Anti-Black Racism and Building Organizational Partnerships: Implications for Recovery-oriented Practice in Mental Health

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Abstract

Objective: There is minimal research on the role racism plays in recovery-oriented practice for Black youth. Clinicians' perspectives on building interagency partnerships have been understudied. We sought to characterize and contextualize interagency relationships in the mental health sector in Ontario and explore their impact on mental health provision.
Research Design and Methods: A mixed methods approach was used to explore clinicians' perspectives on the collaborative nature of partnerships in the sector. An online survey was disseminated to clinicians in Toronto, Ontario between March 2020 and April 2020 followed by 7 focus groups which were conducted in Toronto between May 2020 and December 2020 with Black youth, caregivers, community, and clinicians. Quantitative data were analyzed using SPSS and visualized using social network analysis, while Nvivo 12 was used to perform a thematic analysis.
Results: Interagency collaboration between mainstream agencies was common. Partnerships between Black and mainstream agencies were infrequent. Most mainstream agencies expressed disinterest in future partnerships with Black agencies. Feelings of unpreparedness among clinicians to provide culturally safe responsive care to Black youth became evident.
Conclusions: Project partnerships between mainstream agencies are common. There is a paucity of Black agencies building organizational partnerships with mainstream agencies. There is a limited understanding of the systemic impacts of racism as a barrier to building interagency partnerships and its implications for recovery-oriented

practice. The Canadian recovery guidelines do not identify racism as a social determinant of health or discuss potential implications for recovery-oriented practice. They can be strengthened through implementing system-level change and culturally adapted care.

Introduction

Canada's mental healthcare system and its people are in crisis; our understanding of youth's increased vulnerability to mental illness, poor access to care, and the human and financial costs to us are increasingly gaining attention.[1] However, awareness regarding Canada's Black history and the systemic nature of anti-Black racism (ABR) is lacking. ABR is rooted in a unique history of colonization and slavery that entails discrimination and prejudice that target Black populations.[2] The Centre for Economic and Social Rights (CESR) brought attention to the disproportionate racial health inequities in housing, child welfare rates, access to healthcare and education, income, and the application of drug laws; and concluded that ABR is systemic within Canada.[3]

The association between race, racism, and inequitable mental health outcomes and quality of care in Canada deserves increased attention from the media, government, and academia. Race has been established as a social determinant of health (SDOH),[4] yet antiracist and culturally responsive practices are optional for mental health agencies and clinicians. The Black population in Canada is young with the median age being 29.6 years and 40.7 for the total population.[5] Canada's Black population is growing steadily, comprising 3.5% of the total population and projected to grow to 5-5.6% by 2036.[5] Strong positive associations between experiences of chronic racism and adverse mental health outcomes, substance use, risk taking behaviour, and delinquency have been established.[6] This crisis affects racialized youth uniquely, as ABR and the associated chronic stress have led to poorer mental health outcomes, diminished access to care, and negative care experiences.[7] In comparison to their White counterparts, Black youth wait more than twice as long to access care.[8] Black youth also tend to access care once symptoms have intensified and warrant emergency care or hospitalization.[9] Numerous mental health disorders first appear or become salient during young adulthood and adolescence.[10–12] However, Black youth in Canada encounter disproportionate barriers to accessing mental health services.[13] In addition, the COVID-19 pandemic and associated public health measures may have also put youth at higher risk of psychological harm.[14.] In a study among youth living with mental illness, 83% felt the pandemic had harmed their mental health; less social contact and structured activities were identified as worrisome factors.[15.] COVID-19 has affected Black communities disproportionately due to the compounding effects of systemic ABR. The systemic nature of ABR means it affects the mental health system at the client, organizational, and clinician levels; it also influences how these elements of the system and external sectors interact.

Recovery

Recovery is an approach used when caring for those living with mental illness; instead of the focus being on symptom treatment or resolution, recovery aims to foster resilience and promote self-agency to instill a greater sense of control in life.[16] Anthony (1993, p.15) described recovery as a "personal process that involves reevaluating one's attitudes, values, roles, feelings, and goals to make meaningful contributions in life and achieve satisfaction while living with mental illness."[17] The recovery model gained international prominence following calls from the 2003 New Freedom Commission on Mental Health, which advocated for its use to transform the mental health care system in the United States.[18] In response, mental health authorities, such as the Australian Department of Health,[19] created recovery-oriented practice frameworks to transform their mental health systems and give clinicians tangible recommendations and establish standards for good practice.

In 2015, the Mental Health Commission of Canada (MHCC) published its guidelines for recovery-oriented practice.[20] These guidelines encompass the following six dimensions: a culture of hope, recovery as personal, context, responding to diverse needs, working with Indigenous communities, and the transformation of system and services.[20] The fifth dimension is a starting point for clinicians interested in providing culturally responsive care to Indigenous communities. It encourages clinicians to examine how colonization, residential schools, slavery, and ongoing institutional discrimination have produced intergenerational trauma and impeded Indigenous communities' access to mental health and basic social services.[20] Black and Indigenous Canadian communities have unique, yet shared, histories of colonization and experiences of systemic racism that strongly influence their mental health and recovery. Canadian mental health authorities have formally recognized the need for services[21] and recovery-oriented practices[20] that reflect the cultural diversity in Indigenous communities. A similar approach could be taken to communicating Black mental health needs and devising recovery-oriented practices rooted in antiracism. Compared to non-racialized Canadians, Black Canadians self-reported higher levels of anxiety, depression, and suicidal ideation from 2021-2022.[22] The fourth dimension focuses on meeting the mental health needs of marginalized Canadians, which requires acknowledging intersectional identities, racism, discrimination, and providing culturally responsive care.[20] However, ABR is not identified as a SDOH that affects the recovery process for Black Canadians. ABR prevents Black youth from accessing care,[13] yet connections between slavery in Canada, chronic distress, and intergenerational trauma experienced by Black people today[23] are not elucidated in existing recovery practice guidelines. This work addresses this gap by identifying areas that warrant further research and can inform antiracist practices to make organizational changes, build partnerships, and prepare clinicians to deliver culturally responsive care to Black youth and adults.

Interagency collaboration is an approach to service delivery wherein distinct services collaborate to improve service delivery.[24] Interagency collaboration in this sector is imperative to address barriers to care, enhance continuity of care, and provide culturally responsive care for Black youth. For example, Hurlbert et al.[21] noted that increased interagency collaboration was associated with the prioritization of high-needs children, more appropriate referrals, and decreased disparities in complex service use between

White and Black children. Given that agencies have unique interests, resources, and areas of expertise, collaboration is key to maximizing efficiency, service delivery, and client satisfaction for youth. As a result of greater interagency collaboration between schools and mental health services, children and youth perceived the following positive impacts: increased happiness, and improvements in academic achievement.[24(p336)] Numerous facilitators were found to catalyze interagency collaboration, namely senior managerial commitment, joint training, good communication, an understanding of services between professionals and agencies, shared databases of clients receiving services, and integration coordinators.[24,25] However, there is scarcity of research on ABR and its impacts on interagency work in the mental health sector. This paper visualizes interagency partnerships and draws on Black youth and clinicians' experiences of ABR to contextualize them.

