INDO CANADIAN
WOMEN'S
ASSOCIATION

MENTAL HEALTH AND ADDICTIONS

in the

SOUTH ASIAN COMMUNITY

in

EDMONTON

A Community Consultation Initiative

by

the

Indo-Canadian Women's Association

Edmonton

on behalf of

COVENANT HEALTH, EDMONTON

April, 2019

ACKNOWLEDGEMENT

Indo-Canadian Women's Association gratefully acknowledges the input from the many - women, men and young people from the South Asian community - in making this report possible. They shared their personal stories and experiences openly and gave up many hours through their participation. Several are members of the ICWA and continue to be among the numerous supporters of our cause. For reasons of confidentiality, they shall remain nameless, but they are the true architects of this report.

We also acknowledge the staff of ICWA and the members of the Board who went out of their way to actively seek out the participants for the various groups. They were also instrumental in providing the logistical support required to hold the group sessions.

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Steering Committee

Mental Health and Addictions Consultation Initiative

Indo-Canadian Women's Association

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(***Note: Minor edits completed April 29, 2019***)

INTRODUCTION

This report is the result of a Community Consultation Initiative undertaken by the Indo-Canadian Women's Association (ICWA), in partnership with Covenant Health on the under-utilization of services for Mental Health & Addictions by the South Asian community.

The report contains the background and context of the initiative, the process of consultation and the findings. It suggests further steps and recommendations for improving upon the current usage of these services.

Covenant Health is the largest Catholic Healthcare provider in Canada. It delivers its services through 17 sites in 12 communities across Alberta. In Edmonton, it operates the Grey Nuns' Hospital in the Millwoods region, and the Misericordia Hospital in west Edmonton along with other smaller centres.

ICWA is a registered 'not-for-profit' organization incorporated in 1984, committed to full participation of immigrant women and men in their adopted society. ICWA helps newcomers to the country connect with educational, legal, health and social services through appropriate referrals and counselling. ICWA also advocates for the protection of the rights of immigrant women, men and youth. To these ends, ICWA operates several outreach and other programmes for the immigrant community. ICWA is currently leading a multi-agency effort in training resources for Home Visitation to identify and to assist in the prevention of domestic violence.

The Community Consultation was undertaken by the ICWA from December 2018 to April 2019. It was supervised and led by a steering committee formed out of the Board of Directors of the ICWA. Three Social Workers were among the members of the committee, including one with

considerable experience in the field of mental health. They were among the facilitators for the focus group discussions. Field interviews were also undertaken by a Social Worker.

During the many discussions that were held, participants shared their personal stories and experiences with honesty and openness. This was done in the sincere hope that their voices will be heard, and that help will be available down the road for all sections of the community. This report represents that hope and trust.

BACKGROUND AND CONTEXT

The Community Consultations Initiative arose out of concerns within Covenant Health and other healthcare providers that usage of Mental Health and Addiction services is disproportionately low among the South Asian communities compared to the mainstream in Edmonton. The Addiction and Mental Health Network consisting of representatives from Alberta Health Services, Multi-cultural Health Brokers Co-operative, Canadian Mental Health Association and Covenant Health had been formed to address this and other relevant issues. In 2018, Covenant Health decided to embark on a Community Consultations Initiative to understand the underlying factors e.g. the barriers to access, the gaps and the needs to be met to make the services more accessible and culturally appropriate to the South Asian population.

In July 2018, ICWA was approached to partner in this initiative. The initiative aligned well with the mandate of the ICWA. A contract with an Action Plan, was signed between Covenant Health and the ICWA in early December 2018 with a completion date of March 31. An extension was sought on the date and approved by Covenant Health for submission of this Report by April 17.

ICWA advertised for the position of a Project co-ordinator, undertook interviews and hired a person for the job. The Project Co-ordinator left her position in mid-February for personal reasons and a new person was hired as a replacement. The Chairperson of ICWA's steering committee carried out the bulk of the facilitation and assumed a leadership role for the remainder of the project.

Covenant Health's target service areas have a large population of the South Asian community. This population consists of several sub-communities speaking different languages. The Millwoods region has the highest concentration of the population with over 24,000. Punjabi speakers are by far the most predominant numbering over 15,000. Hindi, Gujarati and Urdu speakers number just under 8,000 combined. The Millwoods region, with approximately half of the total number of South Asians in Edmonton, is highly representative of the City (2016 Census Data – see **Appendix 1**). This region has about the same proportion of the sub-communities as in all of Edmonton.

