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Mental Health in Ontario's East African Diaspora and Telemedicine Opportunities

FINAL REPORT

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EXECUTIVE SUMMARY

Mental health in East African communities has largely been neglected in research, policymaking, and service delivery. Across the Eritrean, Ethiopian, Kenyan, and Somali diaspora communities in Ontario,[1] evidence indicates that formal and informal mental health services are often underutilized or inadequate. This project was conceptualized to create linkages among mental health, East African diaspora communities, and telemedicine—three spheres that typically operate in isolation from one another. By supplementing secondary research and literature reviews with primary data from interviews, research was conducted on barriers that inhibit East African diaspora members from accessing mental health services in Ontario, issues of mental healthcare in East African home countries and their connections to the diaspora, and the ways and potential means of integrating telemedicine, technology, and the Ontario Telemedicine Network (henceforth 'OTN') in proposed solutions.[2] Research found that the mental health issues facing East African diaspora are distinct, owing to conceptions of mental health, triggers, coping mechanisms, and barriers to treatment. By identifying and understanding the issues and nuances of each diaspora community, nine recommendations were developed to connect mental health services in Ontario and East African diaspora communities. This report comprises of: an overview of the project; summary of key findings from primary and secondary research; methodology; and final recommendations. These recommendations are categorized into advocacy, community, and technology solutions. Each recommendation outlines the main problem, justification of the problem based on primary and secondary data, recommendation details, examples of best practices or existing models, target audience, timeline, and implementation feasibility. Ultimately, we hope this report will precipitate action that improves mental health outcomes for East African communities, as well as be a catalyst for further research on these issues.

To execute this project, a team of 12 Master of Global Affairs (MGA) students at the Munk School of Global Affairs – University of Toronto partnered with clients from OTN and the East African diaspora communities in Ontario, including ATEC, African Hub's African Mental Health Support Network, Midaynta Community Services, Uzima, and People to People.

[1] For the purposes of this project, East African diaspora communities refers to diaspora communities from Eritrea, Ethiopia, Kenya, and Somalia.
[2] Initial findings can be found in midterm reports.

INTRODUCTION

Ontario has one of the best healthcare systems in the world. The Ontario Government uses public resources to establish and operate a patient-focused, results-driven, integrated, and sustainable healthcare system.[3] The provincial strategy is geared towards helping Ontarians stay healthy, delivering needs-based care, and protecting the healthcare system for future generations. This mission is served by rolling out a range of services that make healthcare more accessible for Ontario residents.

OTN is a non-profit flagship service in the provincial healthcare system, funded by the Government of Ontario. Telemedicine is an innovative approach to healthcare delivery that utilizes telecommunication technologies to provide clinical care to clients at a distance or in a non-traditional healthcare environment. The technology provides access to healthcare for communities that face barriers to traditional means of access. The service also improves critical care and emergency solutions, and reduces the physical burden on healthcare infrastructure by remotely connecting clinicians-to-patients and clinician-to-clinician. OTN brings virtual care to Ontarians when they need it and where they need it most: at home, in their community, or at hospitals. The service has been developed through collaboration with partners and service-providers in the healthcare system. In a decade of operations, OTN has increased access to healthcare and education across Ontario by successfully building and expanding the world's most extensive telemedicine networks.

Notwithstanding these successes, there is room to improve the provision of healthcare services for targeted communities in Ontario. Mental healthcare services and resources for diaspora communities is one area that requires greater investment and collaboration. Specifically, East African diaspora community members within Ontario's healthcare system experience underutilization and weak access to services and resources (See Appendix 1: Mental Health Resources and Services in Ontario). Accordingly, the project objective was established as follows:

Project Objective: To develop practical recommendations related to, "the issue of mental health within East Africa (both at home and here in Canada) with an emphasis on improving local access to mental health services and the use of technology transfer via telemedicine."

The project executed this mission for a consortium of clients. OTN was the core client, in conjunction with the ATEC/African Hub's African Mental Health Support Network. The ATEC group coordinated with Midaynta Community Services (Somali), People to People (Ethiopian), and Uzima (Kenyan) communities through the duration of the project.

Specifically, the project scope was geared around research and understanding. The target communities for the recommendations were diaspora in Ontario from four East African countries: Eritrea, Ethiopia, Kenya, and Somalia. The variety of related research topics included: triggers

[3] Ministry of Health and Long-term Care, "About the Ministry," health.gov.on.ca, 2017, http://www.health.gov.on.ca/en/common/ministry/.

and typology of mental health conditions faced by these four diaspora communities; cultural conceptions of mental health issues; cultural institutions and practices in the communities; access to and usage of healthcare and mental care services available in Ontario; and capacity and potential of telemedicine to improve access to mental healthcare for patients in these communities. As such, it is important to understand not only the risk factors and triggers of mental health issues, but also how diaspora members seek help and healthcare, in order to improve the quality and outcomes of mental healthcare in Ontario. In particular, understanding health-seeking behaviour and the barriers inherent in seeking help will allow for more effective early interventions (at the mild-moderate stage) and reduce the risk of more severe mental health issues.

Owing to time constraints, our scope could not cover all issues related to mental health, which is a complex topic, affected by a range of systemic issues beyond lifestyles and patient profiles. For example, socio-economic conditions (e.g. poverty, employment, income, education, and gender) influence mental health problems faced by communities both before and after migration. Similarly, the impacts of historical forces such as colonialism and power asymmetries facing Africans and the East African diaspora continue to impact communities in the present, impacting mental health as well as trust of immigration and healthcare services in the West. While we recognize the importance of these factors and remained cognizant of them in the course of our research, we were unable to address them in our recommendations.

The recommendations discussed in this report aims to generate practical solutions for OTN and community clients. In order to meet the project objective, we developed a list of tasks and sub-tasks. This division of work allowed the team to cover an extensive range of topics, while ensuring that the findings contributed towards developing actionable recommendations for the clients. Specifically, the project's analytical investigations were divided among three sub-groups, with each group exploring the following themes:

1. An overview of the issues that hamper East Africans with regards to accessing mental health services here in Ontario.
2. Issues of mental health in East Africa that extended family members and friends here in Ontario are trying to cope with via long distance.
3. Ways and potential means of using telemedicine via culturally and medically appropriate transfer of knowledge to the affected populations (East Africans living in Ontario and East Africa)

Our primary and secondary research revealed that the diaspora communities are exposed to high rates of undiagnosed mental health issues and their attendant risks. However, barriers include cultural differences, stigmatization, linguistic difficulties, as well as mistrust and inability to navigate mental healthcare systems. Our key-informant interviews revealed that many of these mental health issues remain untreated for years, and range from mild to severe conditions.

This situation is resolvable, and there are clear social and economic motivations for preemptively addressing these challenges. Without accurate diagnosis, medically-appropriate treatment, and culturally-sensitive support, members mental health conditions will continue to impact these

communities. Crucially, if left untreated, worsening conditions will result in increased suffering for patients, their families, communities, and costs for the healthcare system. By implementing the suggested recommendations, clients can help build links between the diaspora communities and Ontario's healthcare system, ensuring that patients get the care they need as early as possible.