Research Design and Methods

We characterized the interagency relationships between mental health agencies through the [Blinded] project, a project created by [Blinded] that aims to increase access to mental health services for Black children and youth in Ontario, Canada. [Blinded] is a system change project, that adopted a community-based participatory approach[26] that actively involved Black youth and partner agencies to inform study design and data collection.

The following research objectives guided the work: *a)* to characterize and visualize interagency collaboration and partnerships in the mental health sector in Toronto, Ontario; *b)* to explore clinicians' perspectives on Mainstream-Black agency collaboration, and *c)* to identify the potential impacts the social network structure of these interagency relationships is having on how clinicians care for Black youth.

This study employed mixed methods social network analysis (MMSNA) to visualize the social networks of the agencies that participants worked for. MMSNA involves the collection and triangulation of quantitative and qualitative data, the former describes social networks, and the latter method suggests why those connections exist.[27] MMSNA has been effectively used in research involving organizational behaviour in the education sector and to address public health issues, such as food insecurity and policy in Canada.[28] An MMSNA approach informed study design, with the survey results supporting focus group recruitment and the refinement of questions for the interview guides.

Scope

Data were collected from six regions in Ontario: Toronto, Ottawa, Hamilton, Kitchener-Waterloo, London, and Windsor. The article explores interagency relationships in the mental health sector using SNA and qualitative focus groups collected from Toronto, Ontario. Data from clinicians and leadership were included in this study given our

research objectives and their unique social positioning in the mental health system as caregivers and organizational decision-makers. Limiting this paper's scope to Toronto was sensible given our research goals and the city's racial and cultural diversity. In comparison to the other study regions, Toronto has the largest Black population and the highest concentration of mainstream and Black mental health agencies. [Blinded] is headquartered in Toronto; therefore, political, and social capital were markedly stronger there which catalyzed response rates and allowed us to strengthen the study's design and recruitment strategies ahead of distributing the survey to the other regions.

Survey

The survey was created to provide insight into the nature of relationships between agencies; question development was informed by Social Network Theory (SNT) as we were interested in interacting units, as opposed to individual units.[29] SNT posits that relationships between individual units (termed nodes) and their linkages (termed edges) are the focal points. These linkages provide insight into interagency relationships. To recruit clinicians, we drew on data from Ontario 211 Central (a national services database) and [Blinded's] professional network. This information was used to develop a list of survey contacts, including their contact and organizational information. Agencies were categorized as Black or Mainstream based on internet searches, staff discussions, and discussions with [Blinded's] professional network. Agencies were labelled Black if their mission, values, and work prioritize Black youth and/or communities. Mainstream agencies are agencies whose mission, values, and work do not focus primarily on Black youth. To meet inclusion criteria, clinicians had to live in or work in Toronto or the Greater Toronto Area (GTA) and directly serve Black youth.

The online survey was designed using SurveyMonkey (SurveyMonkey Inc, San Mateo, CA). Survey questions were developed with consultation from the [Blinded] Youth Action Committee (YAC). The survey was also pilot tested with the YAC to ensure questions were reflective of their lived experiences. A purposive sampling approach was used for recruitment which included convenience and snowball sampling methods.[30] Email invitations were sent to potential participants and survey advertisements were circulated to professional contacts and via [Blinded] social media channels (i.e., Instagram, Twitter, and Facebook) (see Appendix 3). The survey was disseminated to English-speaking clinicians who directly served Black youth in Toronto, Ontario between March 2020 and April 2020 (see Figure 1). Informed consent was addressed on the first page of the survey, and a small honorarium in the form of a $5 CAD e-gift card was offered for participation. Survey data were stored in one password-protected company laptop.

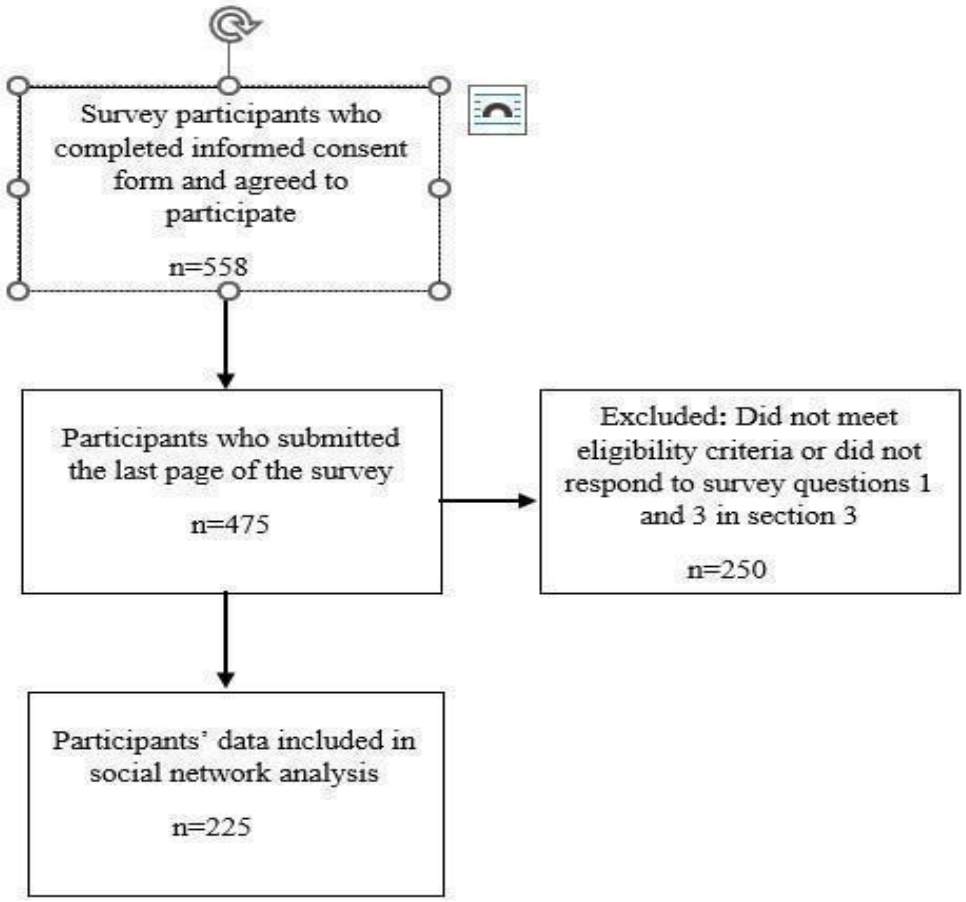

Figure 1. Survey participant flow chart.

Table 1. Social network graph and the corresponding research goal and survey question.

