, which individuals find difficult to navigate.

An additional issue relates to the normalization of some of the challenges encountered within the community. In one focus group, for example, participants spoke about how experiencing violence is normalized in the community, and that, as a result, community members sometimes do not seek help when experiencing or witnessing violence.

Definitions of mental health and mental illness

Participants were asked what mental health and mental illness meant to them. Responses to this question varied greatly both within and across focus groups. Participants in a few of the community focus groups spoke only of illness and the signs of illness, whereas others placed more emphasis on the overall well-being of an individual. Some participants seemed unsure how to distinguish mental health from mental illness, and expressed some confusion about these terms. These variations and points of confusion may have been a result, in part, of how the term “mental health” was presented and translated by the different focus group facilitators. Indeed, even in English, these terms can be used confusingly, with people using the term “mental health” to refer to “mental illness.” For example, it is not uncommon for someone to say that an individual “has mental health,” when in fact they mean that this individual is living with a mental health concern or a “mental illness.”



Sources of support

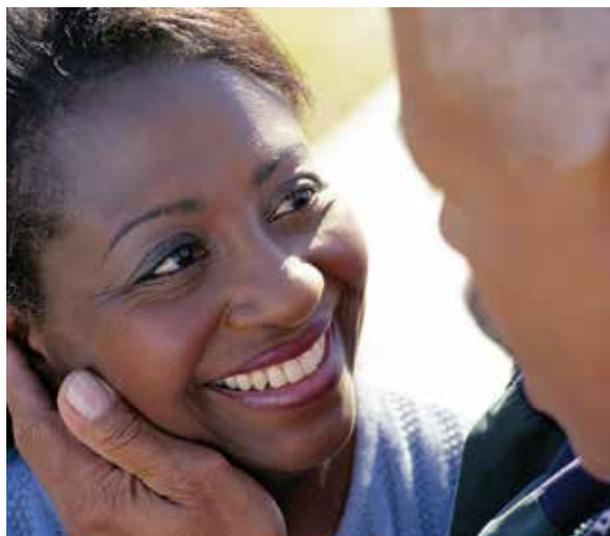
Focus group participants were asked about the types of supports they turned to for mental health issues. Two categories for sources of support came to light in this discussion: (1) formal and (2) informal sources of support.

(1) Formal

Formal sources of support identified by participants included professionals with formal health care training, such as doctors, psychiatrists and other mental health professionals (both private and community based), as well as providers of alternative and complementary therapies.

(2) Informal

Informal sources of support included anyone without formal health care training. Most broadly, participants spoke about the importance of the informal support of people who were simply willing to listen. These included family members, individuals such as settlement workers and groups connected with established organizations that provide other types of services in the community. Other examples mentioned by participants were cultural organizations or establishments and religious leaders.



Within each focus group, differences between formal and informal supports were not clearly articulated. Participants identified a wide range of individuals who they believed were able to provide help for mental health issues.

In addition, alcohol and other drugs were highlighted as methods of coping.

Promising practices

Participants were asked about what services and practices they currently found effective, as well as what they would envision as comprising an ideal service.

(1) Current promising practices

One of the five focus groups did not identify any services or supports that they felt were currently working well. It was not clear from this focus group whether they had in fact accessed or were aware of any health and social services in their community. Other focus groups spoke favourably about community centres that they had accessed where they were able to get information and help for multiple needs, such as information on available financial support and services related to mental health. Some focus groups explained that they learned about existing services through targeted outreach, for example, workers coming to their door to provide information about programs and services. They appreciated this very direct approach. Through the use of organizational outreach, awareness of existing programming was highlighted, which may encourage greater support and referrals within the community regarding mental health. Focus group participants also commented that language-specific services that were located in one place with child care provision worked very well.

(2) Ideal practices

Participants indicated that the ideal would be a service that pays attention to who an individual is and does not make generalizations about the person's culture. The focus should be on what they may need as individuals while taking into account possible cultural and contextual impacts on the person. Also, not surprisingly, language-specific services were identified, along with a multilingual crisis line, as well as services that are flexible, with extended hours including evenings and weekends. This would accommodate the needs of various types of families as well as varying work schedules.

Most of the focus groups spoke about wanting services that reflect a holistic perspective, including a variety of services in one location. This included programs that contain a social aspect (e.g., gardening, sewing) and pay attention to individual needs, as highlighted earlier. Examples of integrated or "holistic" services included home care for elderly family members experiencing both physical and mental health issues; service providers treating clients based on their cultural values and beliefs; and language-specific and culturally specific educational workshops regarding mental health and mental health services.

