Black Mental Health Professionals Speak!
Informing NSHA's African Nova Scotian Health Care Strategy

Principal Investigator & Author

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Date

June 4, 2021

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Acknowledgments

I would like to acknowledge the support I received to conduct this research. First, I would like to thank Dalhousie's Department of Psychiatry for awarding me the Dalhousie Department of Psychiatry Research Fund. Thanks also go to Dr. Jacob Cookey (Staff Psychiatrist at NSHA and Assistant Professor at Dalhousie University) for supporting the submission of my grant application. I am also grateful to research assistants Tolu Oladogba and Joshua Yusuf for assisting with interviews and NVivo analysis, respectively. Finally, and most importantly, I would like to thank the participants for giving their time to share their experiences in this research. It goes without saying that the research could not have been done without you.

Executive Summary

Study Purpose

The main purpose of this two-year study was:

- To contribute to NSHA's African Nova Scotian Health Care Strategy by gaining insights from Black mental health clinicians, administrators, health promoters, policymakers, and professors about how their cultural beliefs, beliefs about mental illness and help-seeking, and education and training influence how they understand and address mental illness experienced by Black people of diverse cultures, gender identities, sexual orientations, income levels, education levels, and other identities.

Study Question

The main study question was:

- How can cultural competency and structural competency approaches that acknowledge the intersections of race, culture, gender identity, sexual orientation, income, citizenship status, and other social identities be more effectively embedded in research, student and faculty education, university curricula, and clinical training within psychiatric and community-based mental health services, as well as mental health policies at NSHA?

Study Objectives

The main study objective was:

- To examine the perspectives and beliefs Black clinicians, health promoters, administrators, policymakers, and university professors hold about the applicability and relevance of Western mental health knowledge, epistemologies, and diagnostic and treatment approaches to Black mental health patients of diverse cultures, gender identities, sexual orientations, income levels and other social identities in Nova Scotia.

The other study objectives were:

- To identify strategies for embedding insights about the intersections of race, culture, gender identity, sexual orientation, income, and other social factors into services and policies at NSHA.

- To identify strategies for incorporating these insights into university research, student and faculty education, curricula, and clinical training within psychiatric and community-based mental health services in Nova Scotia.

Methodology

The study used an interpretive, narrative approach (Polkinghorne, 1988, 1995) to collect and analyze the data. This qualitative approach involves data collection methods that enable participants to articulate, define and give meaning to their experiences.

Sample

A total of 33 participants from the following three participant categories were recruited for this study:

- Nineteen Black mental health clinicians.
- Eight Black administrators/policymakers/health promoters engaged in work on health and mental health.
- Six Black university professors.

The participants were born in the following provinces and countries:

- Nova Scotia
- Ontario
- Trinidad
- The Bahamas
- Jamaica
- United States
- Nigeria
- Kenya
- Cameroon

Data Collection

One-hour audio-recorded individual in-person and phone interviews (due to COVID) were conducted with each participant using interview questionnaires.

Summary of Findings

Beliefs About Mental Illness & Help-Seeking:

- Participants discussed beliefs around mental illness and help-seeking in their culture, including the following: 1) people who have mental illness are cursed and have been victims of demonic possession, a spiritual attack by a witch or wizard, or "voodoo" or "obeah"; 2) mental illness is caused by intergenerational trauma in the form of abuse and other forms of trauma in families, the trauma of being a Black or a racialized person in Nova Scotia and Canada, and the trauma experienced through lateral violence from other Black people; and 3) genetic/hereditary factors are at the root of mental illness.
- Black people who are members of the LGBTQIA community must often navigate the different avenues available for finding faith and faith communities within and outside religions institutions that have been harmful to them.
- The lack of cultural literacy around mental health historically, as well as not knowing how to name it has been a deterrent to help-seeking in Black communities.

How Beliefs About Mental Illness Influence Clinical Care, Administrative Work, Policy, Health Promotion & University Teaching & Research:

- Participants beliefs about mental illness and help-seeking shape their practice, whether it be clinical care, policy, administrative work, health promotion or university teaching and research.

- The social determinants of health, as well as patients' life circumstances are the factors that some clinicians give credence to in their practice.
- Clinicians who were trained within the Western medical model indicated a preference for that approach.

Experiences Working within Western-Oriented Workplaces:

- Navigating Western-oriented workplaces is often fraught with challenges, tensions and complications for those providing clinical services, developing policy and teaching and conducting research focused on mental illness in Black communities.
- The beliefs, worldviews and experiences of mentally ill Black people are often dismissed, negated, or ignored in the mental health system and in university teaching and research, often because clinicians and professors are ill-equipped to address the concerns and priorities of Black people in their work and because they don't fit into Western understandings of mental illness.
- Exploring opportunities to strengthen best practices approaches by combining Western and alternative modalities may be an important step in addressing mental illness in Black communities.

Grappling with Cultural Competence and Structural Competence:

- Offering cultural competency training is meaningless if it is not offered with the proper foundation and acknowledgment of how the health system and decision making can facilitate its application to clinical practice.
- Although many of the participants struggled to define structural competence, the experiences they shared about how they advocated for patients' needs around housing, food, jobs and education, as well as their understanding of how decision-making processes within our various social structures impact people's mental well-being indicated that they were endeavouring to be structurally competent in their work.
- Structural competence must be taken up by the health system and universities to better address the social, economic, environmental, and political inequalities that impact mental health, especially for racialized and other marginalized communities that are more likely to be struggling with these inequalities.

Summary of Recommendations

Workforce Diversity:

- Create pathways for Black people who are interested in becoming health professionals by helping them develop relationships with healthcare professionals for mentorship and guidance.
- Increase the representation of people of diverse backgrounds at all levels of the health care workforce (clinical, policy, decision-making) by reaching out to and engaging people who are diverse based on race, ethnicity, gender identity, sexual orientation, disability, socio-economic status, and education level.
- Develop retention policies and incentives to retain diverse people in the health care workforce.

Training & Education at NSHA & Other Organizations that Provide Mental Health Services:

- Expose psychiatrists and other mental health professionals to more literature and evidence based research on diverse populations through academic days, seminars, and other educational events.
- Provide training on the mental health of diverse populations to staff at emergency units.

- Implement cross-cultural training and education on mental health at colleges and universities.

Clinical Practice:

- Hold NSHA accountable for ensuring that equity remains a commitment.
- Facilitate partnerships between psychiatrists, psychologists, social workers, and other health professionals at NSHA to help NSHA diversify its lens around notions of "best leading practices".
- Move beyond the biomedical model to acknowledge and validate the structural determinants that shape experiences, impact mental health, and that influence help-seeking.

Mental Health Policy:

- Incorporate patients' diverse belief systems around mental illness into mental health policy.
- Incorporate the concerns and priorities of diverse communities into mental health policy.
- Ensure that mental health policy captures people's diverse identities, such as race, gender identity, sexual orientation, culture, age, and disability, etc.

University Research & Teaching:

- Hold universities accountable for providing dedicated funds and spaces for research on mental health and other issues in Black communities.
- Create a dedicated research pot at Dalhousie University and/or through national funding agencies for Black researchers who are conducting studies on health and mental health in Black communities.
- Provide dedicated research funding to develop a Black health research institute that supports Black researchers in conducting research on health and mental health and in getting published and that provides Black graduate students with mentorship and training to conduct research on health and mental health in Black communities.

Study Description

Study Purpose

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Study Question

The main study question was:

- How can cultural competency and structural competency approaches that acknowledge the intersections of race, culture, gender identity, sexual orientation, income, citizenship status, and other social identities be more effectively embedded in research, student and faculty education, university curricula, and clinical training within psychiatric and community-based mental health services, as well as mental health policies at NSHA?

Study Objectives

The main study objective was:

- To examine the perspectives and beliefs Black clinicians, administrators, health promoters, policymakers, and university professors hold about the applicability and relevance of Western mental health knowledge, epistemologies, and diagnostic and treatment approaches to Black mental health patients of diverse cultures, gender identities, sexual orientations, income levels and other social identities in Nova Scotia.

The other study objectives were:

- To identify strategies for embedding insights about the intersections of race, culture, gender identity, sexual orientation, income, and other social factors into services and policies at NSHA.

- To identify strategies for incorporating these insights into university research, student and faculty education, curricula, and clinical training within psychiatric and community-based mental health services in Nova Scotia.

Background: A Review of the Literature

Psychiatric knowledge has greatly influenced the "language of disease" within all mental health professions (nursing, social work, occupational therapy, etc.) by shaping diagnostic decisions, treatment approaches, and therapeutic relationships with clients. Several scholars (Baker, 1995; Breggin & Breggin, 1993; Caldwell, 1996; Coleman & Baker, 1994; Fanon, 1963; Fernando, 1991; Littlewood, 1993; Metzl, 2010; Szasz, 1970; Waldron, 2002 a; 2002 b; 2010) observe, however, that while transcultural and cross-cultural psychiatry are branches of psychiatry that have emerged over the past few decades to challenge the absence of discussions on culture within psychiatry, they have yet to fully engage with how issues of race impact mental illness, given that the concept of race is distinct from the concept of culture. While culture is defined as the traditions, customs, worldviews and patterns of living of culturally diverse peoples which are learned through tradition and transmitted inter-generationally, race refers to the visible markers of difference (skin colour, hair texture, facial features) between different racial groups. Unequal treatment and discrimination meted out to non-dominant racial groups (i.e. racialized groups) may significantly impact their mental well-being, along with discrimination due to culture, gender, income and other social identities, making a case for the need for psychiatry to examine how the intersections of these identities impact mental well-being. However, while issues such as culture, gender, and income have been taken up within psychiatry, discussions and actions to incorporate "cultural" competency approaches within psychiatry and other mental health professions have tended to obscure the issue of race/skin colour (in favour of discussions on cultural difference). Pioneering British psychiatrist and scholar Dr. Suman Fernando (1988, 1991) argues that colour-blind approaches in psychiatry are problematic for two main reasons. First, psychiatrists may deny or ignore their own racial bias and the racial bias in the wider society. Second, psychiatrists who treat individuals as if they were colour-less tend to mask and obscure the significant impact that race has on identity, life experiences, and mental well-being.

The study documented in this report supports existing studies (Bombay, Matheson & Anisman, 2017; McInnis, McQuiad, Bombay, Matheson & Anisman, 2015; Waldron, 2002a, 2002b, 2003, 2005, 2008, 2010) that found that race, culture, spirituality/religion, gender identity, class, and education inform beliefs that Black and other racially and culturally diverse mental health professionals hold about mental illness, their application of diagnoses, their treatment approaches, and their therapeutic relationships with clients. For example, Dura-Vila, Hagger, Dein and Leavey (2011) explore psychiatrists' attitudes to religion and spirituality within their practice and found a strong degree of dissonance amongst migrant psychiatrists between their practice in their home countries (incorporating patients' religious beliefs) and in the United Kingdom (excluding them). Reasons given for not including spiritual aspects included fear of being perceived as ''anti-modern,'' ''unscientific'' and ''unprofessional'' by colleagues, and a desire to fit in and be accepted by the British medical community and secular society. Lawrence, Rasinski, Yoon and Curlin (2015) observe that physicians' race and ethnicity contribute to different patterns of treatment for basic mental health concerns. For example, Black and Asian primary care physicians tended to recommend more treatment options than white physicians when treating depression. Black primary care physicians were also less likely to use an antidepressant when treating depressed patients, more likely to provide in-office counselling, and more likely to refer patients to a psychiatrist. Kales, Neighbors, Valenstein, Blow, McCarthy, Ignacio, and Mellow (2005) found that non-white primary care physicians were significantly less likely than white primary care physicians to diagnose depression and recommend long-term follow-up. Non-white primary care physicians were also less likely to choose newer antidepressants as initial treatment. These studies provide the context for examining the perspectives of Black clinicians, administrators, policymakers, and university professors on

how issues related to race, culture, spirituality and other identities are embedded in the work they are involved in.

Methodology

This study used an interpretive, narrative approach (Polkinghorne, 1988, 1995) to collect and analyze the data. This qualitative approach involves data collection methods that enable participants to articulate, define and give meaning to their experiences. Within Polkinghorne's narrative methodology (1988, 1995), humans are recognized as self-interpreting beings and their interpretation of phenomena is embodied in social, cultural and linguistic practices. Polkinghorne observes that narratives are the "primary scheme by means of which human existence is rendered meaningful" (1988: 11). Therefore, narrative inquiry is not a mere retelling or description of an individual's story, but a dynamic process of interpretation that alters and contributes to the meaning of the story. The importance of individual experience to reality is a key characteristic of an interpretive approach to narrative inquiry. Individuals come to know themselves and others through stories and storytelling. Narrative knowing is a type of meaning that draws together events and actions and notes the contributions they make to a particular outcome (1988). Human experience is organized along a temporal dimension. Attention to the past, present and future is a key feature of narrative inquiry and temporality an essential component of narrative theory (1988).