Figure #	**Research Goal**	**Survey Question**
3	To gain insight into the presence and/or absence of collaborative partnerships between agencies.	Please list one key agency you collaborated with on mental health care projects or issues in the past 1 year, along with the focus of your work.
4	To help build and identify areas for strong interagency partnerships in this sector.	What agencies would you like to work with (that you have not previously worked with)? Please list the names of up to three agencies.

We conducted a Social Network Analysis (SNA) using Gephi (a network analysis software) and calculated the following statistics for social network graphs: in-degree centrality, degree centrality, and betweenness centrality (see Appendix 1). Drawing on work by Sparrowe et al. (2001) and Hochberg et al. (2007), Zhang[29] argued that centrality measures are widely considered most important because they assess popularity, reputation, and how integral a node is to the functioning of a social network; the closer a node is to the centre of a network, the greater its power, influence, and control over information communicated. Degree centrality measures the total number of direct one-step connections a node has to other nodes, and betweenness centrality measures the number of times one node, aka an influential '*bridge,'* lies on the shortest path to other nodes.[31] The survey data were visualized as social network graphs (see Table 1). Data from survey questions about building partnerships and interagency collaboration were used to create social network graphs; each graph corresponded to a [Blinded] project research goal.

Focus Groups

Between May 2020 and December 2020, seven focus groups were conducted with 37 participants across Toronto and the GTA (see Figure 2). Questions were semi-structured and created with input from the project's YAC to reflect their needs. Questions were primarily focused on access to mental healthcare in Toronto, community perceptions of mental health and illness, care experiences, and possible improvements to Ontario's mental healthcare system.

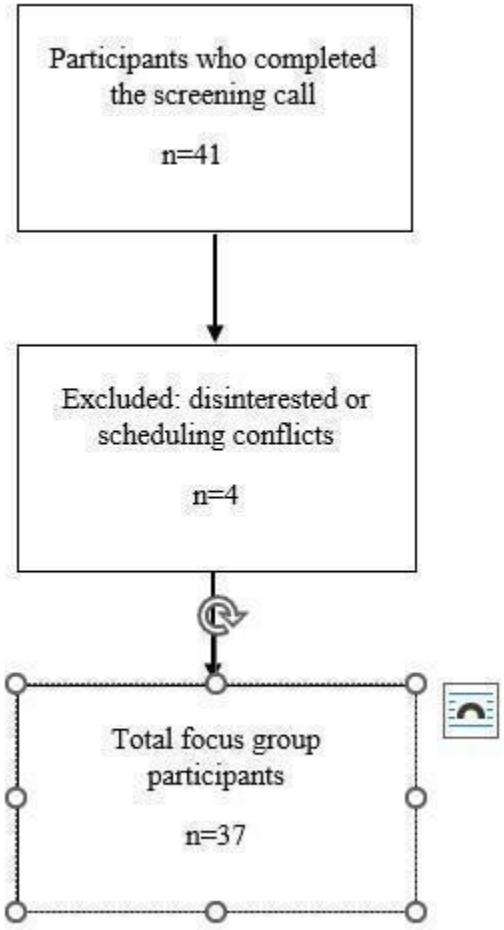

Figure 2. Focus group participant flow chart.

A convenience sampling approach[32] was used, and emails, social media posts, and community liaisons were used to recruit potential participants. Interested participants were contacted first for a screening call to determine eligibility. Inclusion criteria varied based on each focus group. Youth were required to live in Toronto, self-identify as Black, and self-

identify as youth. Clinicians needed to work or reside in Toronto and have a practice or treatment focus that included Black youth. Family and community members were required to live in Toronto and know a Black youth who has accessed mental healthcare.

Eligible participants were sent a post-screening call email that provided them with an informed consent form, meeting instructions, a demographics survey, and an honorarium form. Focus groups were conducted separately with Black youth and clinicians. Additional focus groups were done with 2SLGBTQ+ Black youth, Black youth with experiences in the Canadian justice system, and the [Blinded] YAC. Focus groups were facilitated by the [Blinded] Researcher using an interview guide tailored to Black youth and clinicians respectively (see Appendix 4). Focus groups were held virtually via Zoom and audio recorded with a physical recording device and Zoom. Using Zoom allowed participants to keep their cameras off and utilize a pseudonym to protect their confidentiality. The informed consent form was reviewed by all participants before each focus group began. Focus groups were approximately two hours and involved 2 to 12 participants.

The [Blinded] Researcher and transcription consultants transcribed focus groups with the support of Otter.ai, a transcription software. The [Blinded] Researcher performed a thematic analysis using Nvivo 12 (Nvivo QSR, International), a qualitative analysis software. In Nvivo, findings were organized into codes and themes and refined until they formed a cohesive narrative.[33] Data saturation was reached when no new codes were developed during the analysis. High-level summaries of focus group results, covering themes and lessons learned, were shared and member-checked with participants.

Results

Participants

Focus group participants' ages ranged from 18-59 (see Table 2). 86% of focus group participants identified as Black, and 8% of participants identified as White. Survey participants were predominantly front-line staff (see Table 3). Most survey participants identified as non-White (see Table 3). Namely, 32% identified as Black, Caribbean, or African, 33% as people of colour, and the remaining 34% of clinicians identified as White. Most survey and focus group participants identified as heterosexual and as a woman/girl; however, increased diversity in gender identity and sexual orientation was observed in survey participants (See Table 3). In Toronto, 60% of the survey participants worked at Mainstream agencies, and 40% worked at Black agencies (see Table 4).

Table 2. Demographic characteristics of focus groups participants from Toronto, frequency # (percentage % [rounded]). *Note* some focus group participants did not answer all demographic questions thus the total varies based on the demographic indicator.

Demographic Indicator	**Toronto** **n=37**	
Age	Range	18-59
Race	Black/Caribbean/ African	32 (86 %)
	White	3 (8%)
	Person of Colour	8 (22 %)
	Not Sure	0
	No Answer	0

Gender Identity	Trans	1 (3 %)
	Woman/girl	28 (76 %)
	Man/boy	8 (22 %)
	Third gender	0
	Gender-fluid	0
	No answer	0
Sexual Orientation	Asexual	0
	Bisexual	5 (14 %)
	Lesbian	1 (3 %)

	Heterosexual	23 (62 %)
	Homosexual/Gay	4 (11 %)
	Pansexual	1 (3 %)
	Queer	2 (5 %)
	Questioning	1 (3 %)
	No Answer	1 (3 %)

Table 3. Demographic characteristics of survey participants from Toronto, frequency # (percentage % [rounded]). *Note* some survey participants did not answer all demographic questions, thus the total denominator varies depending on the demographic indicator.