Our team is confident that preemptive and effective diagnosis and treatment of mild and early-stage mental health conditions will generate significant cost-savings for Ontario's taxpayers, and fulfill the core mandate of our provincial healthcare system: provision of need-based healthcare services to all communities. Finally, it is our hope that these recommendations will support initiatives that increase access for other diaspora communities to mental healthcare services in Ontario.

METHODOLOGY

As noted in the introduction, this project presented a challenging analytical scope. Our team was tasked with investigating the following topics, as they relate to the Eritrean, Ethiopian, Kenyan, and Somali diaspora communities in Ontario: triggers and typology of mental health conditions faced by these four diaspora communities; cultural conceptions of mental health issues; cultural institutions and practices in the communities; access to and usage of mental healthcare services available in Ontario; and the capacity and potential of telemedicine to improve access to mental healthcare for patients in these communities. First, the overall scope of work was divided into sub-streams, as well as appropriate timelines. Second, and more directly related to the methodology applied here, the team adopted a mixed-methods approach to collecting and analyzing data.

Workflow Details:

As outlined in the introduction, the project's overall scope of work was divided into three sub-streams, with each stream tackled by a team of four students. These streams and their related sub-topics were:

1. An overview of issues that hamper East Africans with regards to accessing mental health services here in Ontario;
2. Issues of mental health in East Africa that extended family members and friends here in Ontario are trying to cope with via long distance;
3. Ways and potential means of using telemedicine via culturally and medically appropriate transfer of knowledge to the affected populations (East Africans living in Ontario and East Africa).

The project was divided into two sections. In the first half, teams collected available secondary data and conducted detailed literature reviews. Analysis emerging from this part of the project was presented to the clients in the form of midterm reports and presentations. In the post- midterm phase of the project, the teams conducted in-depth key informant interviews with stakeholders identified by the clients and the project supervisor. These interviews were converted into detailed notes, which were the basis for developing recommendations. In the post-interview stage, our team combined all the available information and analysis and arrived at the recommendations included in this report.

Detailed Methodology:

This study was completed through a mixed-methods approach. Our team combined secondary information with primary data to complete the analysis. Specifically, the following process was adopted to collect, synthesize, and analyze information:

1. ***Secondary Research***: The first part of the project involved collecting and collating available literature and data on the three analytical themes/questions discussed above. This process was executed as follows:
    a. Analysis of the background literature, including reports, academic research, and briefs provided by the project supervisor.
    b. Scanning of academic journal databases and key organizational repositories e.g. WHO, CAMH etc. for available literature on the thematic questions posed for each group.
    c. Summarizing information and data from these sources into analytical categories. Sub-questions/themes were developed by each group to organize the information into relevant categories.
    d. Analysis of the findings from the secondary literature into midterm reports.

2. ***Primary Research***: The second half of this project entailed detailed key informant interviews with stakeholders. This phase of the methodology was executed as follows:
    a. Compilation of key stakeholder lists, which were then approached for interviews. Stakeholders included: physicians, academics, community informants (religious leaders, health workers etc.), and OTN partners.
    b. Development of detailed and differentiated interview guides for each stakeholder based on literature reviews and internal consultations.
    c. Completion of in-person and long-distance (telephone and Skype) interviews with key informants.
    d. Interviews converted into detailed notes.
    e. Analysis of interviews.

3. ***Development of Recommendations***: In this final phase, the team organized the data and information into concrete recommendations. This inductive process included the following steps:
    a. Identification of core problems/issues illustrated by the research.
    b. Articulation of recommended solutions.
    c. Location of examples and models to fine-tune recommendations into actionable solutions.
    d. Division of recommendations into thematic sub-groups.

Limitations:

This project is the first comprehensive foray into investigating the mental health conditions of East African diaspora in Ontario. In completing our work, we faced the following challenges:

1. Data and information on the selected diaspora communities in Ontario is largely missing. With the exception of studies on the mental health challenges faced by the Ethiopian diaspora in Toronto, we were unable to locate concrete academic or statistical information on these communities in the city. Consequently, we had to rely on research conducted

with similar diaspora communities in the U.S., Europe, and elsewhere to arrive at the findings.

2. Most of the available information on these subjects is qualitative in nature; quantitative data on this subject is scarce and unavailable in the public or academic domains.
3. The scope of work for this project was vast; covering four distinct diaspora communities in a three-month time period was challenging. While we were able to identify commonalities and shared experiential characteristics, all four diaspora are culturally and ethnically diverse. These distinctions can only be captured in detailed and specific studies conducted on each community, with reference to the historical and cultural context of the country of origin.
4. Interview scheduling was challenging, as they took place over the course of one month and not all interviewees were available during that time.

KEY FINDINGS

The first half of this project was executed by the team in sub-groups. A midterm presentation was scheduled with the client, where the team presented its in-depth findings and analysis of the available literature, background documents, and information available on these issues. To contextualize the analysis and recommendations that appear in this report, here are the core findings for each of the sub-themes:

1. **Overview of issues that hamper access to mental healthcare for East African diaspora communities in Ontario:** In both the Ontario diaspora and home countries, East Africans from Eritrea, Ethiopia, Kenya, and Somalia face distinct problems that are impacted by cultural conceptions of mental health, migration and trauma-related triggers, and barriers to accessing services. Specifically, the following factors influence the cultural interpretation of and attitudes towards mental health in these diaspora communities: the ubiquity of mental health problems across all diaspora; deep stigmatization of mental health issues; presence of all types of mental health problems; the primacy of religion as the interpretive lens for understanding mental health issues; preference for traditional treatments and coping strategies; pre-migration triggers of mental health; post-migration, settlement-related stressors; practical and cultural barriers to accessing mental healthcare services; and mental health conditions and barriers faced by specific demographic groups including women.

2. **Issues of mental health in East Africa that extended family members and friends here in Ontario are trying to cope with via long distance:** There is a significant degree of variation of mental healthcare in Eritrea, Ethiopia, Kenya, and Somalia. Commonalities among the four home countries include misdiagnosis of mental illness, lack of access to medication, unavailability of reliable medical data, a significant diaspora network, and variation based on demography. There is no information or research available on mental healthcare using telemedicine in East Africa, nor could we find research on diaspora initiatives aimed at mental illness in origin countries. Many interviewees voiced that a number of mental health issues in the home countries, and consequently in the diaspora, stem from experiences of trauma (i.e. civil war, asylum seeking, displacement, etc.).

3. **Ways and potential means of using telemedicine via culturally and medically appropriate transfer of knowledge to the affected populations (East Africans living in Ontario and East Africa):** Technological capacity, programs, and challenges to implementing telemedicine vary significantly among the four East African countries examined. Within Canada telemedicine projects are more common, but initiatives targeting specific diaspora communities are rare, and no telemedicine initiatives were located that specifically targeted the four East African diaspora. Telemedicine initiatives linking Africa and Canada do exist, though they do not target mental health or the four East African countries. Telemedicine projects in the Middle East, Asia, Europe, and Latin

America can potentially serve as models, as long as regional differences are recognized. Research gaps identified concern partnership schemes, which were common in the telemedicine projects, and recipients mapping, the difficulties significantly hamper identifying where and how to implement telemedicine projects in East Africa. Three challenges to be addressed were identified: (1) how OTN could work with East African countries given its mandate; (2) a lack of technology and infrastructure in East Africa for telemedicine projects to rely on; and (3) a needs assessment to understand who would benefit most from these projects, and their specific needs.