Lastly, participants from each of the focus groups indicated that their ideal service would not have the current existing time limits per appointment with a service provider, enabling them more time and freedom to discuss their problems.



Service provider focus groups

The findings from the focus group with mental health service providers in the community confirmed much of what emerged from the community focus groups, and also pointed to several other key issues related to mental health service provision in the Jane and Finch community.

Staff resources

Service providers reported a shortage of staff with specialized training in mental health and addictions serving the Jane and Finch community. As a result, it is not possible to accommodate

the number of clients who are in need or to provide the types of specialized services (e.g., language-specific services, culturally appropriate services, mental health professionals) that are required. As a result, there are long wait lists and clients have to travel long distances outside of the community to access language-specific health services that exist in other parts of the city.

Navigating the system

Service providers generally agreed that there seems to be a lack of understanding and awareness among clients about how mental health services operate. There is also a language barrier in trying to remedy this gap and explain services to clients. Even in situations where language-specific services exist, there may be a lack of awareness among community members of their availability. Another issue is the lack of co-ordination and communication between family physicians and psychiatrists. Family physicians may not have access to a consulting psychiatrist and feel limited in their ability to prescribe medications for mental health problems. Those physicians who do refer clients to psychiatrists may not be aware of the treatment plan and feel ill-equipped to contribute to it, even though they may have the responsibility of conferring with the client on an ongoing basis.

Stigma

Service providers also spoke of the challenges to access posed by the social stigmatization of mental health issues. Service providers agreed that many clients do not like to talk about mental health issues and therefore rely on other ways of coping (e.g., substance use) that do not require them to address the issue.

Service gaps

Concerns were expressed about the availability of services for men. Men are perceived as often being less willing than women to seek services, and there is a lack of specialized services for them. There are also underlying mental health issues that influence involvement with the justice system, which are often not considered. This speaks to a lack of early intervention for individuals at risk within the community.

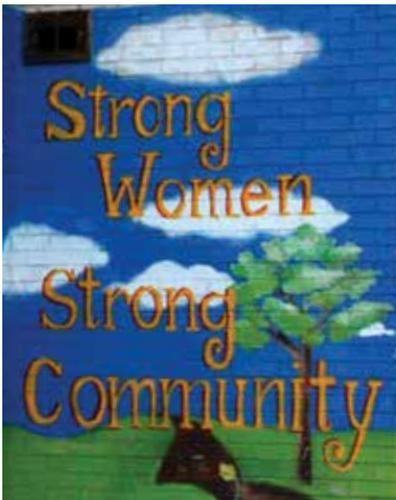
Promising practices

Service providers indicated that services involving collaborations with other organizations were working well within the Jane and Finch community. Where one organization lacked a service, another organization could step in and serve their clients in that area. Service providers also identified support groups as a key resource in the Jane and Finch area. They reported that clients found support groups very useful, especially groups without wait lists, and that many clients accessed them. Other programs that service providers thought were working well were “holistic,” in that they looked at the whole person, balancing an ethno-specific approach with a focus on individuals’ unique experiences, separate from whatever group they might identify themselves as belonging to. Service providers noted that services worked well when they were brought directly to the people—an example of this is settlement services within schools. Finally, service providers indicated that language-specific services worked well for their clients. They suggested that in

future, mental health promotion activities be incorporated within broader existing health promotion activities (e.g., including a mental health component in discussions about diabetes, physical activity, healthy eating and other health-related topics).