Evidence from the interviews with experts in the field, suggests that this demographic possibly suffers from the same rates of disorders such as those related to anxiety, depression and dementia, as by the mainstream. These health issues are exacerbated by stresses commonly experienced by immigrants. These stem from language barriers, cultural contradictions, role-reversals within the family, unemployment or under employment and isolation, and usually suffered across all age-groups. Drug and alcohol misuse among males and youth are quite common.

Data from the Canadian Mental Health Association (CMHA) demonstrates that the usage of these services by the general community is as high as 1 in 5 throughout Alberta. Reliable narrative reports support the contention that compared to their mainstream counterparts, the South Asian community use these services at consistently low levels.

Low usage and, at least the same degree of prevalence of disorders as in the mainstream, provide the context to this report. The focus of the report is on identifying the barriers, gaps and the needs to improving access to the services for this demographic.

Throughout this report, we have used the term '*marginal group'* to describe a section of the South Asian population. This section is characterized by:

- Little or no English language skills
- Least socialized and more isolated
- More traditional and with rural background

- The majority consists of Seniors (men and women), and women who are dependent on their Visa sponsors
- Live within patriarchal and/or multi-generational family structures.

This section consists of recent immigrants, but not always so. Although the largest proportion of this population is from among the Punjabis, they cut across the South Asian demographic.

Cultural context plays a significant part in the issues affecting South Asians. Understandings of mental health issues are based on traditional beliefs and non-science-based information. It is not uncommon among the population to tag all mental health issues with a term – *'pagal'* which is equivalent to the word 'psychotic'.

Mental capacity is central to most South Asian religious traditions. Failure in this area is a catastrophic personal failure on the part of the sufferer, or the parent or the family. It is a cause of 'immense shame' and stigma for the most part. It is considered de-masculinizing to have a mental health problem or illness. This leads to denials all around. While this is partly corrected within the more educated, or the more socialized groups, other sections of the population have strong detractors growing out of these beliefs. These beliefs are sometimes reinforced by Faith Leaders. Problems arising out of misuse or abuse of certain drugs and alcohol, are also contained within the families and hidden from the outside world. This is more so among the recent immigrants, a large proportion of whom have come from the rural areas of India.

Currently, there are very few community-based initiatives that address these beliefs. Individual efforts by healthcare professionals from outside the community, are often ignored, faced with denials or put aside. Also, these efforts do not reach the vast majority of the '*marginal group'* population where the need is the greatest. During the discussions, it was noted that it was difficult for people to share the details of mental health issues with 'other' service-providers.

Any programme that may be devised has to pay special attention to the cultural diversity within the South Asian population, and to the needs of the disadvantaged and the vulnerable sections e.g. the '*marginal group'*.

PROCESS

a. Methodology

The Methodology was developed based on a proposal submitted to Covenant Health representatives. It was designed being mindful that this initiative is a Qualitative Consultation Project and not intended for Quantitative Research. As the process progressed, the information obtained was evaluated and the process adjusted to maintain the quality of the information. These changes are described below.

The initial process was to include

- Interviews with 5 'Experts' from the field of Mental Health, e.g. practitioners or academics,
- 3 Focus Groups divided into age groups for
    - Youth between the ages of 18 and 25
    - Adults between the ages of 25 and 60
    - Seniors above the age of 60,
- Telephone interviews based on a Questionnaire (**Appendix 2**), across a broader population including the '*marginal group'*, with approximately 70 participants.

The Questionnaire was designed in consultation with the Addictions and Mental Health Network by the members of the Steering Committee within the ICWA.

The telephone interviews were subsequently substituted by 'Face-to-face' interviews with 30 people.

This was done as the *'marginal group'* of people was reluctant to share information over the phone or, to attend Focus Groups. The Seniors, for example, in any event have transportation issues, and may not have access to a phone, or their numbers not listed, as many of them live within a multi-generational setting. It became apparent that the information obtained over the phone from this group would be quite limited and of low quality.

Consent Forms (**Appendix 3**) to release information with strict guarantees for preserving confidentiality and anonymity were obtained from each participant in the Consultation Process.

Call-out Notices (**Appendix 4**) for participants were distributed to South Asian stores to be put up as posters, and to other community agencies working with South Asians, places of worship and to the members of the ICWA.

The population targeted was from the Millwoods region and South-east Edmonton. The total number of participants was selected on a 60-70% confidence basis of the Census based population for the Millwoods region.

b. Consultation Process

Expert Interviews

The 5 Experts interviewed included 2 Psychiatrists, one Family Practitioner, one Therapist and an Academic, all associated with Mental Health and Addictions, and the South Asian community.

