

Barriers to Mental Health Care for Racialized Newcomers in Canada

by

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B.A. (Hons.), University of Western Ontario, 2004

M.Sc., University College London, 2006

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Supervisory Committee

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Abstract

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This thesis explores the barriers to mental health care that new, racialized Canadians may face. Using a case study methodology, this project first reviews the literature on identified barriers to care. Several barriers are highlighted in this process including discrimination and racism, service use, language, awareness of services and knowledge of the Canadian healthcare system, socio-economic barriers, cultural beliefs, and stigma. Interviews were conducted with three new Canadians who identify as racialized to further existing knowledge on this topic. The interviews provided a forum for participants to speak to their experiences prior to immigrating to Canada, their experiences following immigration, and their pathway to mental health care. Participants described significant events which they believed to be factors in developing a mental health problem and as a result of this, their decision-making process in help-seeking.

Using the categories from the literature as a framework, themes and sub-themes were developed to understand the experiences of the participants. Additional themes that were added included employment, coping with a mental health problem, and trauma. An in-depth, line by line analysis of the interview transcripts was conducted to provide a detailed depiction of each participant's experience. Each participant interview was defined as a case and compared with the other interviews. This thesis concludes by

summarizing the results and detailing the implications for social work practice.

Implications include anti-oppressive practice, cultural competence, and self-awareness.

Structural and clinical implications are also discussed.

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Chapter 1: Introduction

According to the 2006 Canadian Census, almost 20% of the population were born outside of Canada and this is expected to increase to 25% by the year 2031 (Ng, 2011, p. 2).

Although the diversity of new Canadians is immense, as of 2006 immigrants are predominantly from Asia, Africa, and Europe. Moving to a new country can be a very stressful event in one's life. This is especially true if moving to a country whose practices and customs as well as language are different than that one is most familiar with. The reasons people move to a new nation vary and can include looking for better work or educational opportunities, following a family member, or perhaps escaping a country that is challenged with war, poverty, and other stressors. Whatever the reason may be, immigrating to a new country can be stressful and this stress may result in the development of a mental health problem such as depression or anxiety.

One study, for example reported that refugees are more likely to suffer from psychological distress, post-traumatic stress disorder and depression than their counterparts (Porter and Haslam, 2005, p. 607). This increase may be correlated with the social determinants of health such as poverty and unemployment but may also result from pre-migration stress such as torture, rape, and war (Fornazzari and Friere, 1990, p. 258).

The healthy immigrant effect is a concept which describes how newcomers to Canada are typically healthier (physically and mentally) than their Canadian counterparts (Ng, 2011, p. 1). The Canadian Community Health Survey (CCHS) demonstrates such a phenomenon as it shows new Canadians have lower rates of depression than other Canadians (Ali, 2002, p. 3). Although this appears to be true in many instances, this same

study also shows that for second generation Canadians, the rate of mental health problems increases significantly. Furthermore, other studies have shown that second generation Canadians also have high rates of harmful behaviour such as drinking and drug use (Hamilton et al., 2009, p. 223).

Considering that new Canadians (defined as being in Canada for ten years or less) can suffer from mental health problems (as a result of immigration or not), services should be offered in Canada to meet the needs of this important group. Access to care for new Canadians may be impacted by barriers that limit their ability to seek help and several research studies have shown this to be the case (Lai and Chau, 2007, p. 5). Using a case study methodology, this thesis seeks to understand what the barriers to mental health care are for new, racialized Canadians. To do this, a literature review was conducted to learn about what other researchers have reported, as well as in-depth interviews with three participants who have each been in Canada less than ten years and have utilized the mental healthcare system. These stories demonstrate the interlocking ways pre-migration, migration, and life in Canada can impact one's mental health. After reviewing these life stories, participants share what their pathway to mental health care consisted of and barriers they may have faced along the way to achieving appropriate care. Their experiences coupled with findings from the literature review will be used to identify what barriers—both systemic and personal—may be in place which hinders new racialized Canadian's ability to receive appropriate mental health care.