ADVOCACY RECOMMENDATIONS

Recommendation #1: Create Public Awareness Campaigns[4]

Problem: The stigmatization of mental health issues is one of the most significant impediments to a satisfying life for Canadians with mental illness.[5] The communities studied upheld this trend, although the manifestation of stigma was found to be closely related to specific cultural and religious norms. Accordingly, stigma led individuals and families to deny mental health concerns and avoid formal mental healthcare services.

Justification: Key informants suggested that educating these communities about mental health issues is necessary in order to address stigma.

Recommendation details: Identifying and leveraging community-specific opportunities to openly discuss mental health issues and challenge normative assumptions. Public awareness strategies include providing an overview of what mental health is and how to promote it clinically, culturally, and individually. A speaker series at a community gathering should supplement any demographic-specific campaigns.

Examples: Social media campaigns, or publicly sharing experiences of those who have experienced mental health issues.

1) Mental health awareness education can occur at any new or existing community gatherings. Some ideas include organizing a sports game or a picnic at a local park. These kinds of opportunities allow for the whole community to engage in a fun social event, while also providing community members who have experienced mental health issues with an opportunity to share their story. Speakers can use storytelling toolkits, such as *Headstrong's* "Sharing Your Personal Story: Speaker Toolkit"[6] for public speaking guidelines.
2) *Cope.Care.Connect.* is an example of a successful community-level social media campaign that creates awareness about mental health issues.[7] It is focused on engaging students at Brock University and providing them with resources to improve coping and resilience skills. Key attributes of this model include the provision of community-specific mental health resources (e.g. local helplines and in-person support services) and creating original content (i.e. YouTube videos[8]).

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[4] Additional resources for this recommendation, including contact information of professionals involved in related projects, is available at the beginning of Appendix 2.
[5] Canadian Mental Health Association, "Stigma and Disctrimination," ontario.cmha.ca, 2018, http://ontario.cmha.ca/documents/stigma-and-discrimination/
[6] Mental Health Commission of Canada, "Sharing Your Personal Story: Speaker Toolkit" (Ottawa: Health Canada, 2017).
[7] Centre for Innovation in Campus Mental Health, "Cope.Care.Connect," campusmentalhealth.ca, 2018, https://campusmentalhealth.ca/initiatives/cope-care-connect/.
[8] Centre for Innovation in Campus Mental Health, "Cope.Care.Connect 2017," youtube.com, 2017, https://www.youtube.com/channel/UCieMj79GA57oVEo-1VfdhKA.

Target Audience: Variable – Interviews revealed that engaging specific demographics, such as parents or elderly persons, could be most effective. Informants also identified youth as being most receptive to the use of social media.

Timeline: Short Term (12-18 Months)

Feasibility: Small-scale and cost-effective with large impact.

Recommendation #2: Connect Parallel Issues for Mental Health Awareness and Support

Problem: Intergenerational barriers surrounding mental health in East African communities.

Justification: Interviews and literature indicated that mental health dialogue is more salient amongst younger generations in East African diaspora communities. According to interviews conducted within Toronto's Somali community, young Somalis (women in particular) are more open to discussing mental health than older generations. Due to stigmatization and a culture of shame around mental illness, the older generation in the Somali diaspora is not always supportive of solutions to mental illness. Similarly, a key informant from the Toronto Eritrean community said that new Eritrean immigrants do not extensively interact with older Eritreans, which presents difficulties in bridging divergent approaches to mental healthcare. Indeed, distinct migration, trauma, and assimilation experiences based on generation status not only leads to different conceptions of mental illness, but can also alienate older generations from younger groups. As community-wide initiatives are more likely to have greater impacts and reduce the stigmatization of mental health, it is important to engage every generation in a diaspora community.

Recommendation details: We recommend using issue linkages to engage the older generation. Examples of community issues that parallel mental health include gun violence, youth radicalization, and law enforcement. The main strategy for implementing this recommendation is combining community issues with mental health issues through task forces or community forums. This will connect the younger generation's advocacy efforts with the older generation's decision-making power.

Examples: The Mental Health and Gun Violence Task Force conceptualized and driven by Somali youth at Toronto's Khalid Bin Al-Walid Mosque, leverages the older generation's concerns about reducing gun violence to advocate for providing greater mental health support. The task force connects mental health to the threat of losing government funding due to negative publicity around gun violence. This in turn creates incentives for the leaders of the mosque to engage with younger Somalis' advocacy and ideas.

A similar strategy could include connecting mental health awareness to law enforcement training. A high number of East Africans end up in prisons when they could instead be connected with mental health support. The parallel issue of imprisonment rates could therefore be tied to mental healthcare in advocacy strategies. For example, local police, who often come into contact with these communities, could receive mental health training, increasing their ability to identify when a referral to mental health services should be used in place of a prison sentence. Moreover, police officers should know how the community members can seek mental and general health services. Demonstrating a social concern for the population alongside a safety and enforcement concern is often constructively viewed.[9] A model for this in Canada is TEMPO (Training and Education

[9] For examples of law enforcement responses to mental health: Butler, Amanda. "Mental Illness and the Criminal Justice System: A Review of Global Perspectives and Promising Practices." *International Centre for Criminal Law*

about Mental Health for Police Organizations), a multi-module learning delivery module that aims to address the learning necessary for police personnel to effectively respond to encounters with people with mental illnesses.[10] Advocacy should aim to increase cultural sensitivity and contextual factors in models like these. Improvements will contribute to a concerted systems approach that engages relevant parts of the criminal justice system, communities, and the healthcare system.

Target Audience: Variable – audiences will depend on the community issues chosen, though a primary focus should be on bridging the generational gap.

Timeline: Short Term (12-18 Months)

Feasibility: Advocacy strategies can begin immediately and must be driven by communities through leadership and participatory inclusion at community centres or religious institutions.

Recommendation #3: Create Diaspora-Led Initiatives for Mental Health[11]

Problem: An overwhelmed workforce within the communities.

Reform and Criminal Justice Policy. 2017. https://icclr.law.ubc.ca/wp-content/uploads/2017/06/Mental-Illness-and-the-Criminal-Justice-System_Butler_ICCLR_0.pdf.

[10] Coleman, Terry and Dorothy Cotton. "TEMPO: Police Interactions A report towards improving interactions between police and people living with mental health problems." *Mental Health Commission of Canada.* 2014. https://www.mentalhealthcommission.ca/sites/default/files/2016-05/TEMPO%20Police%20Interactions%20082014.pdf.

[11] Additional resources for this recommendation, including contact information of professionals involved in related projects, can be found at the beginning of Appendix 2.