Interviews were held 'face-to face' with the three medical professionals. The other two were interviewed over the telephone.

Key questions (**Appendix 5**) from the same Questionnaire were used, however, with more open-ended and in-depth discussions. All interviews were conducted by experienced Social Workers. Duration of interviews ranged from 1 to 2-1/2 hours each.

Focus Groups

The 3 Focus Groups were held on:

- January 25, 2019 for seniors attended by 13 seniors
- February 2 for adult Women attended by only 6 women
- February 23 for Youth attended by 15 youths including high-school students and newcomers

A separate 'Women only' Focus Group was organized since it was suggested that in a mixed group, women do not feel safe to speak in a frank, open and honest way, especially among those belonging to the Punjabi community.

Attendance from the '*marginal group'* at the Focus Groups were very low because of transportation issues and the severe winter conditions that persisted through the month of February. The Women's Focus Group on February 2 had an exceptionally low attendance because of extreme cold weather.

A fourth Focus Group was added for Seniors and Adults (men and women). This was held on March 9 and attended by 28 people representing a few of the sub-communities within the South Asian population.

Each Focus Group began with introductions all around, an 'icebreaker' topic, and an orientation to the purpose of the consultation initiative and the Focus Group session. The Questionnaire referred to earlier was used as the basis for the discussions. There was time for comments and questions at the end of each session. The sessions were facilitated by a trained group facilitator.

Interpreters were available, as required, for Gujrati, Punjabi, Bengali and Hindi speakers.

Participants in the Focus Groups came from all areas of south Edmonton including the Millwoods region. The majority of the participants were from the more educated and socialized sections of the community and better adjusted to their adopted country. This is reflected in their reports of usage of the services as detailed in the obtained data.

Face-to-face Interviews

The interviews were held in late-February and during the month of March. A Hindi and Punjabi-speaking Registered Social Worker was hired specifically to conduct these interviews. She sought out the participants at a variety of locations such as at places of worship, shopping malls and at homes on a random basis. In all 30 interviews were held.

The Questionnaire was used as the basis. Consent Forms were provided and signed in each case. Answers were recorded on site which were later transcribed.

Most participants had poor or varying degrees of skills in the English language but came from a variety of backgrounds. For the most part this group were less socialized and isolated within their own communities. There was still a general reluctance to participate on the part of the Punjabi population. But a slightly higher number of Punjabis were interviewed Face-to-Face when compared to those in the Focus Groups. It should be noted that a large proportion of the Punjabi Seniors among the '*marginal group'* are away during the winter period visiting India. This generally affected the overall numbers.

Summary of Participant Data

Table below presents the participant data by language spoken at home and by the group.

	Focus Groups						Face-to-face Interviews			
	Senior 65+	**Women (All ages)**	**Youth 18-25 years**	**Adults (All ages)**	**# of Participants by language**	**Senior 65+**	**Women (All ages)**	**Youth 18-25 years**	**Adults (All ages)**	**# of Participants by language**
Indo-Aryan languages										
Bengali	1	2	5	5	13	1	1	1	2	5
Gujarati	2	1		5	8					
Hindi	2		4	6	12		2	3	1	6
Kashmiri				1	1					
Konkani										
Marathi	1	1		1	3					
Nepali			1		1				2	2
Oriya (Odia)	2				2	1				1
Punjabi (Panjabi)		2	2	2	6	2	5	1	2	10
Sindhi	1				1					
Sinhala (Sinhalese)							6			6
Urdu	3		3		6					
Dravidian languages										
Kannada				4	4					
Malayalam	1				1					
Tamil										
Telugu				4	4					
Dravidian languages										
Total # of participants	13	6	15	28	**62**	4	14	5	7	**30**

DETAILED FINDINGS

This section contains feedback received from all sources i.e. the experts, the women, the men and the youths. Discussions with the Experts resulted out of the Key Questions (see Appendix 5). The Focus Group and the Face-to-face interviews were based on the Questionnaire (see Appendix 2). The responses have been filtered under sub-headings.

The sub-section titled General Response at the beginning of the Summary, thematically amalgamates input from across all participant categories. It is further sub-divided into granular themes including Cultural Orientation, Coping Strategies and Mental Health and Addiction issues in the community.