Recruitment & Sample

A total of 33participants were recruited for this study. While a total of 50 participants was sought, the considerable under-representation of Black administrators and policymakers at NSHA and Black university professors resulted in a smaller lower sample than had been anticipated. Considerable efforts were made to recruit 20 clinicians (psychiatrists, nurses, social workers, occupational therapists, psychologists, counsellors), 20 administrators/policy makers/health promoters, and 10 university professors. However, the study was only able to recruit 19 clinicians, eight administrators/policymakers/ health promoters, and six professors. I learned from several participants who are employed at NSHA that Black policymakers, administrators and heath promoters are considerably under-represented at NSHA and that I had overestimated the number of participants I would be able to recruit from these participant categories. While it was disappointing to not be able to achieve the study's goal of recruiting 50 participants, the smaller sample highlighted the need for greater workforce diversity in the health care system.

The participants that were recruited were born in the following provinces and countries: 1) Nova Scotia; 2) Ontario; 3) Trinidad; 4) The Bahamas; 5) Jamaica; 6) United States; 7) Nigeria; 8) Kenya; and 9) Cameroon. When asked how they would describe their cultural background and identity, participants identified themselves as African Nova Scotian, both African Nova Scotian and African Caribbean, both African Nova Scotian and Barbadian, Black Caribbean, African Jamaican, Jamaican Caribbean, Yoruba (an ethnic identity in Nigeria), mixed race of African Nova Scotian and European background, Cameroonian, Nigerian, Nigerian-Canadian, Kikuyu (an ethnic identity in Kenya), American, and a person of African descent.

Data Collection

One-hour audio-recorded individual in-person and phone interviews (due to COVID) were conducted with each participant using interview questionnaires. Three different questionnaires were used for each of the three participant categories**.** The clinician questionnaire collected data on their perspectives on the role that race, culture, gender, income, spirituality and other issues play in the mental heath services they provide; the questionnaire for NSHA administrators/policy makers obtained data on how their perspectives on those issues inform mental health policy; and the questionnaire for university professors focused on how their perspectives on diversity informs their research and teaching.

Data Analysis

In keeping with the narrative methodology, the process of analysis for this study was guided by Polkinghorne's (1995) theory of narrative emplotment. The analytical process of narrative emplotment involves reading through the transcripts in their entirety to gain a sense of the whole story. The Principal Investigator developed narrative themes pertaining to participants' experiences related to the study topic and objectives. These themes, which emerged from the research objectives and interview guides are indicated in the Findings section of this report (below).

The transcripts were, therefore, analyzed based on these themes. Similarities and exceptions in relation to people's experiences of and priorities across the data were subsequently identified. Narrative methodology is inherently inductive by nature.0 In inductive analysis the patterns, themes and categories of analysis emerge out of the data rather than being imposed upon them prior to data collection and analysis. A theme can be defined as a statement of meaning that runs through all or most of the pertinent data or is one in the minority that carries heavy emotional or factual impact. Themes typically reflect the questions posed during an interview, focus group, or consultation, and reflect the project objectives used to develop the interview, focus group or consultation questions. There are several components to an inductive approach. First, data analysis is determined by the research objectives (deductive) and interpretations of the raw data (inductive). Second, categories are developed from the raw data into a framework that captures key themes and processes. Finally, the findings emerge from multiple interpretations made by participants and from the raw data. These interpretations involve the researcher/principal investigator making decisions about what is more and less important in the data.

Findings

Study participants discussed how their cultural backgrounds, cultural beliefs, personal beliefs, education and training, and employment experiences have influenced their beliefs and understandings of mental illness and help-seeking, as well as how these factors impact their work.

Beliefs About Mental Illness & Help-Seeking

Participants discussed the beliefs around mental illness and help-seeking in their culture, including the following: 1) people who have mental illness are cursed and have been victims of demonic possession, a spiritual attack by a witch or wizard, or "voodoo" or "obeah"; 2) mental illness is caused by intergenerational trauma in the form of abuse and other forms of trauma in families, the trauma of being a Black or a racialized person in Nova Scotia and Canada, and the trauma experienced through lateral violence from other Black people; 3) genetic/hereditary factors underlie mental illness; 4) people are to blame for their own mental illness; 5) people with mental illness can infect others with mental illness; and 6) mentally ill people are weak or violent. Many of the participants also mentioned that there is considerable taboo, stigma, and silence around mental illness in their culture, and that these perceptions influence how people choose to seek help or not seek help for mental illness. For example, a participant stated the following.

> So, in my culture, it is believed that mental health is caused by demons.

Similarly, another participant discussed the following belief about mental illness:

> They also believe that mental health can be inflicted on somebody by witches or, you know, if you offend some people, they can make you sick mentally.

Another participant cautioned that there are other factors underlying mental illness other than spiritual attacks, including challenges finding a job or under-achieving in school:

> It's real. Like based on the context, which I've seen it, it's real. But an underlying factor… Or maybe something I think we need to start changing is that not all of them are spiritual attacks. Like people… Mental health and mental illness sometimes people exhibit different signs of distress because there are underlying causes. Maybe they don't have a job, maybe they are not doing well in school, and all of that. So instead of seeking help, people are going the wrong way. But it's part of the belief, right?

Blaming people for their own mental illness is also common in some Black communities:

> People who are schizophrenic in Jamaica, at the time I was there, were considered mad people. So they were never… It wasn't really like a proper psychiatric diagnosis. Although we do have a mental health institution there but the majority even right when I speak with Jamaicans who live in Canada, they'll say, "Ah, they're just mad," or just worked less or just lazy or something like that. So, it's not well understood.

This sentiment was echoed by another participant:

> Well, like I said, when somebody's having like a psychosis issue or a psychotic episode, people are like, "Oh, he has been afflicted. He has offended somebody." And instead of treating that…seeing that this person is having an episode, they will take them to either a church or be abolished for treatment. And that is that.

The taboo, stigma and shame around mental illness often result in family members shielding the mentally ill person from their community, as one participant observed:

> And, also, another way that I think it was treated was locking them in the house. So, they often wouldn't want community members to know if there was someone who had mental health challenges in the family. And depending on the age, if they couldn't be hospitalized then they sort of kept them in the house. They often didn't go out to events. I would say that has changed now. But growing up, if people were to say "did you interact a lot growing up with individuals with mental health?", I would say "no". But I know they existed.

Obeah, a system of spiritual healing and justice-making practices developed by enslaved Africans in the West Indies, is often viewed as the cause of mental illness in Trinidadian culture:

> Well, I wouldn't even put it within the context of evil spirit do you wrong. I think in the culture that I grew up in, you know, people often would think about obeah or voodoo. Well, not so much voodoo but in Trinidad, we talk about obeah or "putting light on you". There is a spiritual nature for it because it's like doing you wrong, doing you bad. And so, when you think about some of the rituals that people talk about with regards to doing obeah things, if you think about it, it's really…it comes from a spiritual dimension. So, within that context, yes, I think you can talk about it from a spiritual context.

Another participant observed that genetics is also perceived as the cause of mental illness:

> It is also believed that it is hereditary. Because if you want to get married, they will tell you, "Oh, don't marry that person because he's…or his mother was mad." You know, which was like a postpartum psychosis. They don't know that, oh, every time they give birth in the family, the woman will be mad for 6 months and then they will get better. So, don't get married because you can inherit that sickness

Echoing these sentiments, another participant noted that there are scientific explanations for mental illness:

> Yeah, I put a premium on that because I know there is a scientific explanation for mental health issues. So, there's neurotransmitters and all of that. And medication, and all of that, they help. So, like that's how you see someone who's depressed and then they do all sorts of therapies and all that. Occupational therapy and all of that, and they get better. Or give them maybe opportunities to maybe mingle with people who are getting a new job, a change in environment, and they are better.

Parenting or traumatic events are often perceived as the cause of mental illness in Black communities, as another participant noted:

> I think some would blame parenting or some would blame possibly traumatic things that have happened. Sometimes if there's a direct connection, to see that. But often I think we blame the person.

For another participant, epigenetics is useful in explaining how mental illness is caused by the convergence of both life experiences and genetics/biology, specifically how mental illness manifests out of traumatic life experiences that get encoded in one's genetics:

> I always see it as I can't separate the two. That you're a five-year old who sees your dad beating your mom after he drinks, leaves the home, maybe gets arrested, maybe goes to jail, and then he's gone. All these things result in a huge amount of release of a lot of painful neurotransmitters. Over and over, you're feeling painful, negative emotions. And that itself gets encoded into your genetics, epigenetics. And that epigenetics stays with you throughout your life. And we now know you can pass on epigenetics from one generation to another… So, it's very much encoded biologically - your physical experiences, your so-called environment experiences. This debate between gene-environment. It actually gets encoded genetically and passed on. So, it's hard for me to… I can't properly separate the two, but certainly recognize that both are at play.

A generational gap in beliefs about mental illness is partly due to opportunities that individuals have to be educated about it, according to another participant:

> And so, I'm 51. And most people who would be my age would be the first generation to go to university. So, a lot of our parents and a lot of our aunts probably weren't…didn't receive a formal education probably beyond high school and sometimes junior high. And so, their understanding of mental health is going to be very different than my understanding of mental health. And so, they would often probably blame in those cases mental health on things like the environment or alcohol or drugs, and not see it as being medical or clinical. It would often be blamed more on societal factors.

Also discussed was the greater tendency for younger Black people to talk about mental illness and seek help for it:

> But now I've noticed that the younger Black people are coming because they just need to talk or they're feeling something. Like they understand there's a spectrum. And they're coming because they need to open up, they need to have a safe space to speak

The media has contributed to a shift in people's sense of empathy around mental illness, as well as their understandings of the multiple factors that cause mental illness, such as biology and trauma, among other factors, according to a participant.

> I think in recent years, as people are becoming more knowledgeable, I would say since Oprah… Since Oprah, people are more knowledgeable about such things. I mean there are more people who are beginning to see that it can have a biological cause, that can be caused by trauma. You know, those kinds of things. Having a more psychological understanding, I think, than in the past.

Media campaigns on mental illness have also been helpful in creating awareness and decreasing stigma around mental illness, according to another participant:

> I think that beliefs around the cause of mental illness have changed over these past few years, mainly with how…things like Bell Let's Talk and people more openly in our community talking about their challenges with mental health.

African American celebrities are increasingly raising awareness about mental illness and help-seeking, which is helping to address the stigma and silence around mental illness in Black communities:

> That's a really good question because I think at least in the U.S. context, there's been a struggle back and forth. There's been different perspectives. Like there's even a movement now with even like celebrities who are African American who have seen the benefits of mental health now doing campaigns to encourage people to talk about their mental health, to actually acknowledge that that's a part of our full being, to not keep it all in the family, and to ask for help. So, there's this concerted push, which is really good.

Colonialism has had enduring impacts on all sectors of African society, including the education system, which remains heavily influenced by a British model. This model has greatly shaped perceptions and beliefs about mental illness among clinicians in various African countries, as one participant observed:

> So, in Nigeria, most of the school system is very much British, the former British colony. I went there to Ghana for a few weeks during med school, and most of the people in my crew were Nigerian. And all the Ghanaians and Nigerians would approach mental illness similarly to here, both because all of us are getting taught in the same model of UK western scientific understanding.

Traditional/faith healers (or traditional medicine) are often used to address mental illness in Nigeria, as one participant observed:

> Because when you're sick, when you have a mental health problem in Nigeria, you're most likely to be taken to a traditional healer, which are the people that would treat them. Some of them are effective in the sense that what they do is just to make people sleep or they chain them down, which is cruel. But that is the way mental health is perceived.

Another participant echoed these sentiments, stating that seeking out a faith healer to address mental health concerns is often the preferred choice for some individuals:

> There are people who do believe in faith healers. For instance, sometimes if somebody isn't feeling well, with not having any sort of a physical, mental assessment or anything like that, you know, often one would say "you need to go and see mother so-and-so because she's a faith healer and to see what's going on". Or some people may say, "well, you know, you need to go down and see so-and-so to see your business to find out what's happening". So that is also another part of it. And I'm talking about when I grew up. So, there was always somebody who would be "I see a woman, right, I see a woman, or a faith healer". And people would utilize that mechanism rather than going to the physician. They do whatever they need to do. And then they diagnose

> and then they treat. And the treatment could be sometimes people need to, you know, do a lime bath. You know, get limes and do your lime bath. You know, light your candles, say your prayers, do certain things, put certain things in your house. You know, open your Bible and put the scissors in it. You know, those sorts of beliefs. So, that's different. And that is more or less like I am going to see my family doctor or seeing the psychologist because I'm not feeling well. And then they would do an assessment and then make some diagnoses and do some treatment. So, within the context, the faith healer does that. And not only that, it wasn't free. People paid. People had to have money to pay and go see the faith healers. And some people would believe that it worked, and some people it may not work. And then they may change and go to a different faith healer.

In Caribbean culture, reducing stress by participating in the annual carnival festival is viewed by some as one way to deal with mental health problems:

> And another thing that people in my culture would say is like, you know, "I'm not crazy, I just need to have carnival. So, I have carnival for the weekend. I can jump and dance and do it, and I can get off whatever is inside of me". So those were some of the thinking and some of the beliefs I would say from a cultural perspective.