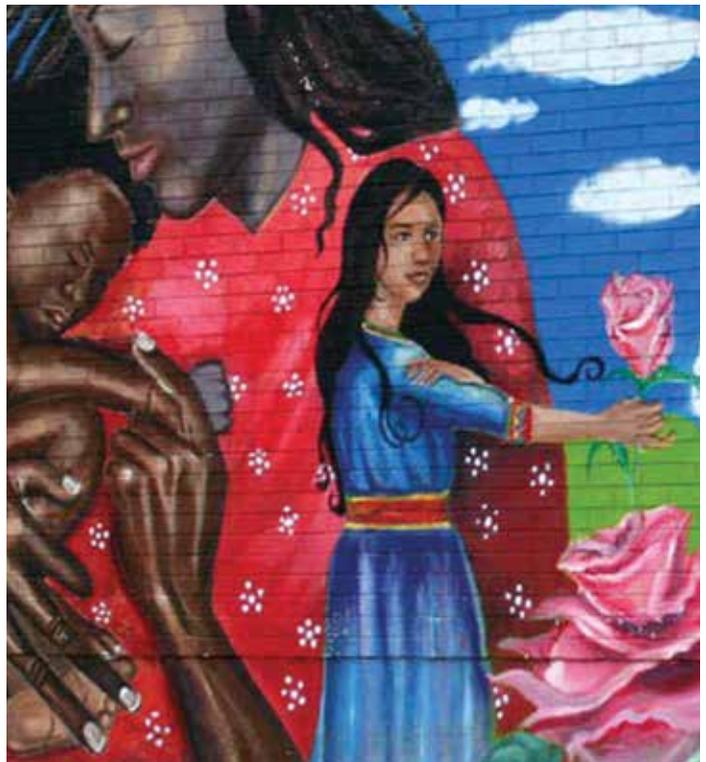
Community assets

Service providers identified positive attributes of communities, sometimes tangible and sometimes not, that serve to keep communities strong and resilient in the face of adversity. Spirituality and organized religion were highlighted as community strengths. Support networks were also cited as important within the community. Women and elders were identified as a particularly strong source of support to one another in times of need. Some communities also have a more positive outlook on mental health, which may enhance their likelihood of accessing services and supports. Being able to communicate in English and having access to language-specific services, however limited they may be, are also assets that contribute to the health of the community.



Recommendations

We found common themes and threads among the community and service provider focus groups with regard to the enhancement and improved co-ordination of mental health and addiction services in the Jane and Finch area. The following recommendations respond to some of the key findings and are intended as suggestions for areas of work that the North West Community Mental Health Network can take on as a collective.



Enhanced partnerships

- *Explore partnerships with service providers outside the Jane and Finch area that have the capacity to provide mental health and addiction services in languages needed by the community—in particular, Somali, Tamil and Vietnamese.* Language barriers were identified as a key issue in accessing services. A notable aspect of this for the Jane and Finch area is that some service users are finding supports in their language, but these supports are in other parts of the city that require time-consuming travel. A response to this may be partnerships with organizations in other parts of Toronto, whereby they would offer part-time services in a satellite location in the Jane and Finch area, according to need.
- *Draw on the expertise of organizations that have established interpretation services.* This would involve organizations that have existing interpretation services discussing their service models with organizations in the Jane and Finch area so that these local organizations could assess the feasibility of replicating these models.

Training and awareness

- *Provide training and awareness sessions on mental illness and cultural competency to a variety of service providers in the community.* Focus groups identified that people turn to a variety of sources for support with mental health problems. Providing training and awareness-raising sessions for service providers not currently providing mental health and addiction services will better equip them to support and refer their clients to appropriate services.
- *Organize an annual mental health fair in a community location with culturally and linguistically appropriate materials.* This event would address the need for public education on mental health and illness and on reducing stigma.

Information sharing

- *Organize an event for service providers to meet and exchange information about their services.* The richness and variety of services offered in the community is an asset. The opportunity to share information about existing resources and build relationships among service providers is vital to the ability to make appropriate and timely referrals.
- *Develop an inventory of mental health and addiction services in the community.* This comprehensive and up-to-date list of services in the community, along with other specialized mental health and addiction services, would be available to front-line workers such as primary care providers, religious leaders, settlement counsellors and youth workers.
- *Develop a plan to keep existing sources of service information, such as websites, up to date.* This plan would include a review of existing information resources, such as Black Creek Connect, and would incorporate a protocol for keeping information up to date.

Further research

- *Explore funding options for further research in the community.* This research project has provided valuable insights into improvements that can be made to services in the Jane and Finch community. However, there is a need for further research that would delve more deeply into the specific needs of the various racialized and ethno-linguistic communities living in the area. This research would provide valuable information for service providers and better enable mental health agencies and organizations to develop culturally responsive programming and services. A better understanding of key mental health and addiction needs in the community would also help the planning and delivery of services.

Appendix

Questions for focus group with community members:

1. What does mental health mean to you?
2. How do you know when someone is not well psychologically and emotionally?
3. Where have you previously turned for support related to mental health?
4. Who do you view as mental health professionals?
5. What barriers or challenges have you experienced when accessing services and support?
6. What do you think an ideal support or service looks like?
7. What have you experienced in the way of service and support that has worked well?

Questions for focus group with service providers:

1. What are the gaps in mental health services in Jane and Finch?
2. How are the gaps affecting specific groups (Afro-Caribbean, Latin American, Somali, Tamil, Vietnamese)?
3. What is your impression of services that are working well in the community?
4. What is working well within the Afro-Caribbean, Latin American, Somali, Tamil and Vietnamese communities?
5. What barriers or challenges have your clients experienced when accessing services and support?