The sub-sections following General Response list the feedback received exclusively from each of the sub-groups, Youth, Seniors and Women.

a. General Response

Summary of Participant Responses on Personal Experiences

One question referred to participant's personal experience about another person with mental health issues. As mentioned in the previous section, participants in the Focus Groups came from a more educated and socialized sections of the community, and better adjusted to their adopted country. By comparison, the interviewees for the Face-to-Face discussions were, for the most part, from the '*marginal group*'. They were less socialized and isolated, and less likely to be seeking out help.

The two tables below were compiled from the responses from each group when asked if they personally knew a person with a problem. They were also asked about the usage of services by the person.

FOCUS GROUPS		
Knows someone personally with MH issues	**Did not seek help**	**Sought help**
YOUTH		
7	1	6
SENIORS		
13	4	9
ADULTS		
21	1	20
TOTALS		
41	6	**35**

FACE TO FACE INTERVIEWS		
Knows someone personally with MH issues	**Did not seek help**	**Sought help**
ALL AGE-GROUPS		
20	16	4
20	16	**4**

The 'sought help' responses between the two groups are starkly differentiated in their levels of access - 85% vs. 20%. In almost all cases, help was sought via the Family Doctor. Some chose not to share any information on the question.

Although the gaps and the needs of the two groups have a lot in common, the barriers to access are different.

Cultural Orientation Around Mental Health

A significant and recurring theme throughout the survey feedback was the foundational role Faith and the Faith Leaders play among the South Asians. The Faith Leaders were identified as essential points of contact for leadership, support, education, and guidance regarding the community's perception and response to matters of mental health.

While these Leaders can be pivotal to the support of any initiative, they can also become part of the problem in so far as they reinforce the 'non-science' based belief systems. They have been

known to normalize incidences of substance abuse, domestic violence and attitudes toward depression, anxiety in women and dementia among seniors. The Faith Leaders perpetuate this unwittingly because of their lack of knowledge and because of their adherence to 'old country' social norms and attitudes. The '*marginal group'* have greater exposure to this influence than the other sections of the community.

Coping Strategies used by the Community

Solutions to mental health issues involve strategies for accessing individual and family resources to resolve mental health concerns in preference over government and/or professional services outside their community. Such strategies include holistic practices such as calling a friend, positive thinking, prayer, physical exercise, deep-breathing exercise (Yoga), writing (analyzing situations, evaluating options, journaling), playing with grandchildren (for Seniors), time-outs (e.g. going for a walk), chanting a mantra, and performing yoga.

For several people from across the age-groups, alcohol or drugs, such as opioids, also constitute a recourse to resolving anxiety and depression.

Though preference was given to the holistic practices, respondents confirmed they would contact a doctor, phone AHS (811), suicide prevention lines, counselling services, or local community agencies such as the ICWA, if they had sufficient reason, to be concerned about their mental condition. This is only possible for those who have the information. A significant number do not have access to information on where to call for help.

There is considerable belief in holistic and spiritual remedies to mental health issues and on faith-based healings. Within the higher functioning participants in the Focus Groups, the Seniors' group was able to clarify however, that while faith can be a powerful foundation for a healthy mental state, it is not in itself the answer to addressing complex mental health needs of the community. It was highlighted that a community member would only reach beyond their community out of despair and when in crisis.

General attitudes, across all groups, appear to trivialize mental illness such as anxiety, depression, bi-polar and eating disorders. Somatic complaints, such as persistent headaches, sleeplessness or insomnia, lack of appetite, general pain, are not recognized as symptoms of deeper mental health problems. More serious expressions of symptoms, such as for schizophrenia, psychosis, are recognized more readily and external help is sought. In one example, a participant revealed that aggression was not recognized as a symptom for dementia until it got out of control.

Mental Health and Addiction Issues identified by the Participants

Responses from participants in these areas were divided under three primary categories - substance abuse, social behaviour and mental health.

Substance abuse was considered by respondents to be a significant issue that was increasing in frequency and severity. Substance abuse occurs across all participant groups and quite prevalent among the youth.Substances identified including alcohol (EtOH), opioids, marijuana, “hash”, nicotine, heroine, fentanyl, “meth”, “doda” (opium, poppyseeds), tandaii, sardaari, sheesha (tobacco), paan, Jadha, Cocaine (in youth), Coca Cola (caffeinated drinks), and chocolate. It was also identified there may be a community preference towards pharmacotherapy interventions which may contribute to the misuse/abuse of prescription drugs such as painkillers. Additionally, though not substance related, addictive activities such as gambling, over-eating, and Teen Patti which is an online card game were mentioned by quite a few of the participants.