Several participants discussed a common sentiment in their community that mental illness is a personal issue rather than a medical issue, and that it can be addressed through prayer, speaking with one's pastor or spiritual counsellor, and allowing God to take over. Therefore, religious beliefs greatly influence perceptions of and help-seeking for mental illness, according to a participant:

> Apart from the fact that the cultural effect, that the religious belief, because predominantly in Nigeria, you have Muslims and Christians, that also affects the way people look at mental health. That prayer can help. So, some people will go to church. Some people will go to the mosque. Or they go to traditional healers.

According to a participant whose clinical training was done in Nigeria, spiritual care was a significant part of treatment in hospitals, with many patients seeking help from a church or mosque:

> So, what I noticed was that even though we had patients who were on medication, spiritual care was a big part of the model as well. So, like patients' families would come and they would pray with them, depending on their religion. Like the Muslims, they'd bring like all kind of things. And other traditional healers, they would bring things to the hospital. And even in the way that the nurses, the doctors talked to the patient, some of them still include spiritualty in their approach to care. And I would also say that that piece, the religion influences whether people are going to seek help in the hospital. So, in my country, so many people when they have mental breakdown, say depression, instead of going to maybe the hospital, they actually maybe go to church or a mosque, and all that. So that influences their help seeking behaviour and their belief about a prognosis, and the cause as well. So, when they believe that it is caused by a spiritual attack…..maybe someone was sleeping and then they woke up just… This is a real-life story. Like just woke up from sleep and then started exhibiting signs of delusion, hallucination, and all of that. And they think someone attacked the person in their dream. So, people like that, instead of coming to the hospital, they would go somewhere else to look for help.

Homophobia is deeply entrenched within religious institutions globally and has been damaging for Black individuals from the LGBTQIA community who wish to find solace in the church:

> But internationally and globally, there are things are happening in countries like Uganda where there is a strong religiously sanctioned, religiously based homophobia that is virulent and terrifying, and informs everything from microaggressions to institutionalized, legalized forms of abuse and oppression of people that either identify as LGBTQIA or are perceived as within that realm because they are gender nonconforming in their expression. So, that's deeply disturbing because it directly affects physical health, mental health, spiritual health in multiple ways. It's deeply disturbing.

For some African Americans who are members of the LGBTQIA community, the church is an important place to address mental health problems, despite how harmful the church has been to the LGBTQIA community:

> But historically, the Black church in a Black community in South Boston… In Roxbury, not in South Boston. And they promoted public health and mental health. And so, their congregants were comfortable with seeking out counselling. Like some of my friends there that are African American that are in the LGBTQIA community had no problem saying they need to go to a doctor or a counsellor or have a therapist. Like they were more rooted in that way. But then there are other streams that I saw that I'm still trying to figure out. And then I remember one time walking around and we're handing out leaflets about LGBT affirming churches and everything. And the dominant white narratives were shared by these white gay guys that were very uncomfortable with the idea of even talking about a church. And from their perspective, they would even say why are Black people who are gay and lesbian even go to church anymore? They didn't get it. They didn't get the palpable weight of the importance of the faith community to people of colour who were also an LGBTQIA community. They just didn't get it.

Black people who are members of the LGBTQIA community must often navigate the different avenues available for finding faith and faith communities within and outside religions institutions that have been harmful to them:

> The research has shown that LGBTQIA people are actually surprisingly much more religious and spiritual than their counterparts that are non-LGBTQIA. They just are trying to figure out different ways of finding that faith community. So, there's this rise of LGBTQIA affirming communities from the Metropolitan Community Church to Unity Fellowship, which was particularly for people of African descent who are also LGBTQIA identified. And that was Carl Bean's work too. So, there are all these churches cropping up to meet the needs of LGBTQIA people in general. But then specifically some that are cropping up targeting specifically the needs of LGBTQIA people of colour. So, in that sense, LGBTQIA people of colour have very interesting stories. There are some that want nothing to do with church because of all the harm and the multiple levels of oppression. Then there are others that are walking this fine line of staying in the church and being open to other forms of support through counselling.

Individuals who seek help from the mental health system are often left dissatisfied because it is not culturally specific, among other reasons. Seeking help in community (including from an authority or

political figure, such as a minister) rather than from the mental health system is common among Black people, as one participant observed:

> The different ways actually that I see is not necessarily through your formal mental health systems. Very much people seek help from community themselves. Like from older people in the community. You know, just from people they know to be like confidential. That kind of thing. They seek out help in that regard to kind of talk through their issues or whatever have you. The problem with that becomes evident when a person truly needs medication. And how it doesn't really matter what you do, people do need medication. And I am a believer in the fact that… I always say that you can never say never. And I would never say to an individual that you'll need medications for the rest of your life because I don't know that.

Another participant echoed these sentiments, noting that reliance on a cohort of friends with whom you can share your concerns has always been important in Black communities:

> So, in our community, cohorts are very important. So, sister girlfriend cohorts, the brothers cohort, the old girls club, the sisters or the ladies auxiliary cohort. Which is very culturally something that we do from the African diaspora perspective. So, one of our seeking behaviours is to go to our cohort of who are the women friends or the men friends we hang with. So, when guys feel angry or and when men feel like stressed out, they'll go to the cohort and they go out on Friday night and down to the Y to play some basketball, run out the anxiety, which is a distraction. And they don't even know that's what they're doing. And then they may just hang out together and just shoot the crap. And usually then they may have a beer or something and go home or do whatever they're doing. Sisters get together. And that's highly protective time. Talk about some of the psychosocial stresses in their lives and kind of generically share. And maybe one or two them who have really intimate relationships know the deep down and dirty. And the old women and the old guys who are in the ladies auxiliary age talk about their grandchildren and how much stress that they think these kids are giving to them. So, the self-seeking behaviours of our community tend to be cohort-driven, connected to community, connected to faith practices.

Despite considerable hesitance in Black communities around seeking help from mental health services, Black people are increasingly seeking out psychiatry and therapy:

> I think they're more open in general to therapy. But, also that can be difficult when the therapists that are available are not people who look like them or understand their unique experience as African Nova Scotians. But even with that, I think they're more open to a therapist. I think they would be more open to a therapist who is white or non-Black then taking the medication.

Several participants observed that, in general, people who are more educated, of higher socio-economic status and who reside in urban areas are more likely to seek help from hospitals, while those who are less educated, of lower socio-economic status and who reside in rural areas are more likely to seek out a pastor or traditional healer.

The lack of cultural literacy around mental health historically, as well as not knowing how to name it has been a deterrent to help-seeking in many Black communities. However, with the increasing

representation of trained Black mental health professionals in Nova Scotia, as well as the growing number of mental health programs in schools, the younger generation is becoming more culturally literate around mental health, as this participant demonstrates:

> And it wasn't until I came here, right… Because I have family members back in the Bahamas who I knew had mental health issues. But we called it… We basically knew… People would call my cousins retarded or dumb. These are some of the terms they would use. And for me, I really didn't think anything of it, right. I was like, "okay, yeah, they're retarded, they're dumb". I never knew that there were other names. It wasn't until I came here and I started working with the Association of Black Social Workers and started seeing individuals with ADHD and the various different disorders. From there, once I found out that, you know, people are not retarded, not dumb, there's mental health issues, I started to explore the various disorders.

As the participants in this study highlight, there is considerable stigma and taboo around mental illness in Black communities worldwide that are often associated with perceptions that mentally ill people are weak or have been afflicted by evil spirits and demonic possession. However, it is also important to note that genetic/hereditary and biological factors, as well as the social determinants of health and life circumstances and events are also perceived as contributory factors influencing mental illness in Black communities. These beliefs, along with the nature of the education and training that Black clinicians, administrators, policy makers and university professors have been exposed to will greatly influence how they address mental illness among diverse individuals in clinical practice, administrative work, policy development, health promotion and university teaching and research.

How Beliefs About Mental Illness Influence Clinical Practice, Administration, Policy, Health Promotion & University Teaching & Research

Participants discussed how their beliefs about mental illness and help-seeking shape their practice, whether it be clinical care, policy, administrative work, health promotion or university teaching and research. According to a participant, his exposure to different beliefs around mental illness has helped inform how he thinks about mental health policy:

> I've had opportunity to live in three different countries. And I've had broad exposure to different cultures and different beliefs. And I think that has always helped me in my discussion about mental health policy, at least in Canada.

Another participant observed that since he was trained within the Western medical model tradition, he has a preference for that approach:

> So mostly understood through the scientific medical model because that's how I've been trained. So that would be like the primary explanatory model that we use. But even within that, so within the domain of medicine, psychiatry is a bit of an outlier because we do focus more obviously on the psychological and social aspects of mental illness. So, the biopsychosocial models is the primary model that we work off of. And in addition to that, so that's recognizing that mental illness arises out of the mind, which is a product of the brain, and the brain is nested within the body. So, we have to identify any biological factors that might contribute to that. The

> psychology being the workings of the cognition that go on in the mind. And then the external environment being the social side. So, any number of social forces could trigger and perpetuate mental illness. And on top of that, probably personally speaking, generally philosophically, I'm also biased towards kind of the western canon. So those, you know, pre-Socratic and Socratic philosophers, Greco-Roman, plus the Judeo-Christian religious background would tilt me towards being able to understand mental illness historically in that lens as well. And then culturally, where the African background in me would reside would be in African cultures. So, growing up with an African father and very much with quite a hierarchical and respectful type society…highlighting or stressing relationships more so than here in the West. Also stressing the priority of the elderly compared to here in the West, and very much a culture of respect in that sense.

The social determinants of health, as well as life circumstances are the factors that another participant gives most credence to in his work:

> My leaning is towards the circumstantial stuff. It just is. So, the determinants of health. It's sometimes a little Euro in its… actually, it's very Euro. But often it's… I mean my leanings is more towards circumstantial stuff. So, I'm fascinated with, you know, how society works, how systems work, how that impacts people. I am fascinated with how people think. So, the cognitive end of how we think and how we see things and how we deal with that stuff that we know is coming is really more on my angle. It's not the greatest word but you know what I mean. Like more kind of the direction I go in when I'm… Not only just when I'm working with people and working with clients, but that's generally how I think. Like that's… I will default to that. I'll analyze it. I won't stay in the default. But that will be my default unless otherwise proven, generally speaking.

An intersectional framework that is inclusive of gender identity, sexual orientation, age, and disability has greatly informed the work of this clinician:

> They have to come into play. Like we're all socialized, right. Saying that they don't is problematic, you know. So I think that my ability to be present in both worlds, I am usually better able to relate to my clients, or at least I…because I understand there's like difference in that duality and intersectionality. I'm also a person with a disability. Like I'm able to recognize pieces. Like when I was completing my studies at a college in Toronto, there were people from multiple different ethnicities, ages and genders and sexual orientation. And that was an amazing experience to broaden my practice. But it was great also that I had the ability to grow up in a rural community but live in the city, live in bigger cities. I think that intersectional practice for me is important.

Working within the confines of NSHA's understandings of mental illness has been challenging to the following clinician who would be interested in including a spiritual component into his work, but has been prevented from doing so:

> I'll just be frank. In working for an organization like the NSHA, it doesn't really liberate you in terms of bringing what you could really bring to a person so that they can regain their wellness or

> whatever. So, in that respect, you're very, very limited. And so, do you know what I mean, I find myself guarded in the way I would practice. If I was doing it like individually or whatever have you, or if I just opened up like a counselling service or whatever, spiritual counselling is probably the closest to what I would try to call it. But that kind of thing, it's really difficult to do when you work within the confines of NSHA. I can only speak to that because I've worked with them for years. To the simple fact like I even tried, you know, when I had like a certain role where I was encouraging people, helping them to move on to places in the community beyond hospitalization, right, and just using inspirational quotes or whatever have you. And they didn't mention anything about God, but I was asked to stop, to refrain from doing it.

Incorporating understandings of faith has been central to the counselling support provided by another participant:

> So, if someone comes and they have a strong faith, and they're dealing with a problem or dealing with an issue or whatever, I want to know how they understand it and I want to know a bit about how it's affecting them. But, also about how do they see their faith, how do they see what they say they believe about God or about themselves and the relationship? How does that impact the issue that you're talking about? Do you see it as a help, a support? Are there ways in which you see it can be supportive? Is there a way in which it's a hindrance to you? How is this affecting you physically. How is it affecting your relationships? So, wanting the person to have a holistic perspective on themselves. So, helping to broaden their understanding of what's happening then. And so, a lot is I'm just helping them raise awareness of themselves, just becoming more aware of themselves.