Justification: A number of diaspora community members involved in mental healthcare are interested in supporting mental healthcare initiatives in their communities back home, but lack the resources or information to facilitate this work. Additionally, many felt overburdened because they are the main points of contact in their Ontario communities. As a result, they also lack the time and capacity to establish or locate mental health connections in East Africa.

Recommendation details: Leaders in diaspora should organize an Ontario network of interested diaspora community members. This would help keep mental healthcare workers and their word-of-mouth networks informed of ways to help back home. It would also present opportunities for healthcare workers to connect with other people doing similar work and to share best practices or coping strategies with one another, helping workers feel less isolated and overwhelmed.

Examples: Creating this network involves reaching out to known mental healthcare workers in the Eritrean, Ethiopian, Kenyan, and Somali communities to gauge their interest in being involved with work in their home countries. After assembling a sizable list of contact information, the community leaders could organize a listserv of diaspora community members and connect them with an existing network of policy papers and best practices – such as the Africa Global Mental Health Institute (AGMHI). The AGMHI, which was formed out of a 2016 mental health conference in South Africa, currently maintains a detailed website and is conducting surveys with psychiatrists in Africa. It keeps its members in touch via a listserv.[12] Given the content for this listserv is already being managed, it would require very little work from community leaders here in Ontario. After generating involvement with the AGMHI, Ontario diaspora community members are encouraged to self-organize within their own region-specific network after, increasing their focus, and allowing for the further organization of province-based conferences and teams. The eventual need for a website or social media account could be a valuable opportunity to apply for government funding to hire an intern with web design and social media skills.

Target Audience: Community organization leaders (outreach phase); healthcare workers and medical professionals from diaspora communities for inclusion on listserv.

Timeline: Short Term (12-18 Months)

Feasibility: Highly feasible; potential partner has already consented to collaboration.

COMMUNITY RECOMMENDATIONS

Recommendation #4: Create Educational Campaigns

Problem: There are major barriers to seeking medically-appropriate mental health services. In cases where community members access alternative authorities such as religious or community leaders, these authorities are less able to provide medically-appropriate interventions or follow-

[12] A listserv is an electronic mailing list, allowing distribution of email to subscribers.

up. To resolve these issues, we recommend developing a set of educational tools about mental health services for the community.

Justification: Since members of the East African diaspora typically direct their mental health issues to religious and community leaders, we believe it is necessary to formulate a customized set of guidelines for diaspora communities that customarily rely on mental health consultation mechanisms. This step is necessary to ensure that religious and community leaders are able to make a medically informed decision, encourage referrals, and prevent the escalation of severe of mental health issues faced by their community members by early detection.

Recommendation details: Developing a set of educational tools about mental health services for the community that involves a community-led stocktaking processes in cooperation with professional mental health practitioners. To this end, as religion is the primary axis of identity in most of East African communities, the process should encourage religious and community leaders to be the primary advocates, and use religious terminology as an entry point. Following, the formulation of guidelines, two-way consultation involving community and religious leaders, and professionals should be maintained in order to improve guidelines where necessary. This could be done through the use of available technological platform (such as those hosted by OTN), a transfer of knowledge platform such as training of the trainers (involving religious leaders, community workers, etc.), and frequent mentorship programs in the community, or a combination of the above. One frequently neglected aspect that can be highlighted in these resources is information on health-seeking behaviour. This is useful for informing community leaders on signs and symptoms of mental illness in order to decrease mis-diagnoses and connect community members to the appropriate form of healthcare.

Examples: The Centre for Addiction and Mental Health (CAMH) Canada along with the Dalla Lana School of Public Health at the University of Toronto has published a series of online guides for promoting positive mental health across the lifespan, referred to as *The Best Practice Guidelines for Mental Health Promotion.*[13] The guides provide practitioners with current, evidence-based approaches in the application of mental health promotion.[14] Additionally, the Centre has published three guides that focus on older adults 55+,[15] children (7-12 years old) and youth (13-19 years old),[16] and refugees.[17] They are also in the process of preparing a guide focusing on

[13] Centre for Addiction & Mental Health, "Best Practice Guidelines for Mental Health Promotion Programs," porticonetwork.ca, n.d., https://www.porticonetwork.ca/web/camh-hprc/resources/best-practice-guidelines-for-mental-health-promotion-programs.
[14] Ibid.
[15] Centre for Addiction & Mental Health et al., "Best Practice Guidelines for Mental Health Promotion Programs: Older Adults 55+" (Toronto: Centre for Addiction and Mental Health, 2010), https://www.porticonetwork.ca/documents/81358/128451/Older+Adults+55%2B/d27d7310-ba6c-4fe8-91d1-1d9e60c9ce72.
[16] Centre for Addiction & Mental Health et al., "Best Practice Guidelines for Mental Health Promotion Programs: Children (7-12) & Youth (13-19)" (Toronto: Centre for Addiction and Mental Health, 2014), https://www.porticonetwork.ca/documents/81358/128451/Best+Practice+Guidelines+for+Mental+Health+Promotion+Programs+-+Children+and+Youth/b5edba6a-4a11-4197-8668-42d89908b606.
[17] Centre for Addiction & Mental Health et al., "Best Practice Guidelines for Mental Health Promotion Programs: Refugees" (Toronto: Centre for Addiction and Mental Health, 2012), https://www.porticonetwork.ca/documents/81358/128451/Refugees/3974e176-69a8-4a5f-843b-a40d0a56299c.

immigrants.[18] The guide focusing on refugees is an especially relevant model because it covers some issues faced by the East African communities in Ontario, including traumatic life experiences, barriers to mental health service access, acculturation difficulties, and stigmatization.

Target Audience: Religious and community leaders.

Timeline: Short Term (12-18 Months)

Feasibility: Provision of guidelines as a reference for the community and religious leaders in diaspora communities, including East African communities is extremely feasible, given the ongoing efforts taken by CAMH to design guidelines for practitioners concerning other targeted groups (youth, adult, and refugees), and we encourage engagement with CAMH during the development of guidelines. An appointed coordinator and/or funding for a coordinator are necessary to materialize this recommendation.

Recommendation #5: Translate and Community-Source Mental Health Resources

Problem: Language barriers impacting access to mental health services were a common concern across all stakeholders and communities.

Justification: Key informant interviews revealed three main issues: the lack of resources available in East African languages for healthcare professionals to appropriately support diaspora communities, the limited mental health-related medical terminology in East African languages, and the difficulties faced by non-native English speakers when navigating Ontario's healthcare system.

[18] Centre for Addiction & Mental Health, "Best Practice Guidelines for Mental Health Promotion Programs," porticonetwork.ca, n.d., https://www.porticonetwork.ca/web/camh-hprc/resources/best-practice-guidelines-for-mental-health-promotion-programs.

Recommendation details: Provide culturally-sensitive resources and services to healthcare professionals, community workers, and members of the diaspora, in their preferred languages. There is only a small pool of translators in Ontario who can translate between English and East African languages *and* who have required medical expertise. Engaging community workers in content creation will ensure that it meets the needs of the community.