	Demographic Indicator	**Toronto n=364**
Cultural Identity/Ethnicity	Black/Caribbean/ African	116 (32%)
	White	123 (34%)
	Person of Colour	119 (33%)
	Not Sure/Other	119 (33%)
		Toronto n=270
Gender Identity	Trans	13 (5%)

	Woman/girl	83 (31%)
	Man/boy	60 (22%)
	Two-spirit	16 (6%)
	Non-binary/gender queer/gender-fluid/agender/ third gender	98 (36%)
		Toronto **n=298**
Sexual Orientation	Bisexual	35 (12%)

	Lesbian	24 (8%)
	Heterosexual	85 (29%)
	Homosexual/ Gay	34 (11%)
	Pansexual	25 (8%)
	Queer	32 (11%)
	Two-spirit	25 (8%)
	Questioning	20 (7%)
	Asexual	18 (6%)
		Toronto **n=219**

Primary Job Role	Management	59 (27%)
	Front-line Staff	139 (63%)
	Coordinator/ Administrator/ Other	21 (10%)

Table 4. Black and Mainstream agencies in Toronto; frequency # (percentage % [rounded]). *Note* that in some cases more than one survey participant was employed at the same agency; therefore, the true total number of participants is not represented in this table.

City	**Black Agencies**	**Mainstream Agencies**	**Total**
Toronto	78 (40%)	117 (60%)	**195**

Social Network Analysis

Interagency Partnerships in the Mental Health Sector

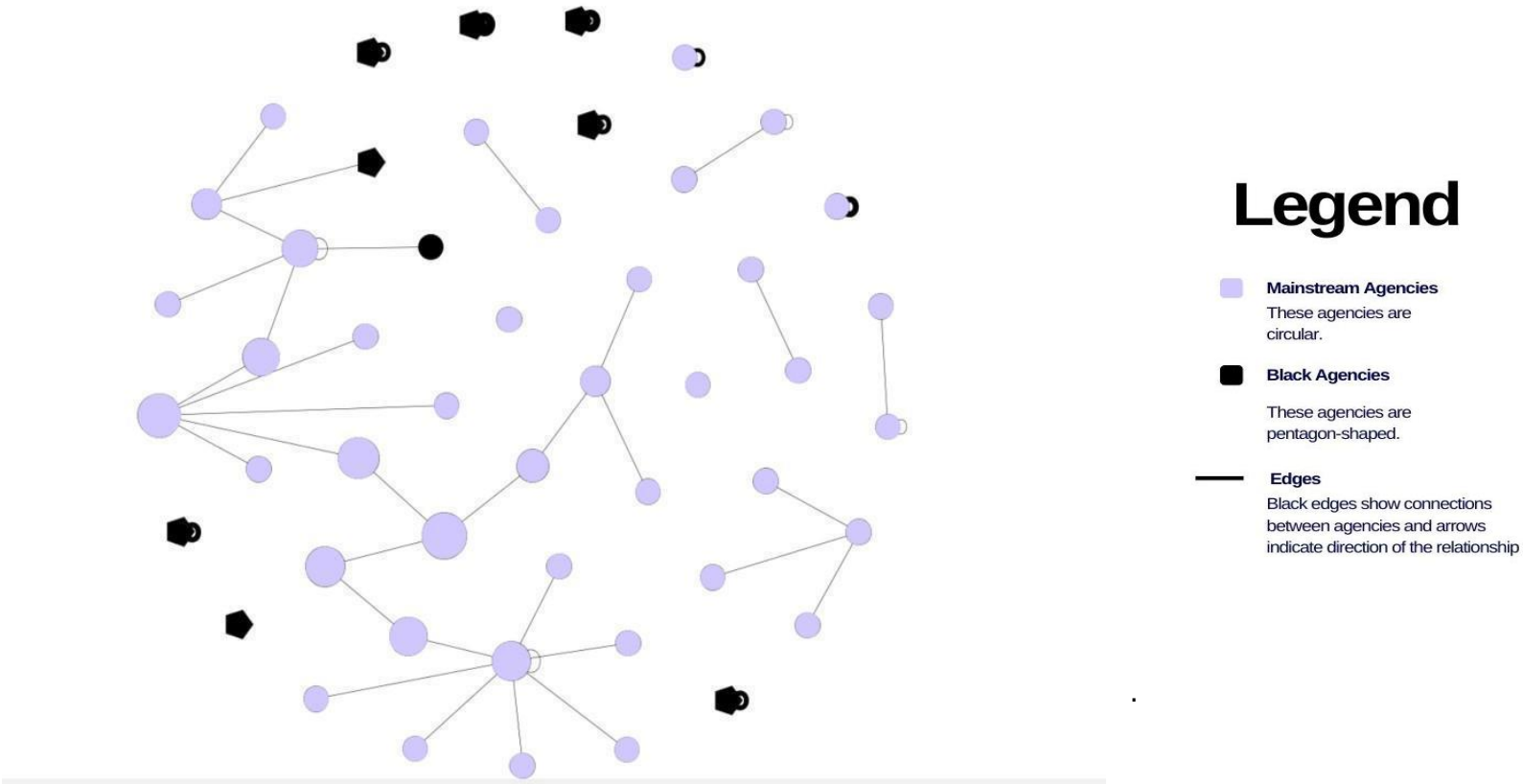

Figure 3. Social Network graph of past instances of interagency collaboration on mental health projects in Toronto, Ontario from 2019-2021. Node size was based on betweenness centrality scores. The small black semicircular shape on some nodes represents agencies that cited themselves as project partners.

From March-April in 2020, the COVID-19 pandemic and demand for services in Toronto were intensifying; despite that, collaboration between Mainstream and Black agencies was rare (see Figure 3 and Appendix 1). Mainstream agencies were overrepresented and often connected exclusively to one another and clustered in the centre of the network, while most Black agencies lay on the outskirts of the network, self-connected or isolated (see Figure 3). Black agencies disproportionally cited themselves as collaborative partners on mental health projects. The largest nodes represent those with the highest betweenness centrality scores (all Mainstream agencies); importantly, these nodes were *bridges*[1] that strongly influenced the flow of collaboration and communication between agencies.

There appeared to be a consensus amongst focus group participants about work in the mental health sector being done in siloes with agencies and clinicians having their attention hyper-focused on competing priorities, catchment areas, and their clients. Discussions highlighted the need for the centralization of resources and a governing body that is tasked with overseeing and maintaining interagency communication and collaboration at the national or provincial level (Table 5, Quotations 3, 4). Despite the ongoing conversations in the sector, within groups, and the array of initiatives and communities working on mental health issues, participants observed that transformative changes to the system did not occur since interagency communication was uncommon. This lack of interagency communication often resulted in similar work being replicated, while systemic causes and marginalized populations, such as Black youth remained overlooked. This poor continuity of care and siloed work led to a lack of systemic coordination which impaired action (Table 5, Quotations 1, 2).

[1] The *bridge* agencies with the highest betweenness centrality scores are the following: Griffin Centre, Humewood House, Skylark Children, Youth, and & Families, Boost Child and Advocacy Centre, Central Toronto Youth Services, and Youthdale Treatment Centres. *Note*: Adventure Place, The Etobicoke Children's Centre, Griffin Centre, and Skylark Children, Youth, & Families have amalgamated and are now one agency, Lumenus.