Finding out the cultural beliefs of patients is the approach this participant takes when providing clinical services:

> And I try to just approach each patient depending on their cultural background and kind of be really open and honest with them and find out what their cultural ideas are around the cause of mental illness. Because sometimes people put a lot of blame on themselves for what's going on with them. And it can be therapeutic for them just to hear that it's not you, that you're not the cause of it, and there's something wrong with…there's something abnormal with your brain

Understanding how cultural beliefs influence mental illness is important in the work this clinician is involved in:

> When we have clients, I need to be mindful to take the time to truly not only do my assessment but to listen to their values and beliefs. Because often sometimes we know when people are talking about spirituality and those sorts of things, it's easy for us to diagnose them as psychotic and schizophrenic, within that context, because of that value belief. And so, for me, it's good to have that sense of awareness from that cultural piece. But, I also need to not make that put blinders on me. Because what is also important is that people's spirituality plays a big role in that. And so having that basic knowledge from that cultural piece, I think it hasn't influenced me but it has really broadened my horizon because I have experienced a different belief, a different culture with regards to how people address and treat mental illness. And so that, as a woman of

> African descent, as a Caribbean woman, no matter, you cannot just dismiss that. But you have to put it within context appropriately so that it does not create any bias or does not influence you to be too judgmental. Because when you have someone in front of you, you really need to get the story, figure out what's going on, and have some validation. So having that history, it's good in a way because it means that I'm not narrow focused. I'm not just… I just don't think linear. But I don't make that influence my profession…my assessment, my holistic assessment, my mental status assessment. I really cannot make that take over.

According to a psychiatrist who participated in this study, the Nigerian cultural identity he shares with one of his colleague's patient allowed him to understand this patient's behaviour as normal, even though other clinicians found it to be abnormal:

> And I think even in my practice, my belief tends to shape how I practice psychiatry. I'll give you an example. For instance, when I was in Europe, when I was doing residency, there was a patient that we had admitted who was actually a lady, and she was a Christian and she was like… You know, she was like big into going to church. I'm not a Christian but I understand a few things about Christianity. And I know that there are some people who say, you know, they are truly gifted, and maybe they are possessed, or they hear the spirit or they go talking to them. And how this lady who was kind of a new immigrant was going around and preaching to people. You know, she was just preaching her religion. And I think she knocked on an elderly lady's house and started preaching. And the woman called the cops, and she was arrested and she was put on involuntary. That she held onto this woman and she was falling onto her knees. They didn't charge her. They just said to me that she was hearing voices and all that. But to make a long story short, she was admitted to our unit. And I was like "oh my god!" So like fortunately she was kind of… She was under my consultant that I was working with. And when I read her story, I'm like this is normal. This woman doesn't have delusions or hallucinations or anything. She was just preaching. And I said to my consultant, who was an Irish woman, that this is common practice. That Nigerians who go from door to door….the most is you open your door and you tell them you don't want to listen to them. But there's nothing absolutely wrong with this woman. She's not… Because she insisted she's not going to take medication. And they were holding her against her will and injecting her because she was held against her will. So, she was held involuntarily. But because I was Nigerian, I was like, "No, no, no, this is not psychosis. This is… come on!" So you know, I talked to my consultant. Then she told me to speak my language and interview her. And she was like, "thank you." And then we discharged her. But can you imagine?

Speaking on the issue of policy, a participant discussed the importance of developing mental health policy that captures diverse social identities:

> In terms of citizenship status or disability or age, mental health has no respect of citizenship. It affects everybody across the lifespan, across all geographical areas. But recognizing that it will happen at a younger age or at an older age. So, you have a policy that captures each age section or each age demographic of people. And that way you have everybody.

Creating policies that acknowledge the cultural aspects of mental illness is central to the work this participant is involved in:

> I've been involved in creating policies or program guidelines that take into consideration the cultural aspect in terms of the clients that we see. Looking at them and supporting them from their own cultural norms and beliefs. So, some of the training that are put in place… And I also do offer training on culture and diversity for the Health Authority. I'm part of a working group.

The cultural identity and experience of this participant has helped shaped polices for individuals with intellectual disabilities and mental illness:

> Yeah, so for instance, in my department, we've been able to engage in policy decision-making, particularly for people with intellectual disabilities and mental illness. Understanding different deficits or difficulties that the patients might be experiencing has shaped how we develop policies in relation to some of the restraints that are used on these kinds of patients. Like for instance, when they're extremely loud, sometimes they get chemical restraints, like prn medication. Sometimes we use mechanical restraints, like restraint chair or the penal bed. But you know, my experience and culture and everything has actually helped me to…has helped my policy decision-making. I don't know if that makes sense.

The social and structural determinants of health is the framework this university professor uses in her teaching to discuss mental illness experienced by Black communities:

> So, a lot of my teaching talks about the social and structural determinants of health, and the fact that mental health needs to be normalized. And that all of us experience some level of mental health challenges. And in some of us, mental illness. And that there's stigma for all populations associated with mental health. And how within the Black community, mental health is often criminalized. So, I often will bring in a number of factors and research that demonstrates how people of African descent are treated when it comes to mental health situations. With hopes to educate those that I'm working with that they may come to understand mental health for Black people with some of the biases that they've developed through society. So, I often find myself combatting and fighting against some of the stereotypes that exist, specifically around racialized communities and people of African descent.

Recognizing that the frameworks used to teach courses on mental health come from a Eurocentric perspective, that there is a dearth of Black professors conducting research on mental health, and that Black people are often not included in research on mental health, this professor is intentional in how she teaches about mental illness in Black communities:

> So, working with lay health practitioners who may be indirectly counselling or directly counselling, it's important for them to have a foundation of the understanding of how Black people are seen when it comes to mental health challenges. And particularly our Black men. I find Black men are often feared because again of some of the stereotypes that go with black men and their physicality and their strength. Black women, because of again some of the labelling and stereotypes that go with Black women. You know, the angry Black woman and hotheaded,

> and all those other languages that come with our Black women. So, I'm very intentional and very clear when I teach any of my courses that deal with mental health. And I'm also very cognizant of the fact that people of African descent aren't included in the research. And that's because we don't collect race-based data. We don't have enough Black researchers doing research around mental health. So, a lot of the examples that our students are learning from are coming from a very Eurocentric perspective. And I'll often make the point that this lens doesn't apply to all people, and that they need to take into consideration… If we think about our immigrant community and historical trauma, and people are beginning to understand more and more the Indigenous experience but not so much the experience of people of African descent who also have historical trauma. So, I make sure that if people are understanding the Indigenous struggle, then I often will make connection to the historical experience of people of African descent, both through the slave trade and the fact that we were also colonized, and the fact that we were kings and queens before we became enslaved.

Combining Western and alternative perspectives in the classroom is central to work of another professor:

> So, thinking about this question, how it plays into how I teach, I… Like we talk about Western. That's the science. But I try to raise the awareness of my students that there are other ways. Because if they have a patient from…let's say a Muslim faith, and their medication is due at 12:00, and they're like, "I have to pray before taking this medication." So how do they navigate that? So, do they force the patient to take the medication first or allow the person to pray? So, I would say that's the only way…that's how I incorporate that knowledge. That I bring myself, the experience of another context into what I do just to help the students have an increased awareness.

Incorporating course readings that feature works by leading scholars who examine the link between critical race theory and psychoanalysis was an approach used by this professor to get her students to think about the specific ways in which racialized people are often perceived as "crazy":

> So, when I was at another university, I taught core courses that were 26 weeks. And there was always psychoanalysis, always critical race theory, and I always spoke about… So, they had to read some kind of Fanon. There were predominantly white students. I'd ask "is there a time when a Black person in your life or an Indigenous person in your life has talked about, you know, something happening and you said, oh, that's just in your mind, or don't worry about it – like that kind of thing". I wanted them to reflect on the way that they could perpetuate this racism through these ideas of mental health and being crazy or not crazy.

Another professor stated that his curricula are based on Western belief systems because it is evidence-based and has been tested:

> And of course, when I'm working as a professor and developing the curriculum, I do it based on the belief system in this part of the world. And it's very important to understand that, you know, our cultural limits. So, we develop it based on the belief system here. And intervention… There's a lot of focus on evidence based. And the evidence based is what has been tested and tried here in this part of the world. And that is what I do. My belief system doesn't come into this at all.

Addressing issues related to transgender identity, along with race, has been an important aspect of this clinician's work:

> So, let's take working…someone who's a person of African-Nova Scotia descent transitioning from male to female. Because it is very difficult because of the intimacies within our community or the relational kind of aspects of who we are for folks to actually be out. And that's becoming less taboo. But to be out and be transitioning, there's a whole potential…multiple losses in that person's life of community and family. And clinically, we have to be able to assess that in terms of one of the risk factors for that person and their assessment about transitioning that most people will miss on a conventional assessment form. We're only looking at what do you think are some of the things that you wouldn't maybe have a difficult time transitioning into or back to in terms of your circle of support? Because some of these folks have already been marginalized from their family but have not necessarily been marginalized in their community. And conceptualizing community of choice for people, and that the whole Black community is out to get them, and saying, well, where are the pockets of support? Who are the chosen family? And how does that look for someone who's Black transitioning to lose community connections during this period of time, or to have to move out of the region? And what are those emotional, cultural ties and losses? So that kind of piece is kind of, as a clinician, I think are those intimacies that as a Black clinician, I could ask in a way without that person feeling, well, they can just fuck it. That's a defensive perspective. And most folks know that there's something more nuanced and emotionally connected to those intimate losses of family, place and community.

Incorporating teachings from the Bible is an important aspect of this participant's work as a doctor, professor and priest:

> In addition to being a doctor and being a professor, I am a pastor. I work in the church as a minister, as a priest. So, when I'm in that setting, of course I have then to understand it forms my academic knowledge of psychiatry. At the same time also from what the Bible says about psychiatric illness.

Diversity was at the core of this participant's clinical pastoral training and influences her work providing counselling support today:

> Part of my training in that clinical pastoral education and part of my training as a certified spiritual care provider is to always have in mind that diversity. That people are different. Even people that were born from the same womb are different. So, I always, always have that at the back of my mind – the diversity of people. So, when I go from one person to another, I don't carry what their culture and then kind of impose it my care for the other person. So, I see each person as a unique person with whatever is happening to them. So, for instance, if the person… If two people have mental health issues, they are still different.

Similarly, this participant uses a theological framework to support patients with mental illness who are diverse based on gender identity, sexual orientation, ethnicity, and disability:

> At the hospital, when I worked in hospital chaplaincy, that became very important because we worked with a lot of people with dementia, you know. So, when you're losing your cognitive function, and it can get disruptive for the staff, it can get rough because some of them will lash out and punch a staff member. So how do we maintain the humanity of the person, even while they're having these challenges? And that relates to my formation, my spiritual formation that everybody's made in the image of God. So, if you are gay, straight, mentally ill, male, female, wherever ethnic group, you know, core humanity is important and a very high significance. So, I mean in Christian service, you're made in the image of God, right. There's something about you that reflects God. And when I look at you, I am looking at an aspect of God. So that kind of philosophical and theological framework is also really important. And of course, the Bible has stories of Jesus exorcising people who they would say were possessed with evil spirits. Whatever you want to do it. But the point is Jesus sees the humanity of this person and works to heal, help the people heal. Not only as an individual but restored to the community, you know. I mean I won't go into the details of that. But those things are important.

Trauma-informed theology and what it means to be a trauma-informed church are important to this participant:

> Yeah, many, many different levels of trauma. And so actually that's one of the things I'm looking into now – what does it mean to be trauma-informed, even as a church? What does it mean to have a trauma-informed church? I'm interested in what is trauma-informed theology? Because I mean trauma is all a part of the Bible too, as well. Yeah, I mean we are damaging to one another because, of course… . And I've also been explaining it to people this way, whatever you have inside when you try to love that's what comes out. If I have anger inside and I try to love someone, that's what's going to come out. I've got hurt inside. That's what comes out. So it's not that people don't want to love their families or love people but what they have inside and stored up is so much pain, so much anger, so much hurt that as soon as they are in relationship and are trying to love others, that's what comes out. And that has helped me to understand and it's helped…it's actually helped people to understand and think about their loved ones who have hurt them and their loved ones who have traumatized them in many ways. So, gaining that understanding and that knowledge and being able to move beyond blaming one another, that's what's going to help us heal. But it has to be happening in community. It has to happen in safe places. And it has to happen amongst ourselves. It's not necessarily something outside can facilitate.

A holistic approach has been useful in helping this clinician address patients' mental health issues:

> Mine is much more holistic. So, I bring together emotional, psychological, physical, spiritual, relational. I put together just a wellness wheel for pastors that includes those things, as well as brings in the spiritual aspects of looking at power. Because strength is one of the aspects the Bible talks about, our strength, which is really about power. And also, the whole issue of volition in terms of choices, making choices. And so, ourselves and our health volitionally as well. So, the difference I think that I see is that often Western psychology, it avoids, it separates people into pieces. It's not holistic. And that only can go so far.

Similarly, this clinician observes that in recent times, there has been more stock put on the social determinants of health:

> We no longer necessarily look at it as a medical model in that it's only medical issues that are impacting individuals, but there are also the social determinants. So, we have to look at the whole person and treat the whole person, as well as incorporating those support networks that are there for the individual. So, we've come a long way in how we're actually addressing the mental health and addictions issues for individuals. Do I feel that there is more work to be done? Absolutely. But I think that, you know, we've moved in a rather different direction over the last number of years - moving more away from the medical model and more to, you know, incorporating the social aspects. That's my belief.