This can also be done by leveraging existing technology to facilitate interpretation between mental healthcare workers outside of the diaspora and diaspora members seeking care. There are smartphone applications and digital platforms for live language interpretation that can be used to improve communication between professionals and patients. One that is made specifically for East African languages in Kenyan and Ugandan languages is called *Safarini Translator*, though it is not widely used, has received poor ratings, and has not been improved upon since 2014.[19] However, a similar model could be improved upon to mitigate language barriers.

Examples:

1) The Ontario Women's Justice Network (OWJN) project, which came out of METRAC,[20] involves the creation of a print resource to identify signs of domestic violence and direct survivors to culturally-appropriate resources in the city. In order to make the resource accessible to as many women as possible, it will be translated into the ten most-spoken languages in the GTA. Community members specializing in issues around violence against women have been selected to inform the content and ensure that it is appropriate for their community's needs. This process includes identifying services for speakers of minority languages to be included in the resource, and ensuring the resource itself is culturally appropriate and written using accessible language.[21]
2) *Say Hi* is a live interpretation application for iPhone and Android that provides automatic speech recognition and text-to-speech translation in 90 different languages and dialect.[22] Currently, *Say Hi* offers interpretation from English to Swahili meaning that this resource can be used immediately for the Kenyan diaspora. Other East African languages are not available, but the platform is growing quickly to include more languages and dialects. Mental health professionals and community experts could inform the expansion of *Say Hi* in order to include more East African languages and medical terminology as it develops.

Target Audience: Community organizations, mental healthcare practitioners, and diaspora communities.

Timeline: Short Term (12-18 Months)

Feasibility: This would require funding for translation. It is also worth considering an honoraria or some form of stipend for community workers who engage in the project.

[19] Safarini Translator, "Safarini Translator," facebook.com, n.d., https://www.facebook.com/SafariniTranslator/.
[20] METRAC is a Toronto-based not-for-profit organization that aims to eliminate violence against women and youth in the Greater Toronto Area (GTA).
[21] Ontario Women's Justice Network, "Ontario Women's Justice Network," owjn.org, n.d., http://owjn.org/.
[22] Sayhi, "Languages," sayhitranslate.com, n.d., https://www.sayhitranslate.com/languages/.

Recommendation #6: Integrate Mental Health Services into Settlement Services

Problem: Lack of resources for providing mental health screening to newly arrived immigrants inhibits the integration process and overall successful adaptation of immigrants to Ontario. Even if an initial mental health screening does not show concerns, the life of an immigrant in the first few months may change the mental health stability of that person. Comparing to general population in Canada, immigrants are less likely to seek out or to be referred to mental health services.[23] Therefore, a follow-up program is needed.

Justification: New immigrants often have better health than the general population.[24] This is due to various levels of health screening throughout immigration process. However, difficulty

[23] Canadian Medical Protective Association, "Immigrant Health Issues: What Physicians Should Know and Do," cmpa-acpm.ca, December 2015, https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2015/immigrant-health-issues-what-physicians-should-know-and-do.
[24] Iman Sheikh, "Canadian Immigrants Arrive Healthy but That Doesn't Last – Here's Why," tvo.org, April 20, 2015, https://tvo.org/article/current-affairs/shared-values/canadian-immigrants-arrive-healthy-but-that-doesnt-lastheres-why.

integrating with local culture, language barriers, and barriers to finding steady employment often leads to immigrant health deteriorating over time. It is important to reveal any health issues, including mental health issues, at early stages in order to create comfortable conditions and a smooth transition for new immigrants. The Canadian Paediatric Society suggests that children go through the screening as soon as families arrive in Canada.[25]

Recommendation details: Implement mental health screening for new immigrants and refugee families, and require consistent visits to a mental healthcare worker for up to a year. The visits will help to track mental health changes during the transition period. If after one year mental health practitioners' assistance is still required, a follow-up program could be provided.

Examples: In response to high rates of post-traumatic stress disorder (PTSD), anxiety, and depression diagnoses among refugees that develop during the settlement process, the Refugee Health Screener-15 (RHS-15) has been developed and successfully implemented by the Pathways to Wellness project in the Public Health Seattle King County (PHSKC). It has been validated in Arabic, Burmese and Nepali, and translated into French, Amharic, Tigrinya, Swahili, Somali, Russian, Karen, and Farsi.[26] The RHS-15 is mainly tested on women refugees, however is applicable to all genders.

Target Audience: Variable – incoming refugees of varying ages, experiences, and background are the targets.

Timeline: Medium Term (18-36 Months)

Feasibility: This recommendation is large-scale, but cost-effective because it targets immigrants when they arrive and begins supporting their mental health needs immediately, before their conditions worsen. However, because immigration settlement is dealt with at the federal level, while healthcare is a provincial mandate, coordination and responsibilities for this screening will require discussions between the two levels of government.

[25] Canadian Paediatric Society, "Medical Assessment of Immigrant and Refugee Children," kidsnewtocanada.ca, April 2018, https://www.kidsnewtocanada.ca/care/assessment#selected-resources.
[26] Crista Johnson-Agbakwu et al., "Mental Health Screening Among Newly-Arrived Refugees Seeking Routine Obstetric and Gynecologic Care," *Psychological Services* 11, no. 4 (2014): 470–76.

TECHNICAL RECOMMENDATIONS

Recommendation #7: Create a Knowledge Sharing Platform

Problem: There is a knowledge disconnect on the types of mental health services available, how to contact the agencies that provide these services, and a lack of formal diaspora-specific health networks to facilitate these linkages.

Justification: Key informants expressed a lack of knowledge about how to contact relevant agencies/organizations. Additionally, a recommendation by the Canadian Science Policy Centre calls for the creation of diaspora-specific health networks, which would allow practitioners and patients to access an untapped resource.[27]

Recommendation details: Creation of a knowledge platform specific to East African communities. The first section of the platform will collect information about practitioners' specialization, country, languages spoken, etc. This is similar to OTN's current directory resource. This section of the platform will help tie together general practitioners and specialists, further

[27] Canadian Science Policy Centre, "Diaspora Scientists: Canada's Untapped Resource of Global Knowledge Networks," sciencepolicy.ca, 2015, http://sciencepolicy.ca/diaspora-scientists-canadas-untapped-resource-global-knowledge-networks.

increasing ease of access. A second section will house data and studies that can be accessed by users in East Africa and Ontario. Lastly, a peer-to-peer support feature will allow community members to anonymously communicate with each other and support each other. Due to the community-oriented disposition of many of these groups, the peer-to-peer feature can create unique recovery pathways based on culturally specific knowledge and lived experiences. Additionally, the peer-to-peer experience may help to offset distrust in the system, creating more opportunities for members of the East African community to receive treatment. With various realms covered by the platform, it will also help to tie together resources, thereby increasing efficiency. Given OTN's familiarity with technological solutions and their ability to leverage existing networks, the organization could play a fundamental role in the implementation of this recommendation.

A first step for achieving this goal is examining the core elements of existing models (examples listed below) and extracting best practices. Next, large-scale data collection will be necessary. Contacts for this should include community members (cultural and community knowledge), practitioners (professional knowledge), and online databases (academic knowledge). Note that this will be completed over time; it is not necessary to collect this information all at once. Finally, it will be necessary to have an individual or organization with the appropriate skills compile the data and design and operate the platform.