Within the category of **Social Behaviour**, respondents were concerned that their community may be normalizing abusive behaviour such as family violence (domestic), abuse of children, elders, cultural and spiritual abuse. In addition, Trans-continental arranged marriages were perceived to create relational power imbalances, entitlement, privilege, control seeking behaviour and discriminatory practices, leading to mental health issues.

The community suffers from at least the same rates of disorders related to **Mental Health** as the mainstream. The issues are exacerbated by the stresses associated with immigrant

populations generally with impact on socio-economic status, family systems, and the health of the community as a whole.

Specific examples include: Suicide (particularly for first generation Indo-Canadians), gambling addiction (e.g. Casino Angels), anxiety, isolation, depression especially post-partum, schizophrenia, bi-polar disorder, Alzheimer's, and dementia.

Alzheimer's and Dementia go untreated among seniors as members in the family do not recognize the symptoms and consider it simply as normal 'old age senility'.

Respondents reported they believed that some mental health challenges may be related in part to the Canadian immigration process, during which many newcomers experience feelings of being overwhelmed, culture shock (family wide), family displacement and isolation.

b. Youth

Youth in South Asian families face intense pressure from parents to perform well and suffer from extreme anxiety and depression. Generational gap is a major contributor.

Most stated that they do not know where to go for help even as they are aware that services are available. Going to the Family Doctor is not considered an option for fear of being discovered by parents or, being stigmatized down the road. School Guidance Counsellors are not considered to be sensitive enough to the cultural nuances of their problems.

Quite often, they resort to substance abuse as a recourse. One youth in the Face-to-face group shared his personal story of substance use. In the ultimate case, suicidal thoughts were mentioned during the discussions.

On the other side of coin, the parents are not able to recognize the associated symptoms and requested training seminars.

c. Seniors

Seniors suffer from shifting roles on their transition to the new society. In the 'old country' they were the elders, the head of the family and treated with respect by other members of the family. In this society, they find themselves isolated, and being asked to perform family chores and generally ignored. This creates depression and anxiety among both men and women.

These elders may have feelings of helplessness, financial dependence, cultural expectations around sharing mental health concerns (stigma), fear of medications, family pressure to remain silent, community feedback regarding certain treatment methods/medications.

There are big gaps in mental health support services for home care and support for seniors and their families. There is also a need for Day Programmes for Seniors to connect with others.

Seniors are more inclined to seek support through holistic means for their problems. Spiritual pursuits, yoga, meditation etc. were the preferred ways of dealing with their own issues.

Seniors indicated significant barriers to accessing the services for fear of the consequences of acknowledging the presence of mental health concerns in their lives.

These consequences include:

- Information disclosed to professionals being entered into the permanent medical records, and this information not remaining confidential.
- Fear the files can be hacked and information leaked.
- The consequences of this information, either the specifics of their mental health and the supports they were accessing, or the very mention of mental health at all could include:
    - "bleeding" into other areas of their lives such as: work, home, families, community.
    - the stigma of mental health impacting matrimonial prospects for children, grandchildren.

Seniors also referred to the inter-generational issues that face them within the family. And, that they are unable to seek support or help in resolving these for reasons stated above.

These circumstances were seen as contributory to mental health concerns such as persistent sadness, depression, powerlessness and hopelessness.

d. Women

Women identified that they would like targeted education on signs and symptoms of addictions and mental health issues. This is essential for them to recognize these among their children and other members of the family.

They are also discouraged from seeking help if they themselves have problems of anxiety or depression. They are generally unaware of where to go and their first point of access to help is often the Community Agencies rather than the Health Services. Transportation is often a barrier to seeking help in this group.

Women were considered at particular risk for depression, and normalization of sadness and anxiety. Extended family members were available for support in the countries of origin during and after pregnancies, whereas locally, a new mother is prone to post-partum depression which largely goes untreated. Home visitations are critical in these cases.

SUMMARY OF BARRIERS, GAPS AND NEEDS

a. Barriers

Deep-seated cultural issues about mental health – associated with stigma and shame, fear of others getting to know (won't get a job, sons and daughters cannot be married) – are among the major barriers to not seeking help.

The types of illness are not differentiated nor understood. There is widespread lack of knowledge that mental afflictions are like any other disease that may be cured, or managed, with medication and treatment.

Addiction is normalized in this population especially for opiates and alcohol. Cases of substance misuse are contained within the family in most instances.