The Diagnostic Statistical Manual of Mental Disorders (DSM), which is the handbook used by health professionals as the authoritative guide to diagnose mental illness, is often misunderstood and taken too literally, according to another clinician:

> I can definitely critique it. I don't know as much about how it should be transformed. But the critiques would include, for example, the DSM. So are our book of diagnoses is often misunderstood or people often will use them as if they're real biological entities, when they're not. It's nothing to do actually with reality. They're just brief descriptions of key characteristics that might point to some disorder, mental disorder. So, they themselves are not. If people actually took the time to read the preamble, it's very much just…it's like a dictionary. Like how did we come to know the word that. We all agreed that that means that. And so, we defined that… This is so variable. That's the big problem with psychiatry and with studying mental illness, is the heterogeneity problem. Everybody always talks about the heterogeneity problem. It's so vastly heterogeneous because of the nature of the beast that we're dealing with – the brain. That's such a complex system that we can't even pretend that we understand it yet. We can only hope to kind of describe it. So, that's one critique, is that the DSM should really be taken just for what it is - at face value and no more. It's nonsense. It's a guideline. Two weeks of sadness means depression? That's just arbitrary. Two weeks means nothing. It means nothing biologically or ultimately in that person's life. It's just a common way that's used to provide us a common language, and that's it. Beyond that, it is meaningless and arbitrary. So, that's one critique of which I'm seeing quite a lot recently, especially as people seem to put too much stock in the DSM.

Participants observed that personal and cultural beliefs, training and education, the Western medical model, the social determinants of health framework, and religion, spirituality, faith and the Bible influence their work on mental illness in Black communities. Many of the participants also shared that the health system and universities are often not prepared to accommodate beliefs, practices, and approaches that don't fit into Western health models.

Experiences Working Within Western-Oriented Workplaces

Navigating Western-oriented workplaces is often fraught with challenges, tensions and complications for those providing clinical services, developing policy and teaching and conducting research focused on mental illness in Black communities. The frameworks, approaches and ideologies that

are most valued in these spaces are often at odds with the belief systems, perspectives and experiences of Black people. According to one participant, the health care system is not designed for Black people because of its failure to understand the mental health impacts of racism and oppression in Black communities:

> And our healthcare system is not designed to support individuals who are Black who live with mental illness. And I don't think that there's enough, as I already said, clinicians who will look at mental illness as also being associated with long term impacts of racism and oppression. And that's not often validated as a factor that contributes to or can even in some cases cause people's mental illness. And that is troubling for me because we're seeing more and more of the impacts of long-term exposure to racism, discrimination, sexism, homophobia on people's mental health.

For Black professors and clinicians working in predominantly white workplaces, they are often not afforded the same level of empathy as their white counterparts if they voice their own struggles with mental health:

> And we're afraid to talk about our mental wellness as Black health practitioners and Black professors because of the stereotypes and stigma that's associated with that. And we don't want to ever be seen as being weak. And I think that would be still true for anybody in the Black community who may be struggling with mental illness. Because there's this façade that we're strong, that we're resilient. And when we start to show signs of not being well mentally then there's other labels that come. Whereas my colleagues who are white, they're protected, they're nurtured, they're guarded. You're asked to pick up their workload. They'll talk about being in the hospital, and the support. When they come out, they're still nurtured and protected. And that doesn't happen for Black folk. And the resources aren't there to support us in the same way.

The Western-oriented health care system fails to empower patients in ways that enable them to achieve wellness, according to another participant:

> And so, you're not really helping people to be their own…you know, just be responsible for their own wellness actually. You actually hamper them and you make them dependent on you as a system when that need not be. People need to be empowered to be well. And we have information, as do they. And it's about an exchange. How do you share that for the betterment of that person? It's not about you knowing everything and that you do it my way and that's the only way.

The lack of holism within Western psychology, as well as its tendency to pathologize normal problems are some of the main flaws inherent to western psychology, according to another participant:

> So, the difference I think that I see is that often Western psychology, it avoids, it separates people into pieces. It's not holistic. And that only can go so far. And the other thing is, it doesn't treat problems and issues in life as normative. Life has problems. And I guess one of the ways in which I work is that things happen, life has problems. So, let's look at what we're going to do about it. How are we going to deal with it? And in normalizing issues, normalizing problems so it doesn't ostracize people. And actually, that used to be more the norm because if you go back -

> life is hard. And it used to be more of the norm in the Black community particularly, life is challenging, life is hard, we find ways to deal with it. We find ways to cope. And so there has really been a decrease in resilience in the ability to cope and the ability to accept difficulties in life. And I'm really seeing it happening within the Black community. And we're losing our resilience and our ability to persevere and to cope, to accept the difficulties of life in a way that strengthens us and empowers us.

Another participant observes that psychiatrists need more exposure to research and literature on racially and culturally diverse populations:

> Like for instance, every Wednesday is our academic day, and we're taught by a different psychiatrist each week. And most of what we learn, the articles that we're told to read, it's very focused on a westernized view of psychiatry and medicine. In the research studies that we review, there's very little representation of people of colour, whether it's Black, Asian, Aboriginal, Hispanic. There's very little representation of any other culture. So, it obviously raises the question of how effective are these treatments that we're reading about and critiquing the research on? Like how effective are those treatments for people of African descent? And are these results generalizable to people of African descent? And then if you try to look for research that's on…like specific for people of African descent, it's difficult to find. So, I do think that in that sense, most of my education has been based on the westernized view.

Some of the modalities that are used on patients, such as cognitive behavioural therapy, are not culturally relevant since they were created for Western cultures according to this participant:

> Yeah, in understanding mental health delivery…. For example, there are some modalities, for example, cognitive behavioural therapy, that were created for a certain population. At the national level and also within, I've asked the question how culturally relevant is that? I know in Toronto they're actually looking at modifying the cognitive behavioural therapy for the Asian population because the way it is structured is not working. So, those are the kinds of things I feel in terms of forms of therapy that in Western culture, one should pay attention to who are we supporting, how culturally relevant is it?

The failure of some Western-trained clinicians to understand and validate perceptions of mental illness that are culturally driven often leads to misdiagnosis and inappropriate treatment:

> In terms of treatment and understanding illness itself, I will start with the illness. I like how you ask the question about cultural beliefs because that is huge. Because if you have an individual whose perception about mental illness, it's culturally driven. And they come to Canada and they're being assessed, you know. So, their willingness, not that they are non-compliant, but their willingness to accept Western treatment may be challenging. And those people might end up in a psychiatric hospital, locked up when they shouldn't be because we haven't spent time to really understand, you know. Because I've seen people that truly believe, be it religion or not, whatever voices in their head is a direct conversation from God. And they truly believe that. In Western culture, it's a delusion.

Another participant discussed how important it is to interrogate notions of "best practices" in mental health and to view them as fluid, especially with respect to diverse cultures:

> So, because the Health Authority is attached to Dalhousie, it tends to have a really strong emphasis on best practices in mental health. And I'm always mindful that even when we look at best practices, that we still are leaning toward Western Eurocentric perspectives of who the research still is done on. And I would say sometimes you have to look at what's leading, what are some of the leading practices? What are some of the best practices from a different perspective or from a different lens? So, yes, this might be the best practice for this patient population, but the research or the emerging research has to be given…or the leading best practices that are coming from communities and cultures has to be given some of the similar weight and opportunity to build the critical mass research to say that this is the best practice. And I always say best practices are fluid. What was best practice around the treatment of anxiety is not the same in 1970 as it is today.

The Nova Scotia Health Authority would benefit from facilitating partnerships between psychiatrists, psychologists, social workers, and other health professions to diversify its lens around notions of "best leading practices" according to another clinician:

> But the Health Authority, from my perspective, has historically been very pigeonholed and rigid around what psychiatry and psychology see are the best leading practices, and seldom take into consideration the diversity of lens of other practitioners such as social work and all those other disciplines that work as part of the interdisciplinary team. And that's not to say people are not willing to give some consideration. It's just that that's not their training. And I think we're becoming much more reasonable as colleagues to give some considerations to that. But not necessarily from a systemic perspective or an organizational perspective.

Western notions of confidentiality and privacy are also often at odds with notions of confidentiality and privacy in Black communities, where having family members and community involved in care is valued:

> And Black folks will challenge that conventional wisdom that, "well, if I'm coming in here with my baby daughter or my 14-year-old into counselling, you're kicking me out of the room?" We're not having none of that, right? So, how Black folks see confidentiality…. And yes, it's really important. But when it comes to children and our elders, that we are the keepers of the most vulnerable. So, there is a community context of care. And how do you operationalize that from a best practices approach or from a confidentiality standpoint? And part of it is the way in which most people will conventionally say, "well, you know, this is a safe place and what you say here…". And I'm like, I won't say that to families when I see them in my private practice or to young people because I'm like "I have the privilege to be with you for an hour, maybe an hour and a half every two weeks or once a month. These people out there, they love you. They need to know some parts of how you're functioning. They don't need to know the intimacy of what we're speaking. But we're going to bring them in because that's the right cultural thing to do". And I think the system doesn't know how to move that because people are so scripted in their training. And if you're culturally responsive in any clinical practice in health and in justice, you will understand the value of relations, and how do you build on some of that, as well as the value of

> community in terms of the fact that Black folk don't see ourselves as islands - which is the conventional wisdom of treatment.

One of the underlying factors for the persistence of Western models in the health care system is the lack of cross-cultural training and information in the college and university curricula, as one participant observed:

> And the sense I'm getting is that the colleges and universities do not have cross-cultural stuff embedded in their counselling programs. Now, this is anecdotal because I have not seen a lot. But I don't think it is an essential part of what they're doing. As I said, that's anecdotal evidence. And I think that until the counsellors who are being trained, the psychologists, the ministers, all of these people, social workers who are being trained, have from day one in their college, undergraduate, whatever program mainstreaming of intersectionality, we are going to continue to have problems. And these folks carry a lot of weight. I was talking to somebody working in the education sector to help Black kids. And I mean the principal, the white teachers, haven't been trained to understand what's going on.

Similarly, another participant observed that Western modalities fail to recognize other epistemologies and therapeutic systems, such as religion:

> The other issue I have is not recognizing other epistemologies and other therapeutic systems. And not just Canada, but some of the intellectuals on the left have collaborated with colleagues on the left. So, they're just very ambivalent about religion, and don't want to look at it. You know what I mean? If you talk about religion, people get a little…they go to the extreme - the pedophiles and whatever. And don't understand that especially for poor Black women in communities both here and in Jamaica, their only space of relief is the church. It's the only place they can get honour and some kind of recognition…is in the churches. So, to me, we need to work strategically with faith-based organizations because they can do a lot of preventive work, right?

Western therapeutic models have been so centered on individualism and one-on one counselling with a therapist that it fails to accommodate other approaches, such as peer systems, religion, and other forms of social support that western-trained therapists can't provide according to another participant:

> Because we tend to be curative in the Western tradition, and we tend to be individualistic. So, it's one person with a therapist. You know, the kind of gazing at the naval for 25 years in the kind of… You know what I mean? The early days of Freudian psychotherapy, and it did whatever. But the group stuff, I want to see more good work. I want to see more peer systems established. It's not only cheaper, it's also more empowering for people to have those systems. And religion does have a role to play and can play a very helpful role in supporting good mental health in terms of what religious ritual can do, which can take the place of healing, in my view, deeper than psychotherapy, and can provide the kind of social support and validation that a therapist or psychiatrist can't.

Since clinicians must often work within a particular scope of practice or protocol, it prevents them from incorporating non-Western or other modalities into their practice, such as mindfulness and prayer:

> As nurses, we can't teach mindfulness, for example. So, it's not something that is promoted. I still have to work within the scope. So, I think part of me, while I understood what is first-class knowledge and that research is great, I do think there's aspects that are not touched on. So, from someone from the Caribbean, even though I am working in this system, this model, I do sometimes struggle with my own beliefs. I do have issues at times. I mean I can't really go say anything to anyone. But I just suffer with it. I want to sit sometimes with some people, based on the condition they have, I can see that they maybe just need a hand and maybe I could say a prayer. But I can't say things like that to people in the hospital. So, sometimes things like that are a little bit of a challenge. Yeah, maybe just even to be able to like play some music for people and just dance and be happy. I mean I know it sounds kind of goofy and silly but again, stuff like that is just not part of the protocol. You know, maybe taking a client out for a walk. Yeah, walking is one thing that we recommend here. So, that's something I could definitely do with my patients. But beyond just mainstream things like that, I wouldn't be able to like say play some…like just bring some music, some Bob Marley and dance with somebody, and make them feel happy.