Examples: In addition to OTN, there are other models of knowledge sharing platforms for medical professionals, such as Anzu Medical, practitioner databases, and one made available by the College of Physicians and Surgeons of Ontario. Additionally, there are some diaspora-specific networks in other fields, such as the Network of diaspora in Engineering and Science (NODES), which brings together engineers from different diaspora communities.[28] Patient-to-patient platforms are also already being used to improve mental health outcomes. An example of this is Big White Wall. In this online community, people help each other and share what is on their mind, safely and anonymously. People can express themselves using both words and pictures, and the application helps ease feelings of isolation. The site is available 24/7, and is monitored by clinically trained 'guides'.[29] It is necessary, however, for further evaluation to be carried out on if and how Big White Wall can target diaspora communities in order to fulfill their unique needs. Therefore, there is a need to amalgamate these ideas, combining a medical platform with diaspora-specific information, and adding a patient-to-patient support feature. Best practices can be adapted from all three models.

Target Audience: Variable – practitioners and members of the diaspora communities would use the platform.

Timeline: Medium Term (18-36 months)

[28] Canadian Science Policy Centre, "Diaspora Scientists: Canada's Untapped Resource of Global Knowledge Networks," sciencepolicy.ca, 2015, http://sciencepolicy.ca/diaspora-scientists-canadas-untapped-resource-global-knowledge-networks.
[29] Big White Wall, "How It Works," bigwhitewall.com, n.d., https://www.bigwhitewall.com/V2/about.aspx.

Feasibility: The creation of a computerized knowledge platform is extremely feasible. There is a tremendous amount of foundational work already being carried out, but there is a need to take this work further, by quantifying practitioner specialization, country, etc. It is also essential to promote the platform amongst community members. This should be done through already-established community networks, such as community groups and religious organizations. This way, the platform will address the under-utilization problem.

Recommendation #8: Build Cultural Knowledge and Sensitivity to Reduce Mis-Diagnoses and Mistrust in the Healthcare System

Problem: A lack of cultural sensitivity leads to frequent misdiagnoses and mistrust in the formal healthcare system.

Justification: Primary and secondary data reveals that some patients interacting with mental health professionals are at risk of misdiagnosis. This risk stems from a combination of language barriers, insensitive interpersonal communication, and mismatched treatment expectations. Literature on refugee and diaspora mental health shows that cultural identities–including ethnicity and tribal lineage, and religion–are the principal lenses through which Eritrean, Ethiopian, Kenyan, and Somali immigrants orchestrate their lives. However, mental health professionals are generally unaware of the critical importance of these factors. One interviewee with knowledge of the system reported that some patients drop out of therapy/counselling early on because they find practitioners' diagnostic inquiry intrusive and insensitive. Over time, such adverse outcomes erode trust in the mental healthcare services provided by the province. This outcome is exacerbated by: linguistic differences; cultural differences in roles and responsibilities (e.g. gender); bringing up trauma rapidly; focusing on the past rather than the present or future; and failure to understand the impact of resettlement and migration.

Recommendation details: Enhanced access to cultural educational tools, resources, and training for practitioners to build sensitivities toward patient backgrounds and experiences. Specific actions to be taken include:

- Building linkages and interactions between mental healthcare professionals and community healthcare workers to create a mechanism for sharing information and knowledge on patients' cultural and religious backgrounds.
- Creating, storing, and making accessible qualitative resources on the OTN website that enable mental healthcare professionals to tap into this repository of cultural knowledge when dealing with patients from diaspora communities.
- Arranging two-way training and educational workshops where mental healthcare professionals and community workers could interact and work together to build cultural sensitivities.

Examples:

1. A formal Diagnostic and Statistical Manual of Mental Disorders (DSM) technique is the creation of a *cultural formulation.* One example from the Netherlands was completed with a Somali refugee with PTSD. The practitioner created a detailed vignette (adjusting for patient confidentiality and privacy regulations) that delineated the patient's life and experience in detail. This template was then published academically, and made accessible for mental health professionals in the Netherlands and beyond.
2. The *Paraprofessional Counseling Project*,[30] based in the Netherlands, trained refugees and asylum-seekers, through classroom education and placements, to act as first-level paraprofessional counselors. These paraprofessionals worked with mental healthcare professionals to provide psychosocial care services within the asylum-seeking centres, acting as a resource and model for cultural sensitivity.

Target Audience: We recommend that these interventions should be made available widely. The electronic resources should be housed within OTN's online digital repository of knowledge and resources for healthcare professionals. Cultural sensitivity training sessions and interactions should be arranged at the convenience of participants–preferably in or around physical community settings so that practitioners get first-hand exposure to the lived experiences of patients.

Timeline: Short Term (12-18 Months)

Feasibility: This recommendation is very feasible, owing to publicly available and community-supplied information and resources. However, it is also time-intensive.

[30] B Kieft et al. "Paraprofessional Counselling within Asylum Seekers' Groups in the Netherlands: Transferring an Approach for a Non-Western Context to a European Setting." *Transcultural Psychiatry.*, U.S. National Library of Medicine, Mar. 2008, www.ncbi.nlm.nih.gov/pubmed/18344254.

Recommendation #9: Increase Data and Research on the East African Diaspora

Problem: A pervasive lack of primary and secondary research specific to Ontario and East African diaspora communities in general.

Justification: The need for more primary data will enable a more effective targeting of diaspora communities and provision of mental health services based on robust research. While available data varies widely among our four countries of focus, all communities would benefit greatly from a needs-based assessment of mental health resiliency within target demographics. Specifically, Eritrean communities appear to have the least amount of available data, underscored by the fact that the majority of the data on the Eritrean diaspora exists in American contexts.[31] However, this lack of data extends beyond the diaspora communities here in North America; "in general, it is challenging to obtain credible prevalence figures on psychological distress and mental disorders across cultural and language boundaries, and even more so in complex humanitarian emergencies."[32]

Recommendation details: For OTN to show reasonable cost effectiveness in improving mental health resiliency of these communities, indicators must be developed to show the current state of affairs, resources must be allocated for the collection of this data, and academic grants should be extended for primary research. In addition, collaboration should be considered with the Canadian

[31] Addn Aray, "Eritrean and Eritrean American Health Assessment," *McNair Journal* 20 (2015): 20–35. http://forms.gradsch.psu.edu/diversity/mcnair/mcnair_jrnl2015/files/Araya.pdf
[32] Saida Abdi et al., "Culture, Context and Mental Health of Somali Refugees: A Primer for Staff Working in Mental Health and Psychosocial Support Programs" (Geneva: United Nations High Commissioner for Refugees, 2016), https://data2.unhcr.org/en/documents/download/52624.

Mental Health Association, an organization actively seeking to map the complexities of this emerging field of data.[33]

Examples:

1. The Canadian Mental Health Association has issued equity indicators in the health field.[34] These include geography, income by neighbourhood, immigration status, age, and sex. Additional indicators gleaned from our interviews include: time since immigration, and years spent in in the immigration system
2. The Canadian Mental Health Association has also released performance indicator measurement materials for consistent assessment.[35] They created a repository for databases at every step of the continuum of care.[36]

Target Audience: The focus must remain on demand-driven patient needs and academics that can help us better understand these needs.