Awareness of the availability of the diverse services, especially for addictions, is extremely low particularly among the '*marginal group'* and seniors. People do not know where to go for which service. Also, most participants did not know the roles performed by healthcare professionals in the field, e.g. a Psychiatrist, a Psychotherapist, Psychologist, Social Worker and Counsellors, or even that of a Nurse or a Pharmacist.

This is not necessarily the case among the youth or the more socialized and educated population.

Personal stories listed some less obvious barriers to access such as transportation needs and extended opening hours for clinics and centres. Plans for improvement should include solutions to these issues.

The age of the counsellor or a facilitator affected the connectivity of the seniors and older adults. These older age-groups were less comfortable confiding to a younger person. Traditionally, it is the elder that gives advice in this demographic.

b. Gaps

The biggest gap is in the education on mental health and addiction issues across this whole population.

Education of parents to recognize symptoms of mental health affliction or addiction in their children is crucial and this had been a recurrent and important theme.

This population strongly believes that they will be well understood only by service providers from their own cultural background due to their cultural familiarity.

There are only a handful of South Asian service-providers – Psychiatrists, Social Workers, Psychologists, Therapists and Counsellors. There is a significant deficit in trust with the mainstream providers of service. This acts as a barrier to access. The ones accessing the

services do so via their Family Practitioners who are mostly of South Asian origin. However, very few can find a South Asian provider at the next level of service.

This is not always a language issue but a connectivity issue. Interpreters cannot fill the gap since interpretation can be biased based on their own cultural proclivity. The same is true for a member of the family being present during consultations.

Schools do not generally have Guidance Counsellors with cultural sensitivity training on South Asian families. Youth in South Asian families suffer from extreme anxiety and depression as a result of fear of performance in the face of high expectations from their parents. They do not feel understood by their Guidance Counsellors when reassurance and support is needed. Also, these Guidance Counsellors are not sure where the students could be referred to.

A Resource List of South Asian health-care professionals in the field is not currently available with Counsellors and Family Practitioners so that referral services are facilitated.

Newcomers to the country are subjected to unhealthy delays (up to 2years) to access assessment and prevention services. New mental health concerns may arise during the waiting period because of the stressful nature of the settlement process in a new country.

c. Needs

Two primary needs emerged out of the discussions. These are paramount in improving the usage of services by all sections of the population.

The first requires a structured multi-pronged mass education programme which will reach into the homes and the '*marginal* group'.

The second crucial feature of the delivery of service should include a 'one-stop shop' staffed by service providers specializing in service to South Asians. Such a place needs to be designed to provide a 'comfortable, welcoming and safe environment' with emphasis on confidentiality. The population should be able to access holistic services related to wellness in such a place.

The ideas to meet these needs are further developed and described in the later Section on Recommendations.

RECOMMENDATIONS

1. SOUTH ASIAN HEALTH AND WELLNESS CENTRE

Serious consideration should be given to establishing a multi-service Health and Wellness Centre specifically for the South Asian community. Such a Centre will incorporate social spaces, training facilities, provide for child-care options and offer culturally sensitive services in the areas of counselling, psycho-therapy, and treatment, along with wellness programmes e.g. Yoga classes, and other activities. Models for such Wellness Centre exist elsewhere in Canada e.g. Poundmaker's Lodge treatment centres for the Indigenous population.

a. It should be fully staffed by members of the South Asian community who have an intrinsic appreciation of the culture and the community dynamics.
b. It should offer and preserve guarantees of confidentiality to gain trust of the users.
c. It should have services available in multiple languages especially in the languages of the majorities within the population.
d. It should offer Outreach and Home Visitation programmes.
e. It should offer services to youth in such a way that they can access these without fear of being discovered by parents or relatives. Suggestions were received from the Youth group that the centre for the Youth be set up separately but combined with a Sports or an Athletics Facility. A variation on the same theme would be to offer counselling and referral services within the Sports and Athletics Facility.
f. The Centre should be based in the community and operate at an 'arms length' from traditional care-providers such as Covenant Health. Operation of the Centre could be via existing Agencies working in the community.
g. The Centre should be served by buses and be open for extended hours much like the current Community Activities Centres.