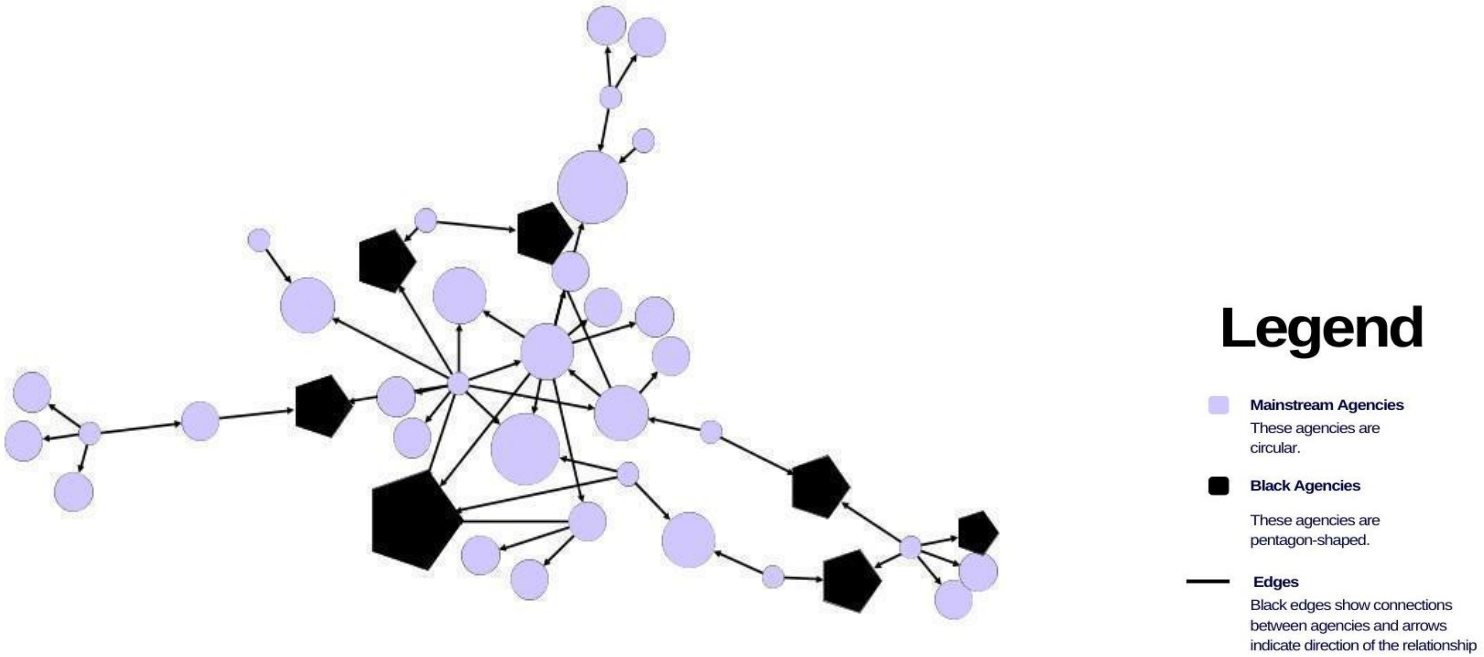

Figure 4. Social network of agencies' expressed interest in future collaborative partnerships with other agencies in the mental health sector.
Node size was based on in-degree centrality scores.
The arrows show the direction of the connection between nodes.

Future Interagency Collaboration

Most SNA survey respondents working in mainstream agencies did not express interest in future partnerships with Black agencies (see Figure 4). Though mainstream agencies outnumber Black agencies, there was some Mainstream-Black diversity among the largest nodes. TAIBU Community Health Centre was the largest node with four incoming connections because it was the agency identified most often as a future collaborator. Mainstream agencies primarily demonstrated interest in collaborating with each other; these agencies in Toronto were seen cited as potential collaborators.[2] These findings underscore the importance of fostering and sustaining stronger, more diverse interagency collaborations that could develop and expand culturally responsive care.

Clinicians felt ill-equipped to refer Black youth to appropriate services and voiced the urgent need for a connective intervention such as a community of practice or centralized database that housed a comprehensive list of resources and supported them in making referrals (Quotations 5, 9). Sharing information about agencies' characteristics such as fees and the availability of culturally appropriate services were also critical in ensuring clinicians felt confident in making referrals for Black youth (Quotations, 6-8).

Focus Groups

Mental Health Service Provision: Impacts of Anti-Black Racism

Focus groups held with Black youth suggest that they encountered negative experiences in the mental health care system (Table 5, Quotations 10, 11). In some cases, Black youth felt dehumanized by clinicians, which they attributed to clinicians' conscious and unconscious biases (Table 5, Quotations 12, 13). There is a tendency among clinicians to discredit and distrust Black youths' complaints regarding mental illness symptoms, particularly when they relate to mood disorders such as ADHD, depression, anxiety, or trauma while over-diagnosing them with conditions that manifest more

[2] These agencies were identified as potential collaborators: Black Health Alliance, TAIBU Community Health Centre, BlackCAP, Caribbean African Canadian Social Services, Black Legal Action Centre, Across Boundaries, Women's Health in Women's Hands, and Tropicana.

psychotic symptoms like schizophrenia and bipolar disorder. Black youth experience difficulties in communicating with and seeking help from clinicians for mental health issues when there is a disconnection between their symptoms and clinicians' beliefs about how symptoms present in Black people.

Black youth often felt that they had to be vigilant for signs that their clinicians may hold racist or stereotypical beliefs about Black people (Table 5, Quotation 12). Due to the systemic nature of ABR and its entrenchment in Canadian institutions, it seeped into the client-clinician relationship and influenced the experiences of Black youth when receiving care. Regardless of intention, clinicians' implicit biases often dictate how they understand and diagnose Black youth. Frequent microaggressions, ABR, dismissal of symptoms, and suboptimal care often acted as barriers that prevented Black youth from accessing care out of fear and disenfranchisement.

Increasing Black representation among clinicians was discussed in focus groups with Black youth as one strategy agencies can employ to provide culturally responsive care (See Table 5, Quotation 15). If clinicians can empathize with Black youth regarding similar challenges in life, candid conversations can occur, and continuity of care and appropriate diagnoses may be more likely. Focus group participants reflected on their desire for clinicians who shared a similar racial background and the potential impact that could have on their care experience (Table 5, Quotation 16).

Black youth stated that they wanted to work with clinicians who understood their culture and could relate to their specific needs and experiences (Table 5, Quotations 14, 15). However, there remains a lack of Black clinicians in Ontario's Mainstream agencies. Due to the power imbalance and lack of Black representation in the sector, service provision rarely meets the needs of Black youth. There was a lack of culturally responsive resources and treatment options that clinicians can use or recommend to Black youth and their families. Too often, Black youth tried to seek care but were met with clinicians who were ill-equipped to care for them and unaware of suitable referral options.