Western notions about what is empirically verifiable has led to a reluctance to validate other epistemologies related to mental health:

> So, I think that that's my problem with the Western thing, is that they don't…they're reluctant, slow to accept other epistemologies about mental health, and dismiss those systems as not empirically verifiable. And to them, what is empirically verifiable? It's empirically verifiable at a particular point in time. So, because you don't have the tools right now to validate it doesn't mean it's not valid.

One of the participants held a different view of the Western model, however, seeing its benefits rather than its drawbacks:

> So, from the Western perspective, I think there are lots of good stuff because, you know, we learn skills with regards to assessment, we learn skills about treatment and management. We learn, you know, therapies like whether we do cognitive behaviour therapy.

It also important to be cautious about critiquing everything about Western medicine outright, according to another participant:

> I've also come across extremes where it's like the whole system is a bunch of bunk, and you need to just dismiss it. And personality disorders don't exist, ADHD doesn't exist. And I'm like there's too much evidence from what I've seen in practice and what I've read to simply dismiss these phenomena of human experience as simply bunk. So, that troubles me too -- that kind of radical social work means to dismiss all of this. I'm like, no, because not everybody that formed that information and pulled together all that data were coming from a dominant power-oriented space. We need to pay attention to that. We need to pay attention to what the World Health Organization, for example, is finding. We need to pay attention to both the critics of things like the DSM and the people that have done the research to say this is a phenomenon in human living that is deeply distressing on a mental health level, and we need to do something about it.

Similarly, another participant stated that there are a lot of good things that can be taken from Western medicine, however, it is important that it be combined with other beliefs:

> I believe a lot of work has been done. And science has advanced so much. A lot of interventions have been developed to treat different illnesses. A lot of research work has been done across the country and even in different universities here in the country or even in the States or even other parts of the world. We're using the evidence. We're using an evidence-based approach to provide services. So, I really strongly believe evidence-based approaches looking into the various mental health interventions that we provide is really very important in what we do. And I think it's just being able to combine what people's former beliefs are to see how you can integrate sometimes. What you can take from it is really very important because the healing itself involves the individual's beliefs and how they are willing to participate. So, we need to carry them along. We need to recognize what they believe, and acknowledge it, and utilize it as well as what we are doing.

As the participants observed, the beliefs, worldviews and experiences of mentally ill Black people are often dismissed, negated, or ignored in the mental health system and in university teaching and research, often because clinicians and professors are ill-equipped to address the concerns and priorities of Black people in their work and because they don't fit into Western understandings of mental illness. While it is important to be cautious about dismissing outright Western perspectives and practices, exploring opportunities to strengthen best practices approaches by combining Western and alternative modalities may be an important step in addressing mental illness in Black communities.

Grappling with Cultural Competence and Structural Competence

For the last several decades cultural competence has been the framework that medical and health professions education in Canada has used to address the tensions that arise in the relationship between clinicians and patients from culturally diverse communities. Cultural competence focuses on developing "linguistic competencies" that focus on culturally sensitive, non-judgmental ways to build rapport with patients, as well as communication skills that help build relationships when working in "multicultural settings". It also focuses on in-depth self-examination of how one's own beliefs and values influence behavior and therapeutic relationships with patients, learning about the patient's worldview, gaining an appreciation for differences in communication styles and etiquette between and within cultures, including non-verbal communication techniques that consider patients' use of eye contact, facial expressions, body language, touch and space, recognizing different literacy levels of patients, appreciating how patients' life experiences shape their health, and understanding the culturally-specific ways in which health is expressed across cultures, as well as the role that culture plays in responses to health, illness, disease and death (Metzl & Hansen, 2014; Stanhope et al, 2011).

It is important to point out that while cultural competence approaches are important for enhancing clinical dialogue, they don't often emphasize the role that social structures and politics play in impacting health outcomes in marginalized communities, and in interactions between patients and health professionals. Therefore, the term "structural competence" is increasingly being used to highlight how clinical interactions between health professionals and patients can engage more with the many structural factors that impact health and mental health. In other words, addressing poor health outcomes in marginalized communities requires that health professionals, health policymakers, and health educators

not only demonstrate clinical cultural competence, but also consider how the social, economic, political, and environmental factors that influence health disparities operate both within and above individual interactions (Metzl & Hansen, 2014). In this section, the participants discussed their understandings of cultural competence and structural competence and how they apply these concepts to their work.

Cultural Competence

Cultural competence was succinctly defined by one of the clinician participants:

> So, for me, cultural competency is that when I have a client, and my client could be a person, could be a community, could be my organization. I think it's important for me to truly understand not only my own values and beliefs but also their values and beliefs. And organizations, also the organizational culture. And so that is the first step. It starts with me really doing some reflection about my values, my belief, my biases, all those things that can cloud my vision, my perception, and can make me judgmental. So, I need to clearly…to have a clear understanding of self. And then I also need to have a clear understanding of my client, whoever that may be, of what is meaningful, what is meaningful to them, and what are the kinds of things within this relationship that we're trying to develop that will make them feel okay. And, so for me, if I can understand that and we have that common understanding…. And then I need to be able to figure out with whatever steps that need to be taken, how am I going to interact with that person to support him or her on this journey of recovery? So, for me to be culturally competent, it's not just about my knowledge, skills, expertise and competency from that piece, it's about from that person piece. And we have to look at it not just only from the physical or mental piece, but we have to look at it from the spiritual, emotional. We don't often do this…we have to look at it from the environmental aspect of that piece. Because all those things factor into, you know, whether we want to talk about positive factors or negative factors. I mean, all those things factor into that person's journey of recovery or wellness. Does that make sense?

Integrating students' diverse belief systems into research and teaching is how one of the professors in this study demonstrates cultural competence:

> For me as a professor, cultural competency for me means being sensitive to different cultures and diversity that might be present in my research group and in my lab, in my classes. Like, I have probably eight different countries represented in my students. Part of being culturally competent is… Some of them… I have Muslim, Buddhist, Christian. And just anything, people that believe in nothing. And we're so much together. Like we work so much in harmony and laugh and do anything. I find a way to understand what people believe and be able to integrate it into what we do. Creating a common ground for people to live in harmony without stepping on each other's toes or shaming anybody because of what he or she believes. So, everybody there to the best of my knowledge feels happy and included in what we're doing.

Understanding the cultural context and beliefs within which patients are situated can go a long way in identifying effective ways to address their concerns, observed another participant:

> I think it's dangerous when… For any area of medicine that doesn't understand the roots of a person, where they're coming from. And so, even in the case of this woman that I had dealt with, I was able to sit in with her and her nurse practitioner. I think it was a nurse practitioner. But just to be able to help explain even… She was Indigenous. And I didn't know a lot of her cultural practices and beliefs myself. So, I had to ask her because she's wasn't from this area, she was from out west. And so, once I had a little bit of an understanding then I could relay even in some of the ways that she was approaching things. And so that was helpful. So, I think it's really important. I believe that help can be given. But I also believe that you really need to understand who you're working with and where they're coming from. And be that her cultural traditions and beliefs, be that the experiences that a person is going through, if it is some type of trauma or abuse, I think you really have to have an understanding of that. Some practitioners might not when it comes to the cultural component. And I think that that can be a detriment to the individual that they're working with.

Applying cultural competence in the clinical setting must involve identifying patients' specific needs and priorities:

> How we apply it is to ask people…I mean recognize, you know, their background, recognize their culture, recognize their preferences, how would they like us to work with them. If there are special considerations that we need to have, you know, making our environment more accessible to all. For individuals that use wheelchairs, we have wheelchair accessible entrances. For individuals that require a wider area, we build things to make sure that we're able to accommodate everybody. Doors are wider. The bathrooms have been labelled to show that we recognize and we're sensitive to what people's genders are. We're not imposing, to say you have to be this or that. We recognize people and welcome and embrace them for who they are.

Another participant discussed the importance of focusing on the most marginalized Black patients:

> I think I demonstrate cultural competency in my work because I always start with Black, queer and trans folks. I always start from that position. And so whatever anecdote I tell or information I provide comes from the most marginal or the margins…on the margins of margins. And I'm like, you know, if we start here then how can that shift even how we think we know about best practices? And so that's what I do there. And because we start there, it means I find that I'm often contradicting or correcting what other people, mostly white people, state as fact about something. I'm like, well, actually that's not how it is for everybody. And you just stop taking the general population because it excludes Black people. So, let's start with Black people and work outwards.

Another participant noted that helping LGBTQIA clients understand their identities and the experiences they encounter related to those identities is key to helping them address their mental health concerns:

> Like with my LGBTQ+ clients, we talk about gender and gender construction. And you know what if that didn't even exist, we'd just be what we are, right. So, the same with African Nova Scotians or Black people, race and how, you know, validating their experiences of racism. Because I think when you have a clinician who is not aware or is aware but doesn't understand

> racism because they've never lived it but doesn't take the opportunity to listen to their client either….they just disregard racism, right? And I think that is where the collide comes with a lot of people were not wanting to access services because they don't believe what I'm telling them.

It is important that clinicians practice caution in declaring themselves culturally competent since it is an ongoing process:

> I'm always very careful in using the word cultural competence and cultural safety because people begin to believe that they have one course in cultural competence and cultural awareness, and now they're culturally competent. And it's on a continuum. And no one in my opinion, including those of us who are racialized, are never 100% culturally competent. It's on a scale. And it moves, it grows. And I think you can always be learning how to be more culturally competent or culturally aware or create a cultural safety.

Another clinician echoed these sentiments, noting that cultural competence is an ongoing process:

> Like just providing care without judgement. And I would say that it's a process. So, it's not a destination, it's a process. And it's ongoing. And it starts with awareness of one's beliefs – whatever that is – and values, and how it can impact the other person. And I would also say that another element is intentionality of just wanting to understand from the other person's perspective as a clinician. Like for mental health, what I want to say, there has to be a balance. For example, if someone is suicidal, and they're telling me because they're from another culture, "I'm not suicidal. I just cannot take it anymore." There has to be a balance between is this person suicidal or is it just their belief? So that's why I said like intentionality of wanting to understand, to have a bigger picture of what exactly is going on, and providing care, and meeting them where they're at.

Clinicians must understand what cultural competence means for them before they consider what it means for the client:

> I think that there's a big gap. I think from my perception and my experience, there is a misperception that people believe that they understand cultural competency. I'll just use myself as an example. It is the new buzz within the context of racism, within the context of truth and reconciliation, those things. Like everybody is about talking about culturally competent and culturally safe and cultural ability and culturally whatever. And I don't really think people have taken the time to pause, to really say, well, what does that look like for me? Never mind for the client. When I talk about that, what does that mean to me? What does that look like to me? And if I don't understand that, how am I going to be able to engage with someone to talk about that? And I think in the hospitals, in healthcare agencies, in organizations, I think there is a false…it's really a false sense that people truly feel they understand.

NSHA has invested considerably in moving cultural competence forward, according to a participant:

> So, I believe most of our workforce understands cultural competence right now. There's been so many avenues whereby education has been provided. In class, education has been provided.

> LMS education opportunities have been provided to staff. Even among us managers, we have sessions. I remember we had a team from East Preston came to one our managers meetings, and they actually gave us, you know, a session on what they're doing out there, what's available out there, additional information on how we can refer people to their program. I know NSHA really invests a lot in improving cultural competency. I've taken those classes even right from the time I was a new staff member working here. And, I've been exposed to it several times. So, it's been reinforced.

NSHA is also recognizing issues impacting the LGBTQIA community, according to another participant:

> I know NSHA participates in the LGBT Pride parade. It's a recognition of the fact that we recognize and support every culture. On our unit, we participated in a community of practice out of Ontario which they have a session when they have a presentation on diversity for the LGBT community. And our staff did participate in it. They were so excited to see that because, you know, it shows how to view…even recognizing without asking…recognizing how do people want to be addressed. Is it going to be he, she? The proper pronoun to use for individuals because you want to make sure you respect and treat them how they would like you to address them. So, there's a lot of investment in teaching and supporting staff to recognize diversity and to treat every individual with respect based on their preferences with culture and all of that.

Holding NSHA accountable for ensuring that equity remains a commitment is also essential in addressing cultural competency, as this participant explains:

> So, holding people…holding NSHA accountable to their own equity commitments is one thing. And looking at changing them because they're very archaic, even the language. Recognizing that racism is also structural too, and that it's not just personally mediated and cultural competency but actually it's a colonial system that we live in, and how does that impact? What does that mean for the organization? It's been built on that. So, we're just changing the conversation. Which is something I always do. I always bring it… I'm relentless, put it that way, in bringing that to the table. And I've been… It's been welcomed because people I think have been a little bit thirsty for it. Recognizing that something has to change.

Other participants discussed the lack of cultural competence demonstrated by the health system in addressing the belief systems and needs of people of diverse sexual identities, as well as African Nova Scotian and Indigenous communities. For example, many people are not equipped to address issues around sexual identity, according to a participant:

> It's a missing tool in our arsenal. We are not fully equipped to address the pressures of this day. We're not equipped to address sexual identity.