2. COMMUNICATION AND EDUCATION

A multi-pronged Education and Communication programme should be structured to target the population, especially the *'marginal group'*.

a. The Faith Leaders must be engaged, and their support enlisted. The role of the Faith Leaders cannot be emphasized enough in this context. They can often be the barrier through their own lack of science-based information. It is crucial that partnerships are built since they are the gate-keepers for a large section of the community. South Asian Health professionals need to build good rapport and trust with them. A starting point may be an Inter-faith Conference on Mental Health and Addictions followed by further training and exchange of information.

b. Faith Leaders and healthcare professionals should jointly hold community-based seminars in the primary language of the community in order to reach the target population. Distribute Resource listings at these seminars in the vernacular.

c. Hold educational seminars for Community organizations (almost every community has their own cultural organization). Distribute information packages in the vernacular.

d. Vernacular Television, Radio and media can be used very effectively for mental health education and awareness. It should have regular 'chat-shows' and columns on mental health issues. Punjabi TV is well established and quite sophisticated in their programming. This will have wide audience since the seniors and others in the community spend a significant proportion of time watching TV or reading newspapers in their language. Regular programming is essential for getting through to the community.

e. Presentations or Workshops at Community Conferences and other gatherings, on stress management, healthy living, parent awareness should be considered. Schools and workplaces should be included.

f. It is important that the effort in this area be sustained over time and be repeated at regular intervals.

g. Printed educational materials on the basics of mental health should be made available in schools, places of worship and other community centres along with a listing of the resources with contact information. Materials are to be produced in South Asian languages.

h. Educational video series made in appropriate languages should include diagnosis, symptoms, treatment, options and supports in the community. These videos can be made available through the Edmonton Public Libraries, and community agencies such as the ICWA, the Mennonite Centre, and Islamic Community Services.

3. DELIVERY OF SERVICES AT COMMUNITY ORGANIZATIONS

a. Consider the delivery of mental health education and support programmes through community agencies and other organizations where the community visits frequently. A highly successful programme titled 'Heart Healthy' was delivered in several ethno-cultural community organizations by a well-known Cardiac Surgeon several years ago.

b. Deliver Parent Awareness programmes through schools so they learn to recognize the indicators of Mental Health and Addictions problems.

4. RESOURCE DIRECTORY AS A REFERENCE FOR ALL

a. Family Practitioners are the first entry point for most patients. A Resource List of service providers and healthcare professionals specializing in provision of service to South Asians should be developed for distribution to ALL Family Practitioners and other professional care providers.
b. It should also be distributed to Community Organizations and Agencies working with South Asians.
c. Guidance Counsellors at schools should have copies of this Directory.

5. INTERPRETATION SERVICES

a. Increase cultural sensitivity among health-care professionals around confidentiality and access/understanding of systemic options for ESL clients.
b. Include information on 'informed choice' for patients to include, or exclude, friends or family during consultation.
c. In the absence, or choice, of not to include friends or family in the consultation process, translation service, as requested, should be a standard patient option provided at all mental health consultations.
d. Improve access to translators, translator services, or translation software. Provide translation options at key medical locations - hospitals, emergency rooms, pharmacies, etc. Native language speaking members will be sensitive to cultural idiosyncrasies of the language that other translators may not be.

6. NEWCOMERS

a. Increase the speed and availability of prevention supports (including assessment) to newcomers particularly during the initial settlement process.

b. Review newcomer orientation services to ensure mental health and addiction support and services are clarified upon arrival.

7. SOUTH ASIAN MENTAL HEALTH HOT-LINE

Create a hotline including native speakers (e.g. Punjabi, Hindi and Urdu) with cultural context as access points to provide information regarding available services for all.

8. RE-BRAND THE SERVICE

Consider renaming and rebranding the existing service as Health and Wellness Service.

LIST OF APPENDICES

Appendices are numbered in order they appear in the text

APPENDIX 1 CENSUS DATA – EDMONTON & MILLWOODS

2016 CENSUS DATA BY LANGUAGES SPOKEN	ALL EDMONTON			MILLWOODS		
	TOTAL	**MALE**	**FEMALE**	**TOTAL**	**MALE**	**FEMALE**
All Indo-Aryan languages	54,775	28,055	26,720	24,100	12,305	11,795
Bengali	2,275	1,200	1,080	330	175	155
Gujarati	5,540	2,870	2,670	2,370	1,245	1,130
Hindi	8,010	4,020	3,995	2,215	1,100	1,110
Kashmiri	20	10	10	10	5	5
Konkani	145	75	70	45	25	20
Marathi	505	260	245	140	70	70
Nepali	1,895	990	905	305	155	150
Oriya (Odia)	70	40	35	10	5	5
Punjabi (Panjabi)	26,425	13,570	12,855	15,745	8,055	7,685
Sindhi	905	420	480	210	85	120
Sinhala (Sinhalese)	1,180	615	565	110	60	50
Urdu	7,810	3,985	3,825	2,615	1,330	1,290
All Dravidian languages	6,440	3,340	3,100	1,715	875	835
Kannada	195	95	95	25	15	15
Malayalam	3,315	1,700	1,615	995	505	485
Tamil	2,025	1,065	960	475	240	235
Telugu	890	465	420	210	110	95
Dravidian languages	25	10	10	10	5	5