Black youth and clinicians noticed that complexity and continuity of care were issues that Black youth often encountered when trying to access mental health care. Youth who present with numerous behavioural issues or a history of violence were often deemed too complicated for clinicians to take on (Table 5, Quotation 17). The lack of support for youth as they transition from emergency to non-emergency care resulted in youth disengaging from care and feeling overwhelmed regarding next steps or how to reintegrate into society (Table 5, Quotation 18).

Table 5. Focus group quotations.

Number	Quotation	Participant, Focus Group #
Theme 1: Interagency partnerships		
	Sub-theme 1: Lack of collaboration in the mental health sector	
1	I feel like there was a point in the community when we were talking about continuity of care and then it's like it disappeared…After, you build that [trust]– bring all those walls down, do all that work, built all that trust. To have to change workers or you know, move to different programs or things like that. I'm not talking about the stuff that's beyond our control or beyond an agency's control… I think that's something that is often forgotten about because there is that stigma…that already exists around originally connecting to the service. And then once you're connected, you make all those connections you build that trust with that worker, and then it's like, I just feel like more and more there's this short-term service and… a lot, like a lot of change in workers and things like that and not as much care for that continuity of care and… like I just a lot of my students just come back and my clients come back and they're like, I am not explaining the story all over again, I'm done with this, but you haven't gotten to the end of the work and… they agree and we connect with the new service and the new worker and that was hard work to connect them to the first one and they're on to the second one and somehow we got to that meeting and then you know, maybe that person doesn't understand or they experience those barriers are all over again because they're passed around to a different service… Black youth that I've worked with, I know they'll say like 'yeah no, I'm done.' It's like the system is not set up [for their needs]. They'll be pretty much saying, "the system is not set up like for me or my needs," and while you want to say something different… It doesn't always feel that way, even for me. It's hard to sometimes convince them to keep going in that system	Kayla, Clinicians, FG1
2	They're in their silos, right. Everybody has their family of schools, and they go around and do their reports. Now, I happen to be placed in the school group, one of the two school groups where there is probably the largest population of BIPOC youth.	Ebony, Clinicians, FG20

3	I just wanted to go back to that point about resources. I think there's a lot of really great grassroots initiatives happening across the country but there needs to be this centralization of resources because… I'm sure there's amazing work happening, but I would love for us to somehow have this platform to be able to know that this is stuff happening so that we can connect to better serve the communities affected.	Aisha, Clinicians, FG2
4	Because, like with us there's an organization that basically has the funding to facilitate the community of practice and it's gonna be hard because there's no one person who's going to want to take on a lot of extra work so I think there's needs to be an organization that kind of mans this going forward, whether it's your organization or another that kind of keeps this alive provincially all the way through and it should provincially.	Donna, Clinicians, FG2
	Sub-theme 2: Interest in future interagency partnerships in the mental health sector	
5	I don't have a resource I can give somebody that's culturally appropriate in every region...Maybe if [Blinded] could even create like a COP, like a community of practice where there are certain agencies that sit at that table to kind of drive this work forward to better understand what this should look like so it's continuous and doesn't just stop.	Donna, Clinicians, FG2
6	The best predictor of successful management of your mental health is having a trusting therapist that you can talk to. So, if you don't have that connection, if you don't trust them, they don't look like you and you feel even perhaps more judged or even when you're in their presence and you can't bring that connection like how is that therapeutically beneficial? So, I would prefer… to have some sort of list within all of the regions, where I do work there's a lot of young people who can connect to the service across the province? So, it can be someone from Brampton, from Peel from Durham, from Simcoe and I don't know. I would love to give them… I can give them a general list of publicly funded resources. But also, to highlight PS If you want something more culturally appropriate like this is the organization to go to.	Liza, Clinicians, FG2
7	Liza: Even for some of these individuals they can pay private, maybe through work or whatever and I don't have a list to give them, and I'm like 'oh great! You want one? Like I don't know where there is maybe a psychotherapist in the Vaughan Area for them, so a directory would be fantastic.	Liza & Aisha, Clinicians, FG2

	Aisha: And now so many of the clinicians are going online, right? And they have new capacity, so this is a great to kind of make this more possible-	
8	I also think that part of the solution is information sharing and I think it was [another participant] that was saying that sometimes she doesn't know how to refer or where to refer to when people are in need, and I think that somehow we need to be able to be more visible when it comes to where we are in terms of resources.	Katrina, Clinician, FG9
9	We also need to tell people, this is people you can call whether they call SAPACCY, whether they call Delta resource centre, whether they can call CAFCAN and say okay I need help. I am recognizing this; they could be some centralized database…We can just type up and pull up like okay this is where people find you know who to call. If you're in crisis? You go to the [organization's] website and they have a list of different places to access care and someone who can ---I volunteer bank of people who just willing to say okay, BAM. Like um the Kids Help Phone. And we can say BAM this is the Black Help Line [sic]. The Black HelpLine phone. You can call and we will find somebody to help you, twenty-four-seven, no matter where we are. We need some sort of a robust system, and that's my big dream. Big dream!	Tammy, Family & Community, FG3
Theme 2: Mental health service provision to Black youth		
	Sub-theme 1: Negative experiences in mental healthcare	
10	I've had a lot of negative experiences with psychiatrists. …especially as a person of colour. They will look at you and will be like, '…there's no way you have ADHD.' Like that's something that white boys have... It's not something that Black women deal with. And then, like, they will look at the symptoms that you have and try and match it to the DSM. And all of a sudden you will be diagnosed with bipolar or schizophrenia because women of colour are generally over-diagnosed with schizophrenia or bipolar, even if they don't have it. How do you present yourself to a doctor who is now thinking that you might have bipolar, or schizophrenia when it's like trauma? You know, or anxiety and depression and ADHD. But now you kind of get stuck in a cycle of having to explain yourself.	Alex, Black Youth, FG4

11	I wonder if this whole awakening when it comes to anti-Black racism is going to like, continue to I guess happen? Because even just going through, like the different systems and programs available in regard to mental health in Toronto. My race is always seen as an afterthought. Even though being Black is not all who I am, it is a significant part of me. and I feel that sometimes it's not treated as something---like the barriers that I face and the situations that I face. That it's not seen as an integral part of all the things that I have to deal with.	Jalisa, Black Youth, FG4
12	Usually when you are going to a non-Black counsellor, and you are talking about mental health. You have to explain why you can't talk to your family or your community about it. It's like "why haven't you talked to your parents?" and I am like "my parents aren't supportive" and they are like "have you tried talking to your parents again?". "Yes, I have!" You know it's like I live with them. You aren't going to tell me what I know, I know them more than you. And also, just experiences as a Black person, you know why you have some fear being the only Black person in a space. Um, fear of the police, you know you have to explain those things, and it's just why am I teaching you? Why? [laughs] You are the counsellor, shouldn't you have some training or something? You know? Have someone who's Black in your network? It's frustrating.	Bella, 2SLGBTQ+ Black youth, FG5
13	I guess I was experiencing gaslighting by this white mental health professional, navigating the role of a 6-foot dark-skinned Black man and saying that I am being followed, or under [more] scrutiny than other populations, and they are saying "how do you know you are being followed" or "how do you know you are being watched?" [I] just constantly have to explain that is very exhausting.	Sam, 2SLGBTQ+ Black Youth, FG5
	Sub-theme 2: Desire for more Black clinicians	
14	That's the main thing for me. I don't know about others, but someone who understands-someone with similar background, lived experience so they can connect, and they understand the terminology, and the vocab. They understand like… the person would make me feel more like myself?	Gigi, Black Youth, FG4
15	I think pushing and financing the Black people-- the young Black people to go into the medical field. To go into the mental health field, because that's how I feel that things are eventually going to change.	Shawn, 2SLGBTQ+ Black Youth, FG5