Timeline: Long Term (36-90 Months)

Feasibility: OTN's limitations on aggregate data collection is a foreseeable roadblock. However, we believe this inability to disaggregate individual health concerns can be more effectively addressed in secondary research to complement any existing gaps in primary data collection.

[33] Uppala Chandrasekera, "Our Journey to a Data and Performance Measurement Strategy," network.cmha.ca, n.d., http://network.cmha.ca/our-journey-to-a-data-and-performance-measurement-strategy/.
[34] Uppala Chandrasekera, "Our Journey to a Data and Performance Measurement Strategy," network.cmha.ca, n.d., http://network.cmha.ca/our-journey-to-a-data-and-performance-measurement-strategy/.
[35] Centre for Addiction & Mental Health, "Performance Indicators for the Mental Health and Addictions System in Ontario" (Centre for Addiction and Mental Health, 2016), http://network.cmha.ca/wp-content/uploads/2017/06/Performance_Indicators_for_MHA_System_in_Ontario_Final_ApprovedbyCouncil.pdf.
[36] Centre for Addiction & Mental Health, "Mental Health and Addictions Data in Ontario" (Centre for Addiction and Mental Health, 2015), http://network.cmha.ca/wp-content/uploads/2017/06/Mental-Health-and-Addictions-Data-collection-in-Ontario-July-15-2015.pdf.

VALUE PROPOSITION

There is value for all clients to partner on implementation of these recommendations to achieve their **mutual goal of improving access to mental health initiatives, resources, services, and practitioners.** Outlined below are several key value proposition points of this partnership for both OTN and East African community advocates:

The Value Proposition for OTN

OTN is a leader in connected care and telemedicine,[37] providing access to technical expertise and physicians. The organization itself does not provide mental health services but rather connects physicians to patients, specialists, and resources. OTN seeks to extend their services to the diaspora living in Ontario, and possibly to provide advice to East African communities on establishing similar services at a later date. The value in partnering with the Community Advocates for OTN could include:

- Greater access to on-the-ground knowledge of the effectiveness and use of their services;
- Increased opportunity to link physicians in their network to new clients and colleagues within the East African diaspora;
- Increased awareness of OTN's services via public awareness campaigns;
- Increased use of OTN's services via public awareness campaigns and networks organized by the Community Advocates; and,
- Opportunities to pilot innovative technology initiatives upon approval of the Community Advocates

Value Proposition for the Community Advocates

The East African community advocates strive to improve access to services and create greater awareness of mental health conditions within the communities they serve. For community

[37] Ontario Telemedicine Network, "OTN," otn,ca, n.d., https://otn.ca/.

advocates, OTN can generate several opportunities by assisting with establishing referral pathways, networks, information accessibility, social awareness campaigns and accessing innovative technologies that could aid in overcoming current barriers for addressing mental health challenges in the community. For the community advocates, the value in working with OTN could include:

- Access to a network of expertise via OTN's services;
- Access to innovative methods and technology in accessing hard to reach communities;
- A partner to co-advocate with for future initiatives to address mental health challenges in the community;
- Improved access to mental health physicians and services through OTN's network; and
- Communicating with OTN on funding and resource opportunities.

CONCLUSION

The recommendations outlined in this report aim to improve access to mental health resources and overall mental health outcomes for the Eritrean, Ethiopian, Kenyan, and Somali communities in Ontario. Using primary and secondary data, our team aimed to understand the needs and nuances of each community, as well as the capacity and limitations of the Ontario healthcare system. The advocacy, community, and technical recommendations provided are feasible to implement and will have both immediate and long-term effects on the target communities.

A number of recommendations hinge on collaboration between OTN and community organizations. To this end, piloting solutions in diaspora communities is one method to fulfill the needs and goals of multiple stakeholders. For example, two-way training and educational workshops can be piloted by OTN using one diaspora community as the target beneficiaries. The Somali community in Toronto could be used as a pilot community, as there is a concentrated community presence as well as momentum for addressing mental health issues. OTN could identify Somali healthcare practitioners who would facilitate a training for community or religious leaders on how to diagnose mental health conditions, identify health-seeking behaviour, and how to connect community members to the appropriate healthcare. This training could take place in-person in a community center or mosque or through OTN's teleconferencing platforms. It is important that pilot projects are designed and implemented with scaling-up in mind. By establishing an evaluation mechanism for this workshop, OTN and participants can provide feedback and learn what works and what can be improved before scaling. A successful pilot project with demonstrable impact could lead to the project being adapted for other diaspora communities.

We encourage OTN and East African community advocates to implement and adapt the recommendations according to their self-identified needs and capabilities. It is critical that continued momentum on the goals of this project are driven by the clients, through the following steps:

1. **Identify the recommendations that are most feasible to implement:** Take entire recommendations or pieces of recommendations and create plans of action. These plans of action should clearly determine target issues, target audience(s), available resources, potential funding opportunities, and a coordinator to organize and lead activities.
2. **Determine intersection points where collaboration is possible:** Community advocates and OTN should build on the foundational partnership established through this project. This could take the form of monthly meetings, proposals for collaboration, and sharing of resources. An example of a collaborative effort is if OTN wants to pilot a mental health project or resource, one of the diaspora communities could be used as a pilot demographic.
3. **Advocate for further research/funding:** This project should be the first step in developing solutions for mental health issues in the East African diaspora communities. Following this project, more research should be executed on the issues faced by these communities and successful models of mental health support, strategies should be adapted to community contexts, and collaboration should heighten among clients. Successful outcomes will have far-ranging impacts for the clients, and these successes can be translated to other diaspora communities in Ontario and home countries.

Over the course of the project, the consultant team identified key strengths of the clients which should be leveraged for continued action. There is clear willingness from the community and experts to develop solutions and there are existing models and technologies that can be models for these solutions. Strong community ties, related funding opportunities, and complementary goals and strengths of the clients were also evident. This project highlighted the need to connect these factors to develop comprehensive and well-researched solutions to improve mental health in East African diaspora communities.