APPENDIX 2 QUESTIONNAIRE

Interview Questions

If South Asians are feeling sad, stressed or lonely, would they go for help? Where?		
What are the Mental Health and Addiction issues in the S.A community and what is the S Asian community's perception of these issues?		
Can you identify some of these issues as related to Mental Health and Addictions? (i.e. alcoholism, gambling, etc.)		
Are S Asians clients aware of resources in Mental Health and Addictions that exist now in the community?		
If SA clients tried to access these services, would they be able to do so?		YES/NO
If yes, then what do you think they like about these services?		
If no, then what are their barriers to accessing services?		

Do you know of someone who had a MH or Addiction issue and did not reach out to seek help?	YES/NO
If yes, why didn't he/she seek help?	
In your opinion, what would have made him/her seek help?	
Based on your knowledge of South Asian community members' experiences, what changes do you recommend to the existing Mental Health and Addictions services?	
If you wanted to create a user-friendly MH and Addictions, service what would you recommend?	
Any other comments?	

APPENDIX 3 CONSENT FORM

Consent document - Focus Group

Addictions and Mental Health Project

I _____ consent to participate in a focus group conducted by staff of the Indo Canadian Women's association.

I participate of my own will and consent to share my views without breach of confidentiality.

I have been informed and understand that

- Confidentiality will be maintained in the group.
- My identity will not be revealed in the final material.
- All views will be recorded as anonymous.
- Photographs of flip charts, audio recordings and notes of focus group discussions will be destroyed no later than March 31st 2019.
- Names, locations or dates will NOT be made public.
- NO photographs will be taken of participants.
- I grant permission to the Indo Canadian Women's Association (ICWA) to use the information provided for their project.

_____ _____

Signature: _____ Witness: _____

Date: _____

APPENDIX 4 CALL-OUT NOTICE

Call Out for Participants

for

COMMUNITY CONSULTATION MEETINGS

The **Indo Canadian Women's Association** and **Covenant Health** have partnered up to better understand how the Mental Health and Addictions Services can more appropriately meet the health needs of the South Asian community. What are the community's needs? What improvements need to be made? What does the healthcare system need to know about South Asian culture and issues affecting mental health?

Are you a member of the South Asian community who has insights or wisdom you would like to share? We want to hear from you.

We are hosting Community Consultation Meetings at the ICWA office:

1. Friday, January 25 - 1:30-3:30pm - Seniors
2. Saturday, February 2 - 1:30-3:30pm - Women
3. Saturday, February 23 - 1:30-3:30pm - Youth
4. Saturday, March 9 – 1:30-3:30pm (Seniors and Adult)

There will be language interpretation to host inter-language communication.

******STRICT ADHERENCE TO CONFIDENTIALITY WILL BE OBSERVED******

To **REGISTER** please contact:

Phone: Indo Canadian Women's Association at 780-490-0477 during office hours (Monday to Friday) from 9.00 am to 4.00 pm.

Address: 9342 34 Avenue NW, Edmonton- T6E5X8, Alberta.

Email: info@icwaedmonton.org

KEY QUESTIONS FOR MENTAL HEALTH AND ADDICTION PROJECT

If you are feeling sad, stressed or lonely, would you go for help? Where?

What are the Mental Health and Addiction issues in the community and what is your perception of these issues?

Can you identify some of these issues as related to Mental Health and Addictions? (i.e. alcoholism, gambling, etc.)

Are you aware of resources in Mental Health and Addictions that exist now in the community?

What do you know about MH and Addiction services?

If you tried to access these services, would you be able to do so?

If yes, then what do you like about these services?

If no, then what are the barriers to accessing services?

Do you know of someone who had a MH or Addiction issue and did not reach out to seek help?

Why do you think the person did not go for help?

Based on your knowledge of South Asian community members' experiences, what changes do you recommend to the existing Mental Health and Addictions services?

If you wanted to create a user-friendly MH and Addiction service what would you suggest or recommend?