16	The biggest barrier, again, it's like you know for people around me, I think our skin colour for sure, are we going to find someone that looks like us that could speak to our names and help us unpack and be blunt in an objective and healthy way?	Lisa, Youth and Justice, FG7
	Sub-theme 3: Agencies' unwillingness to treat multiple and complex needs	
17	It's funny, like the people that need the most help have the hardest time getting it because there's so many issues, no one wants to take ownership of that person and say, 'yeah, I will treat them.' It's like, no, you're too complex for me. So, I don't know where you fit in. But you don't fit in here. I find that happens a lot, especially with folks with […] a violent history, behavioural issues…They can't get through the door, you can't have the help."	Mary, Clinician, FG1
18	I think that one of the biggest things is like "ok great…we can give her care, we can give her emergency care, we can give continuous care" but there shouldn't be these separate entities like there should be a connection? … Yeah it's great to get that emergency care great but …that person's ready to enter the world and function but it's not a switch. [It] isn't you switch me on and I'm good for the rest of my life, I have to have an learn the skills to be good ... so yeah... like if I don't have somebody holding my hand and that's the only way I've learned to do things how am I going to do things if someone is not there anymore? So really there's a disconnect with services I think and it's really not helping. While I do think it's great there are networks. I think that that's super important because if one place isn't super great or a perfect fit it's nice to know where else you can go that you may not have to start immediately from square one again... I also think you know ... individual data is really overwhelming and daunting. Getting thrown thousands and thousands of resources, great it's good to know they're there but it's just sort of paralyzed by choice effect and we don't know where to start.	Thea, Youth Action Committee, FG6

Discussion

Despite clinicians' interest, interagency partnerships were rare in our study, particularly between Mainstream and Black agencies. This could lead to Black youths' mental health needs being neglected by Mainstream and Black agencies. Black agencies are often tasked with providing mental healthcare and meeting youths' basic needs with comparatively limited funding, reach, and political capital. Mainstream agencies were seldom interested in serving as collaborators or official project partners with Black agencies. In focus groups, clinicians identified barriers to interagency collaboration, such as their lack of cultural awareness, siloed work, competing priorities, and weak commitment from leadership to address ABR. These findings corroborate results from other high-income regions which identified similar interagency barriers to collaboration.[34,35] Complemented with clinician's focus group data, a clearer picture of the interagency relationships and areas of weakness in the mental health sector emerged. Long-term collaboration between agencies and more inclusive hiring practices (See Table 5, Quotation 15) were viewed as imperative to provide Black youth with mental health services that are culturally responsive. Given that agencies have unique missions, interests, resources, and areas of expertise, interagency collaboration is key to maximizing efficiency, service delivery, and client satisfaction for Black youth and families. Additionally, clinicians need to deliberately re-examine their praxis, culturally adapt tools and resources, and continuously combat ABR in their work. This could bolster their recovery-oriented practice and produce improved mental health outcomes for Black youth.

Focus groups conducted with Black youth highlighted their desire for Black representation among clinicians. Findings indicated that for Black youth, working with a clinician who had a shared lived experience and racial background, helped them feel seen and increased trust. Black youth expressed frustration with experiencing ABR, and having clinicians dismiss their symptoms and reduced them to behavioral or psychotic issues (see Table 5, Quotation 5). Cokley et al.[36] observed that Black students were mainly referred to one specific clinician when they presented with anger issues, and after in-depth conversations with Black youth, that clinician noticed that depression manifested differently, for instance as behavioural concerns for Black students. This indicates that some mental health symptoms may be a manifestation of clinicians' ABR and internal biases that incorrectly construct Black youth as erratic, angry, and dangerous. The findings speak to the need for increased attention to how ABR is both structural and structuring in mental healthcare environments; it shapes the system and services including barriers to care, and it impacts how Black youth are perceived, diagnosed, and treated. There is an urgent need for consistent ABR training for mental healthcare staff, and for continual review of policies and practices in mental healthcare settings to ensure that they do not uphold ABR and exacerbate the marginalization of Black youth. Anti-racist solutions, along with the transformation and integration of mental health systems are foundational to recovery-oriented practice.

The fourth dimension of the Canadian recovery guidelines[20] briefly highlights the need for clinicians to reflect on race's role in recovery and their internal biases to provide culturally responsive care to all racialized communities. This study builds on the existing guidelines for recovery-oriented practice[20] by delineating how ABR in particular acts as a systemic barrier to the building and sustaining of organizational partnerships in the mental health sector. These guidelines recognize the general impact that racism and discrimination have on access to mental healthcare and quality of care for Indigenous people in particular given their history of colonization and intergenerational trauma.[20] However, a section dedicated to recovery-oriented practice for Black communities is missing. Despite abysmal national awareness and attention, Black enslaved people were present in Canada for over 200 years. Since then, ABR has evolved and given rise to entrenched intergenerational trauma, chronic stress, and a myriad of economic and health inequities.[23] Future recovery oriented-practice guidelines and resources need to move beyond merely identifying race as a SDOH, to highlighting racism's systemic nature with a focus on how ABR manifests at the client-clinician and organizational levels. Evidence-based and culturally responsive tools that can guide clinicians and leadership step by step are needed.

Most Black agencies in our study region are local and lack the resources and political capital required to expand, conduct program evaluations, and offer high-quality mental health services. These Black agencies often provide mental health services due to the demand and the immense trust communities place in them, in addition to other essential services such as food programs, religious services, housing support, and education. The multitude of services being offered, and funding constraints often result in decreased quality of care and short-term services for Black communities. The Community Foundations of Canada[37] reported that despite comprising 3.5% of Canada's population, Black-led and Black-serving organizations were chronically underfunded, receiving an abysmal 0.03% and 0.015% of funds respectively between 2017-2018. In response, funders[36] have pointed out that supports offered by mainstream agencies can be used to serve everyone. This type of discourse insinuates that culturally responsive services for Black populations are not requisite. In contradiction, this study demonstrated that Black youth recognize that trust is an integral component of the client-clinician relationship and highly funded mainstream agencies were failing to meet their needs. Despite these challenges, a few [Blinded] agencies have persevered and acquired funding to expand mental health and addiction services

for Black youth regionally[3] and nationally.[4] Increased interagency, particularly Black-Mainstream collaborative efforts such as these are urgently needed to demonstrate to Canadian governmental decision-makers and funders that Black mental health services are necessary, effective, and can be scaled up to make transformative changes to our mental health system.