The specific concerns and experiences of African Nova Scotians continue to be ignored in the delivery of mental health services:

> It's bad. It's so bad. So, what do I think? I think we're not there. I don't think we're there. And I know that we're not at the forefront until they're held accountable to their own process, until

> they're held accountable to the African Nova Scotian community that they're not really representing, that they're not really supporting. They're basically giving us the same services that they gave everybody else. It's not equitable. And then we don't even get those services because how do we get them? Especially in communities that are isolated like the Prestons, where it's already difficult to even have the conversation. Where are those services? And another thing is we live in communities where everybody knows everybody. Not everybody wants everybody to know about this, right? It's like if I have a mental illness and I go to a centre where I know they have mental health treatment and somebody sees me from the community walking in there, that is a hindrance in and of itself. It's just a fact.

Discussions on cultural competence tend to focus on Indigenous people at the exclusion of Black people and people of other races and cultures, according to another participant:

> They're trying. I think they're trying. And a lot of it, especially in Canada, what I find when they talk about that, it's usually geared towards Indigenous or First Nations people. But I've never really heard anything said about Black people or… It's more like around the Indigenous population, which is a good model because if one understands that and practices that then we can take it to the broader level. But I do think there's a lot of emphasis on that and not a lot on any other cultures and so on.

Another participant observed that hospitals often neglect the specific spiritual needs of Indigenous people:

> Now, even in Nova Scotia, we have Aboriginal people. We have the Indigenous people in different communities. That also has its challenges. But does our policy allow them to come to us? Because they believe in practicing their faith, you know, in offering sacrifices. But you go to any hospital, we have a temple or a chapel or you have a place… So, there is a chapel where a Christian can pray. But you have a mosque. But we don't have a place for them to offer their sacrifice. Traditional beliefs. For them to come to us, okay, you are in the hospital, we want to offer… Now, we have a no scent policy, right. But for them to offer a sacrifice, there will be scent. Already we have a no scent policy. So why would they come when part of their belief is something to smell?

According to one of the professors, cultural competency goes beyond one or more courses or a research paper:

> That people think that if we teach a couple of courses around differences around race, around Black people then we're helping our students become culturally competent. And it's beyond a course. It's beyond a lesson. It's beyond reading a research paper. It takes a lot of practice, it takes a lot of exposure, it takes a lot of learning to even begin to understand the experience of people of African descent. And it is very complex. I think we need to have more dedicated courses and time to understand the experience of racialized individuals, particularly people of African descent. We're doing an okay job with our Indigenous population. We're doing better. We need to have full courses dedicated to people of African descent and looking at the complexity of what that means and what that is. And even then, you know, we'll be helping them become more culturally aware.

Another professor observed that it is not enough to talk about cultural competency, it must be put into practice by first identifying patient needs and knowing how to interact with the patient:

> So cultural competence, I think action again is very, very important. It's the doing. I've taught in university to different people, different levels, doctors and so forth. And what I told them was that it's important for you…you don't have to understand all of Sigmund Freud or Carl Jung or these people, you have to know how to transmit your feelings that the patient needs. What is it that that patient needs? The patient doesn't need that information about Sigmund Freud. The patient needs to know how to interact with another person. You need to know how to interact with that patient…with that person. Not as a patient but as a person.

Many nurses have an awareness of cultural competence, but don't necessarily apply it to their practice on a daily basis:

> Because I'm going to sort of focus in on where I'm at now because I am in a role where I'm mentoring like newer nurses, novice nurses coming to the field. And so you know, from what I've been told is that, you know, cultural competency or to understand that has been kind of weaved in, woven in through the curriculum. So, at any point that you have somebody in, it's something you consider. I get all that. But do you really do that? So, you know, kind of what I see is, you know, we kind of all have a general awareness of it. Whether we make it applicable to our practice on a daily basis, I don't believe we do. For example, I look at how… Like when I think about a forensic environment, and it's very, very custodial – very custodial, very disturbing actually to be in – where you see, you know, a person's rights…they just don't have any rights. Like they just don't have a lot of say. It's very punitive, it's very custodial. If a person even airs what they think and it's not looked at in a favourable way, that can have repercussions. Like in terms of, you know, their freedom or their liberties or, you know, you have to do this, that and that. You can't even think for yourself. I think people would be really shocked. Because I really feel like there's people that work in that environment on a day-to-day basis that don't see it that way. And so, when I think about a person who is—you know what I mean—gender identification, and how that is not sort of woven into their plan of care on a day-to-day basis… How that's not even sort of talked about. How that's even looked at as perhaps a mental illness when it's really not. But how do you then figure out what's illness versus what's not? It's the same with when I think about, you know, African Canadian, Nova Scotian, the importance of family, how important family is in terms of that structure. And how you use family as a pawn to get them to do what you want them to do, right. So, the person has to choose between family and treatment. How do you make that choice for a person where family is the more important thing? Those are things I look at that that we really don't do. We don't even talk to individuals about what their own beliefs are when it comes to mental illness.

Conceptualizing an African-centered cultural competency approach is important, according to this participant:

> So, the competency, we focused on competency, cultural competency, more in terms of African culture in terms of, you know, dress and some language, some ways of doing things. But we haven't thought about what's the African cultural competency for what we've developed since we've been here. That part is missing. So, for us as Black communities here, what's our cultural

> competency that we've developed from living in Nova Scotia and being ca ommunity? Because identity is always evolving.

There are obstacles in applying cultural competence in clinical work, according to this participant:

> Formally we present in the formulation. It's called a formulation where we present all of the different factors that lead to someone developing their mental illness. So even in that training, we don't always have time to think about that in our minds and write out a formulation each time or say it verbally to our supervisor. So, just that, the fact that we aren't able to do that every time you see a patient kind of is a hindrance to us being able to think about cultural aspects.

Offering cultural competency training is meaningless if it is not offered with the proper foundation and acknowledgment of how the health system and decision making can facilitate its application to clinical practice.

> But it's offered without, at least from my perspective, without a proper foundation or basis. So, what we've learned is how does it help us improve the services we offer, and how does it help you as an individual in what you do on a day-to-day basis and how it could be more effective with the clients you have, for example? So, it's a case of we'll just train you on these and things will be better. But there's no structure around it, there's no framework. So, how does this help move things forward? And what are the other supportive tools within the system that ensure whatever you have learned you're able to practice? Are you able to become more effective if the system is supporting or enabling you to be able to apply the lessons you've learned? So, I don't see that… I don't see much of that.

Structural Competence

While structural competence was a concept that most of the participants were unfamiliar and had struggle defining, one participant did provide a succinct definition of the concept:

> And what I mean by that is thinking about the environments and the environments that we have no control over, the structures that we did not design, and that we're forced to live, work and be in that don't support us as people of African descent. And so above and beyond, you know, your typical 11 social determinants of health, we need to look at the social system, the justice system, the education system. All those systems impact the experience of people of African descent. The political structure. And these are things that we don't have a lot of control of but definitely affect us mentally, physically, emotionally, psychologically. And we're aware of that. But we're very limited in what we can do. We're often very powerless in how that impacts our existence.

In defining structural competence, another participant pointed to factors in our social system that privilege some people over others:

> Structural competence. Yeah, I would say it's just the way the system works, the way it oppresses people, the way it privileges some people, and the way it further alienates some people. We talk a lot about social determinants of health. But the structure is in a way… Like the

> system was developed in a way that continues to privilege some people over others. Like we talk about even rural and urban. So, say in Truro or other rural areas, they don't have access to mental health care services.

Understanding mental illness as an outcome of broader issues and processes was how another participant conceptualized structural competence:

> The thing about what I would say for the structural piece, it enables you to really look deeper. It really does. It takes in all those aspects, all the social determinants of health. It takes in the political aspect as well. It takes in everything. So, if I say cultural, the first thing that comes to people's mind often, from my experience, they think of it from culture - the skin colour, you know, whether you are Caribbean, whether you are African. You know, that sort of piece. When you think about it from a structural level, it really enables one to pause for a moment and say, well, what is this? And I think it's broader. You're not just into the fishbowl. It forces you to look at all the other structures. And not only structures but the processes as well. Structures and processes that sort of dovetail, that really impact the health and well-being of this person. You know, physically, emotionally, mentally, and spiritually. So that's how I would describe that.

An understanding of structural competence with respect to addressing patients' broader social and economic needs by partnering with agencies outside the health system exists in the forensic setting, according to this participant:

> It is happening. However, I think what's happening is in the forensic setting I think what they're seeing as their way, even though they are connecting with those services – food bank, addiction services, it doesn't matter – they'll all outside agencies. They've kind of been identified that…what the person needs. It's almost like they want to dictate in terms of how people deliver services. If you know what I mean. Not so much like maybe the food bank. That's pretty kind of straightforward. But when I think about kind of addiction services and that… And the forensic services is abstinence-based.

Many clinicians don't consider the broader social context and systems that impact their patients' lives and well-being:

> I think for most clinicians, they don't have a large…they don't have time. So, their perspective is pretty narrow. It's a pretty narrow. Actually they're not even thinking of the person in terms of the whole sense of their social system, they're just thinking of this person sitting in front of me right now, and that's it.

Demonstrating structural competence and advocating for one's patient is central to what many psychiatrists do, according to one of the participants who is a psychiatrist:

> Well, I think that psychiatry, unlike many other specialties, it kind of comes as a part of the package that you would have to intervene, you would have to advocate from time to time on behalf of your patient. And the people I'm working with, I see that a lot. I see that they're trying to see… And there's an understanding that, you know, somebody's mental health doesn't just

> depend on the pills they give them or even psychotherapy. That there's so many other things that are impacting on people's mental health. So, I see that a lot of psychiatrists get that. I get that sense from the people I'm working with, you know.

Similarly, another psychiatrist indicated that, like most psychiatrists, he makes considerable efforts to intervene and advocate for patients who are dealing with challenges related to housing, unemployment, the school system, immigration and other structural determinants of health:

> And I think like most psychiatrists, especially for people who are poor or are unemployed, you know, you get involved in people who need housing, proper houses, people who have unemployment problems. Some people who have had to drop out of school for one reason or the other. You know, you're kind of getting involved in encouraging them to find something to do to get engaged, to be occupied with something. And especially the issue of poverty, that's something that comes up a lot of the time. I think that people with mental illness can easily fall through the cracks in terms of social amenities in terms of housing, in terms of educational opportunities, and things like that. And immigrants are… The sense that you get from immigrants is that, you know, like when people are, for instance, applying to come into Canada, a lot of the time it is based on their occupation and other things that they can do. But when they come into the country, you find that a lot of people kind of struggle. Because to get into your own occupation, even though that was the basis on which you were granted immigration papers.

Medication is often prescribed to patients whose mental illness is due to social factors that can be addressed without medication, according to another participant:

> Again, it's about holistic health. If somebody has… For instance, you have a patient who cannot…who doesn't have a job. And because he doesn't have a job, for some reason he became sick. And then they worry, and they are concerned about the fact that they don't have a job, they cannot provide for their family. So, if you continue to give the person medication, the spiritual or the emotional part of that person's health is not being taken care of. So, I always say that if a doctor or a nurse has a patient like that, I would think that not only giving the person the medicine… Because the medicine can only work so far. You will not take away the issue for the person. So, I would think that medical health professionals should in some…either in a direct or indirect way, find a solution to that. Not in the sense that they will have to become the only focus. But if there's somebody that's a secondary person to get that solution to that, I think would be helpful for the person.

Clinicians' failure to address some of the root causes of mental health problems that may be due to social and economic factors, often means that the patient's treatment will be unsuccessful, according to this participant:

> Well, that's what I'm asking the clinicians in the sense that it's one thing to say, okay, well, yes, you're going to be asking them to address maybe an issue around depression or anxiety. But again, if you're not looking at the whole picture of the individual. So to say, okay, well, well, yes, I'm going to give you some skills around improving your anxiety, but if you're not looking at the core root or the core cause of what's making the individual anxious. Is it they're becoming anxious because they don't have food security or they don't have a steady income, or it's because

> there's some support network issues? So, if they're not addressing all of the other issues, like you said, the structural issues, then that person is not going to be successful in their treatment. So, they need to start to ask these questions and address these underlying issues and help them to resolve where these barriers are.

The failure to address patients' social and economic needs, such as housing needs, is often due to the fact that these issues are seen to fall outside the mandate of mental health programs, as one participant explained:

> We tend to use just the cultural competency. And the mental health program, the way it's structured, is very, very narrowly defined. You're working specifically with individuals with mental health issues. We do advocate and work with other people like the example I've given you around housing. But housing is not in our mandate, you know.