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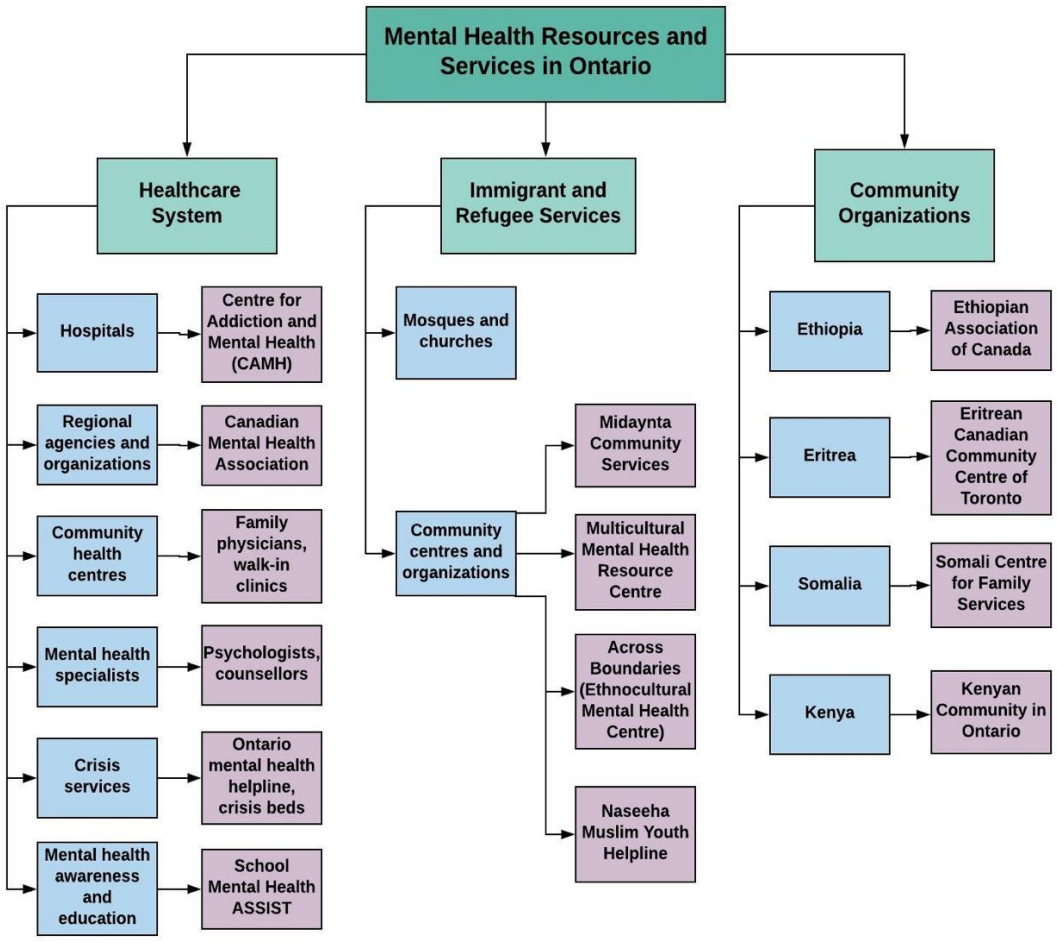
APPENDICES

Appendix 1: Mental Health Services in Ontario

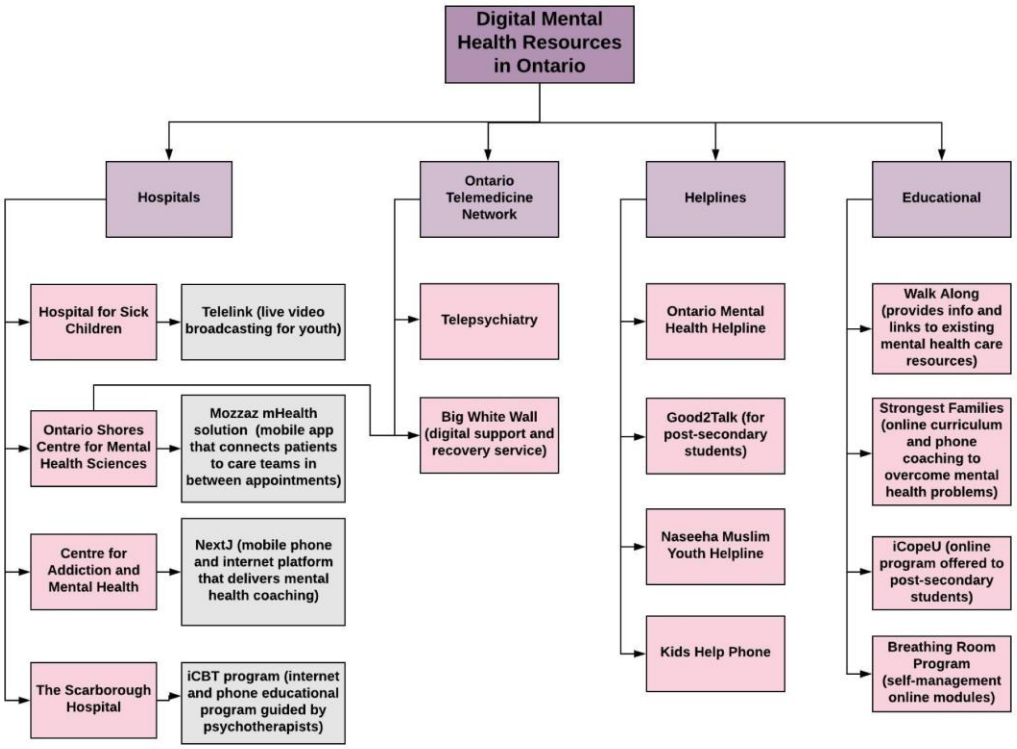
There are a wide variety of mental health programs and services designed to meet the needs of Ontarians. These resources are delivered primarily through community organizations and hospitals or health clinics (see Figure 1). However, the Ontario mental health system is often described as a fragmented patchwork of services, where access is too often determined by what people can afford and where they live. Consequently, vulnerable populations such as immigrants and refugees are often unable to access the appropriate resources. East African diaspora communities are especially affected due to the lack of cultural sensitivity, adaptation, trained paraprofessionals, and language accessibility in the formal healthcare system. Instead, these diaspora communities typically utilize informal mental health services, including those provided through religious institutions or community centers.

Figure 1: Mental Health Resources and Services in Ontario



Additionally, the prevalence of digital mental health services in Ontario is increasing. Technology-driven mental health solutions are cost-effective and have wide-ranging impacts, from cutting down on travel time for patients and healthcare workers to increasing early intervention for mental illnesses (see Figure 2). However, these services are also rarely tailored to specific demographics such as East African communities, demonstrating an untapped potential for improving mental health service delivery.

Figure 2: Digital Mental Health Resources in Ontario



Appendix 2: Additional Resources

Recommendation-Specific

Recommendation 1 (Public awareness):

- Naseeha Muslim Youth Helpline provides free public awareness materials that can be circulated at community gathering places. (Naseeha, "Spread the Word," naseeha.org, n.d., http://naseeha.org/spread-the-word/.)
- The Cope.Care.Connect project is led by students under the direction of Associate Professor Dr. Kelli-an Lawrence. For more information on the project, please contact Dr. Lawrence at klawrance@brocku.ca.
- For examples of educational videos that are similar to those of Cope.Care.Connect's public awareness campaign, please see the U.K. based "Time to Change" videos (https://www.time-to-change.org.uk/category/blog/video) and the "National Alliance on Mental Illness' educational videos (https://www.nami.org/videos).

Recommendation 3 (Diaspora-led initiative):

- A listserv is an electronic mailing list, allowing distribution of email to subscribers. Those interested can contact Dr. Michelle P. Durham, Assistant Professor in Psychiatry at the Boston University School of Medicine, providing their names and e-mail addresses. Her e-mail address is michelle.durham@bmc.org.

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