This work provided a snapshot of interagency collaboration in the mental health sector; it also unearthed clinicians' attitudes towards future interagency work. All survey participants directly worked with Black youth in their role at their agency. Interagency collaboration between Black and Mainstream agencies was uncommon, with most Black agencies being isolated from the network (see Figure 3). In contrast, some clinicians self-reported interest in future collaboration with certain Black agencies, hence the larger size of the Black nodes and the interconnectedness of the graph (see Figure 4).This study's qualitative findings contextualize the siloed and homogenous nature of interagency work in Toronto's mental health sector. Black youth recounted negative care experiences rooted in ABR and called for increased clinician representation and preparedness to treat Black youth with complex needs.

Building interagency and community-based partnerships is an integral part of the recovery process; this is evident in the Canadian recovery guidelines, but racism is not explicitly identified as a SDOH. ABR is likely a strong barrier to interagency collaboration and community partnerships between Black and Mainstream agencies. To provide culturally responsive care, recovery-oriented practice guidelines need to recognize ABR as an SDOH that shapes recovery and intersects with other determinants that impact mental health outcomes, care quality, and access.

Limitations

There is currently no comprehensive national list of clinicians, which initially complicated recruitment planning. However, our partnership with 211 Central facilitated the creation of a verified list of agencies and leadership contacts who were able to connect us to clinicians. While non-probability sampling methods are cost-effective and advantageous when used in exploratory research that focuses on populations with specific characteristics,[32] the use of this sampling approach in our survey recruitment means the results are not representative of all clinicians or agencies in Toronto, Ontario. COVID-19 protection measures that increased clinician workload, burnout, and turnover were factors that may have affected survey recruitment.

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[3] Centre for Addiction and Mental Health. Mental health program supporting Black youth is expanding after years of advocacy [Internet]. CAMH News & Stories. 2022 [cited 2022 Aug 12]. Available from: https://www.camh.ca/en/camh-news-and stories/mental-health-program-supporting-black-youth

[4] Kids Help Phone. New partnership: Kids Help Phone & BlackNorth Initiative [Internet]. 2021 [cited 2022 Sep 25]. Available from: https://kidshelpphone.ca/publications/new-partnership-kids-help-phone-blacknorth-initiativ

Exploring factors that may have influenced interagency collaboration and the characteristics of agencies that were labelled leaders in the sector were outside the scope of this research. Future research should involve larger sample sizes and focus on identifying causal factors associated with greater interagency collaboration between Mainstream and Black agencies. Additional longitudinal studies and evaluations that assess the effectiveness of current services that cater to Black youth are warranted. Study findings should be interpreted with caution as explanatory inferences about interagency collaboration cannot be made with a non-random sample.

Focus groups were held virtually to minimize COVID-19 risk. Therefore, some youth may have moderated their responses given their shared housing environments and the likelihood of being overheard. Individuals who did not have access to technology or reliable internet may have been unable to participate. Collecting qualitative and quantitative data virtually was advantageous in reaching busy clinicians and increasing the accessibility of participation for Black youth and family members with disabilities or flexible work schedules.

Future Directions

These guidelines[20] indicated that collaborative partnerships between mental health agencies and other sectors can improve access to mental health and social services as communities contain diverse resources, knowledge, and skills that can expedite recovery.

Focus group findings, built on the SNA findings, demonstrated how ABR translates into negative care experiences, and highlighted areas that clinicians can target for evaluation, inclusive praxis, and collaboration with Black agencies. This study contributes to existing recovery-oriented research by elucidating how experiences of ABR can impact the recovery journey and identifying potential areas clinicians and leadership can target to instigate change.

Additional quantitative research that explores potential causal factors such as ABR involved in building multisector and interagency relationships in the mental health sector is needed. This research can complement larger studies that focus on the quality of mental health service provision and experiences of Black youth in Mainstream and Black agencies in other cities in Ontario. Additional research that focuses on Black agencies and clinicians is required to explore their perspectives and interest in collaboration with Mainstream agencies. Research grounded in a community-based participatory action approach[26] that meaningfully involves youth in all phases of the research process and explores the richness of Black youth's care experiences is needed.

In partnership with [Blinded], data from this study is being used to develop an organizational practice framework and clinical practice framework which can be used by clinicians and leadership interested in recovery-oriented practice for Black youth.

Implications for Clinicians and Leadership

The findings and critique of the Canadian guidelines for recovery-oriented practice have important implications for clinicians and leadership at mental health agencies. Despite uptake of these findings, Black youth, demonstrate that their recovery is impeded as it is shaped by experiences of ABR and chronic stress. First, clinicians and leadership should adhere to the existing guidelines for recovery-oriented practice, while recognizing that to meet Black youth needs, they need to be complemented by building Black-Mainstream partnerships, using and developing culturally adapted tools, extensive ABR training, culturally adapted therapeutic modalities, and staff with lived experience.

Leadership needs to foster a culture of respectful collaboration when building partnerships and engaging with Black communities. This can be accomplished by requiring the collection of race-based data, sharing data with Black agencies, and supporting their program evaluations. Race-based data can be used to inform effective service development by assessing needs and gaps for Black and racialized populations. Accountability and transparency are integral to this systemic change, which can involve the creation of formal methods of providing feedback, complaints, suggesting organizational changes, addressing community concerns. Ultimately, leadership should actively model inclusive and anti-racist recovery-oriented practice for clinicians and all staff.

Conclusions

The results underscored the lack of interagency relationships and disinterest in building Black-mainstream partnerships to address mental health issues in the sector. The harmful and systemic impacts ABR has on service provision and care experiences of Black youth were also revealed. These findings can inform organizational policy, program evaluation, and strategic planning to establish and sustain interagency communication and collaboration between Black and Mainstream agencies. Black youth and clinicians repeatedly identified racism as a formidable barrier to care both at the system and at the individual or client-clinician level. Despite the widespread adoption of the Canadian recovery-oriented practice guidelines, recovery for Black youth has remained elusive. Future research and program evaluation can build on this work by studying the factors that have facilitated the building of strong interagency and community partnerships which are integral to the recovery process for Canadian Black youth. To become inclusive and culturally safe for Black youth, the next iteration of the Canadian recovery-oriented practice guidelines needs to frame Black mental health access and outcome disparities as systems level issues that warrant systems level solutions.

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Ethics Approval

All research activities and procedures were reviewed and approved by the Community Research Ethics Office [CREO project #[Blinded]].

Authors' Contribution Statements

[Blinded] led the writing of the research paper, survey data collection, and the social network analysis. [Blinded], Project Manager of [Blinded], edited the document and collaborated on content decisions. [Blinded] led the collection and analysis of the focus group data, they also collaborated on content decisions and edited the document.

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