The failure to acknowledge how the specific experiences of newly arrived immigrants have implications for their mental health is a significant gap in the health system, according to another participant:

> When migrants come into the country, it is assumed that we are healthy. But when they come into the country, there is a system that says that you are not eligible for healthcare access until three months after you land. Meaning that I came into this country in August of 2012. But I was only eligible to go get my health card three months after. So, I begin to ask myself, what if this person gets sick within that period prior to you being qualified to go get a health card? And then I looked at the literature review I was doing recently…what if a migrant comes into the country, or what if a refugee came into this country during the pandemic, like prior to the pandemic, and he or she is unable to go get the health card at that time? Because for you to go get tested, and you learn that you have it. So, for me, I see that as a gap in the system, in the healthcare structure. So as a health promoter, I would love to have that policy revisited for everybody to have universal access to a healthcare system. When they come in, now they aren't able to get the same access, equal access to healthcare. And I think, speaking to the immigrants this week, it affects their mental health negatively. Yeah, it affects them. Like keeping aside the language barrier, the cultural barrier, but for you to be able to access the system because of the structure in place, it's something for me that has to be revisited. Because you can't get your health card until three months after you come into the country. And then if you do… One of the articles I read, when these immigrants now stay in the country, due to overcrowding, poor housing conditions, their health now deteriorates. And then in order to cope with all this mental stress, they get into substance use.

According to a participant, social workers demonstrate structural competence through advocacy efforts that ultimately help patients access services:

> My experience with the social workers in the hospitals, I tell them jokingly, I say "you're next to God". The social workers in the hospitals are gold, in my experience. They know the system, they know how to work the system. So, I very often would refer people - people with poverty, housing, so on and so on. Sometimes they don't know that they can ask to see a social worker. Those social workers, I've seen them work magic. So, I would say at that level of helping people

> to access services, that the social workers, in my experience… Let's say you have an interdisciplinary team at a hospital. And somebody's really suffering from food insecurity. Their health is about food insecurity. And a social worker would say, "Let me connect you to a food bank," or whatnot. That's being structurally competent.

According to another professor, developing her students' competencies around advocacy through a social justice lens is how she gets students to think about being structurally competent:

> Yeah, personally in my course, I talk about that. So, it goes beyond the pathophysiology of a disease. It's what can you do as a nurse to advocate for your patient through a social justice lens?

Helping students to identify the many structural factors that create barriers to accessing services and that have implications for their mental health is one way this participant applies structural competence in her university teaching:

> So, through assignments, so I remember in one of the courses, students were asked to look at part of their solution for the particular… Any topic that they chose, part of the solution is to look at resources in the neighbourhood, and how those resources are accessed by the population, or not accessed, and what are the facilitators and barriers to access? So that's one of the ways that we put that to them. For the fact that maybe there are 10 physicians, 10 family doctors in a rural area does not mean that everybody has equal access to it. Then, we also get them to think about like transportation. Some things are as simple as giving patients brochures and pamphlets. Not everybody can read. But people assume that… I have a patient, "When you get home, read this." But they cannot read. And if all the information is in what we're giving to them, that's going to impact whether they would maybe further seek help in the future or comply with whatever recommendations we're giving them.

Although many of the participants struggled to define structural competence, the experiences they shared about how they advocated for patients' needs around housing, food, jobs and education, as well as their understanding of how decision-making processes within our various social structures impact people's mental well-being indicated that they were endeavouring to be structurally competent in their work. Consequently, it is time that structural competence be taken up by the health system and universities more broadly to better address the social, economic, environmental and political inequalities that impact mental health, especially for racialized and other marginalized communities that are more likely to be struggling with these inequalities.

Conclusion

The culturally diverse Black mental health professionals, professors, mental health administrators, policymakers and health promoters that were recruited for this study shared their beliefs about mental illness and help-seeking, how their beliefs and Western understandings of mental illness and help-seeking influence clinical practice, policy, health promotion and university research and teaching, and how they understand and apply cultural competence and structural competence in their work. They discussed several beliefs about mental illness and help-seeking that are common in their culture, including the following:

- People who have mental illness are cursed and have been victims of demonic possession, a spiritual attack by a witch or wizard, or "voodoo" or "obeah".
- Mental illness is caused by intergenerational trauma stemming from abuse and other forms of trauma in families, the trauma of being a Black or racialized person in Nova Scotia and Canada, and the trauma experienced through lateral violence perpetrated by other Black people.
- Genetic/hereditary factors are at the root of mental illness.
- Mentally ill people are to blame for their own mental illness.
- Mentally ill people can infect other people with their mental illness.
- Mentally ill people are weak.
- Mentally ill people are violent.

There was a consensus among the participants that there is considerable taboo, stigma, and silence around mental illness in Black communities, and that these perceptions influence how people choose to seek help or not seek help for mental illness. Many Black people who seek help from the mental health system are often left dissatisfied with the lack of culturally specific mental health services. Consequently, they are more likely to seek help in community (including from an authority such as a political figure or spiritual leader) rather than from the mental health system. Homophobia is deeply entrenched within religious institutions globally and has been harmful to members of Black LGBTQIA communities who seek solace in the church. They must often navigate the different avenues that exist for finding faith and faith communities within and outside religious institutions due to these enduring harms.

Participants also discussed how their own beliefs about mental illness and help-seeking have influenced their work, whether it be clinical practice, administration, policy, health promotion or university teaching and research. It is important to note that colonialism has had enduring impacts on all sectors of African society, including the education system, which remains heavily influenced by a British model. This model has greatly shaped perceptions and beliefs about mental illness and how it should be addressed among some of the clinician participants from Africa, many of whom stated that they preferred that model since it was embedded in the training and education they received. While other participants observed that they give more credence to a social determinants of health framework, they noted that the medical model was the most valued approach in their workplace. Several participants discussed how challenging it was to work within the confines of the medical model at NSHA. According to some of the participants, Western notions about what is empirically verifiable has led to a reluctance to validate other mental health epistemologies within the health system in Nova Scotia. The lack of holism in Western psychology, as well as its tendency to pathologize normal problems are some of the main flaws inherent to Western psychology, according to one participant. Another participant observed that some of the modalities that are used on patients, such as cognitive behavioural therapy, are not culturally relevant since they were created for Western cultures. The lack of cross-cultural training and information in college and university curricula are some of the reasons for the persistence of Western models in the health care system, according to another participant.

Since clinicians must often work within a particular scope of practice, it often prevents them from incorporating non-Western modalities into their practice, such as mindfulness and prayer. Some participants shared that they would like to incorporate a spiritual component into counselling support and clinical practice, in general, but have been prevented from doing so. For many of the spiritual leaders who participated in this study, diversity has been a central aspect of their clinical pastoral training and influences the counselling support they provide to patients. For example, one spiritual leader indicated that she uses a theological framework to support patients with mental illness who are diverse based on gender

identity, sexual orientation, ethnicity, and disability. Also discussed was the importance of developing mental health policy that fully acknowledges the diverse social identities of patients, including race, culture, gender identity, sexual orientation, and other factors.

While one of the professors in the study stated that his curricula is grounded in a Western belief system since it is evidence-based and has been tested, another professor observed that she is intentional in how she teaches about the mental health experiences of Black communities since the frameworks used to teach courses on mental health at her university are heavily influenced by a Eurocentric perspective. She also observed that there is a dearth of Black professors conducting research on mental health, and that Black people are often not included in research on mental health. Several professors indicated that they demonstrate cultural competence and structural competence in several ways, including integrating students' diverse belief systems into research and teaching and developing students' competencies around advocacy through a social justice lens.

Finally, understandings of cultural competence and structural competence were discussed by participants, as well as how these concepts were applied by in their work. When asked to comment on how cultural competency is taken up by the health system, many of the participants observed that the health system fails to demonstrate cultural competence in addressing the belief systems and needs of people of diverse gender and sexual identities, immigrants, African Nova Scotians and Indigenous communities. While cultural competence is considerably well-understood in the health system and among health professionals (although it may not be practiced effectively by health professionals), structural competence is not yet a well-known concept, as evidenced by the number of participants who had never heard of the concept before. This speaks to the importance of providing training on structural competence in the health care system in Nova Scotia. Metzl and Hansen (2014) identify the following five core intersecting competencies that must be included in structural competency training:

- Recognizing the structures that shape clinical interactions.
- Developing an extra-clinical language of structure.
- Rearticulating "cultural" formulations in structural terms.
- Observing and imagining structural interventions and
- Developing structural humility.

Recognizing the structures that shape clinical interactions requires an understanding of how medical and health care decisions are impacted by economic, physical, and socio-political forces, as well as appreciating the ways in which health professionals and patients are affected by upstream decisions and the political economy of healthcare. Developing an extra-clinical language of structure involves health professionals shifting their focus beyond hospitals or clinics by grappling with theories and concepts from disciplines such as sociology, anthropology, and history, understanding how chronic diseases are created by the elicitation of physiological and cellular adaptive responses to resource-poor environments, using the extra-clinical language of structure to move medical and health professions education forward in ways that focus on addressing the social realms through which health and illness are produced and maintained, and articulating how disease can be understood as the product of social structures interacting with biologies. Rearticulating cultural presentations in structural terms requires that health education begin to develop concepts and theories that not only embrace a diagnostic focus on culture, but also the cultures or systems of privilege and oppression that shape illness. Observing and imagining structural interventions recognizes that health and illness are outcomes of structural forces that reflect specific financial, legislative, or cultural decisions made at particular moments and that, consequently, can be subject to various forms of intervention. Finally, developing structural humility refers to the trained ability of health

professionals to recognize that structural competency is limited and merely provides an entry point for understanding and addressing health in marginalized communities (Metzl and Hanson, 2014).

Recommendations

The recommendations outlined below highlight suggestions provided by participants for how the mental health needs of diverse patients can be addressed through: 1) workforce diversity; 2) training and education at NSHA and other organizations that provide mental health services; 3) clinical practice; 4) mental health policy; and 5) university research and teaching.

Workforce Diversity

- Create pathways for Black people who are interested in becoming health professionals by helping them develop relationships with healthcare professionals for mentorship and guidance.
- Increase the representation of people of diverse backgrounds at all levels of the health care workforce (clinical, policy, decision-making) by reaching out to and engaging people who are diverse based on race, ethnicity, gender identity, sexual orientation, disability, socio-economic status, and education level.
- Develop retention policies and incentives to retain diverse people in the health care workforce.

Training & Education at NSHA & Other Organizations that Provide Mental Health Services

- Expose psychiatrists and other mental health professionals to more literature and evidence based research on diverse populations through academic days, seminars, and other educational events.
- Provide training on the mental health of diverse populations to staff at emergency units.
- Implement cross-cultural training and education on mental health at colleges and universities.
- Develop educational tools for mental health and addictions services.

Clinical Practice

- Hold NSHA accountable for ensuring that equity remains a commitment.
- Facilitate partnerships between psychiatrists, psychologists, social workers, and other health professionals at NSHA to help NSHA diversify its lens around notions of "best leading practices".
- Address the stigma around mental illness in the Black community.
- Move beyond the biomedical model to acknowledge and validate the structural determinants that shape experiences, impact mental health, and that influence help-seeking.
- Acknowledge the importance of faith, spirituality, and religion in how some communities understand and seek help for mental illness.
- Acknowledge and validate the unique experiences of LGBTQIA populations who seek out spiritual care and counselling from the church.
- Support LGBTQIA patients in understanding their identities and the experiences they encounter related to those identities.
- Address homophobia in the church.
- Support Black communities in developing cultural literacy around mental illness.
- Employ an intersectional framework to understand how mental illness and help-seeking are shaped by the intersections of race, culture, gender identity, sexual orientation, citizenship status, age, disability, and other identities.

- Critique the relevance of cognitive behavioural therapy and other Western therapeutic modalities to diverse people.
- Interrogate notions of "best leading practices" as they relate to treatments used for diverse patients.
- Recognize cultural competence and structural competence as ongoing processes of learning.

Mental Health Policy

- Incorporate patients' diverse belief systems around mental illness into mental health policy.
- Incorporate the concerns and priorities of diverse communities into mental health policy.
- Ensure that mental health policy captures people's diverse identities, such as race, gender identity, sexual orientation, culture, age, and disability, etc.
- Ensure that mental health policy reflects the unique backgrounds, education, and training of diverse health professionals and how these factors shape their clinical practice.
- Develop mental health policy that includes evaluation methods that identify and include key measurable indicators for ensuring that cultural competence and structural competence are being practiced.

University Research & Teaching

- Hold universities accountable for providing dedicated funds and spaces for research on mental health and other issues in Black communities.
- Create a dedicated research pot at Dalhousie University and/or through national funding agencies for Black researchers who are conducting studies on health and mental health in Black communities.
- Provide dedicated research funding to develop a Black health research institute that supports Black researchers in conducting research on health and mental health and in getting published and that provides Black graduate students with mentorship and training to conduct research on health and mental health in Black communities.
- Provide funding for a Canada Council Research Chair dedicated to Black research.
- Incorporate diverse perspectives on mental illness in university research, curricula development and teaching.
- Provide more dedicated courses that focus on the experiences of racialized people, especially Black people in Nova Scotia.
- Offer full courses dedicated to people of African descent.
- Develop curricula and assignments and select course readings that reflect students' everyday lived experiences, and the experiences of others in the community and around the world, that prepare students for the health care workforce, and that provide students with the necessary skills for developing strategies that are focused on solving real world problems.
- Develop students' competencies around advocacy through a social justice lens.

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