Chapter 2: Definitions and Literature Review

Definition of Terms and Concepts

There are many terms used to define someone “new” to Canada. Terms found in this thesis include immigrant, newcomer, new Canadian, and refugee. Most of these terms are used interchangeably (with the exception of refugee which is separate). For the purposes of this thesis, the first three terms encompass a person who has resided in Canada for ten years or less. Sometimes the word ‘immigrant’ is critiqued as there appears to be no expiry date. In other words, people may have lived in Canada for 20 years but are still referred to as immigrants but mainstream society because they were not born in Canada. Therefore, terms such as recent immigrant (a Canadian Census word meaning in Canada for five years or less), or new Canadian are used to decipher that someone has arrived in Canada relatively recently. As the word ‘immigrant’ is most common, it is used throughout this thesis but is synonymous with new Canadian and newcomer.

Refugee is separate in that immigrant is typically a person who arrives in Canada because they wish to live or work here or because they were sponsored by a loved one to move here. A refugee includes a person who is leaving their country due to political violence, war, or other event which puts their life in danger. Two of the participants in this project arrived in Canada and claimed refugee status at the border which means when they arrived, they asked the Canadian government to grant them refugee status which would allow them to stay in Canada and be granted residency (which provides health insurance and, if necessary, financial assistance).

This thesis specifically speaks to the experiences of racialized new Canadians rather than all new Canadians. This does not mean that non-racialized new Canadians do

not experience barriers to care – including some of the barriers to care identified in this thesis – however, this thesis deconstructs some of the additional barriers and social determinants that only impact or predominantly impact people of colour in Canada which adds to the difficulty of seeking mental health care and which limits their ability to seek appropriate mental health care. The term racialized is used throughout the thesis rather than terms such as visible minority because it speaks to the experiences people of colour have during the process of discrimination and/or racism. In essence, it speaks to the social constructs that occur during racism and discrimination rather than solely the characteristic of one's skin colour.

Literature Review

The literature review looked at peer-reviewed articles using indexes as well as grey literature such as agency reports. Electronic indexes used to find these articles include Pubmed, PsychINFO, Google scholar, and MEDLINE. Although the literature is minimal in describing barriers to mental health care in immigrant groups in Canada, there are many papers which highlight various factors that contribute to this experience.

Factors include language, awareness of services, socio-economic factors, discrimination/racism, cultural beliefs, and stigma.

Discrimination and racism

Unfortunately, discrimination and racism are experienced by many new Canadians and this not only impacts their mental health, but immigrants may encounter various kinds of discrimination when navigating the healthcare system. For example, Beiser, Simich, and Pandalangat (2003) reported that 11% of their sample had experienced some kind of

racial discrimination during previous encounters with the health care system which made them less likely to seek care (p. 237). Furthermore, Li and Browne (2000) found that 45% of the Indian, 35% of the Filipino, and 5% of Chinese participants reported having experienced discrimination due to their race (p. 150). New Canadians may feel discriminated by not feeling heard in a healthcare setting or by experiencing less access to appropriate services.

Service Use

Before exploring what the literature reports about the types of barriers to care, understanding mental health service is important in identifying why this topic is of such importance. When thinking about service use, it is not only important to view in terms of how many people are accessing care, but whether or not that care is appropriate and equitable. Chen, Kazanjian, and Wong (2009) write that the mental health needs of Chinese Canadians (as well as other new Canadians) are not being equitably met (p. 624). They also report that Chinese Canadians (particularly those over the age of 55 years) are less likely to consult mental health professionals than non-immigrant Canadians. Chinese Canadians are also less likely to be hospitalized for a psychiatric condition than non-immigrant Canadians (p. 625). This is mirrored in a study from the United States that found this population (older Chinese immigrants) to under-utilize mental health services in that region as well (Abe-Kim, et al., 2007, p. 94). One Canadian study found that 11% of Canadian-born, non-Chinese participants contacted a mental health professional in the past 12 months whereas only 2.9% of immigrant Chinese participants did (Chen, Kazanjian, and Wong, 2009, p. 631).

A study in the United States found that among Latino immigrants, only 15% received any type of mental health treatment which is less than American-born Latinos (Caplan, et al, 2011, p. 590). O'Mahony and Donnelly (2010) found that immigrant and refugee women were less likely to seek care or receive equitable care for post-partum depression in Canada (p. 918). Finally, a study by Schaffer et al. (2009) found that immigrants with a diagnosis of bipolar disorder were less likely to receive care compared with the Canadian population (p. 739). Immigrants in this study were about one-half as likely to have had contact with a psychiatrist (20% compared with 42%) as well as less likely to have contact with any other mental health professional (11% compared with 32%) (p. 739). The above studies show that immigrants – especially racialized immigrants – access mental health services less than the Canadian population.

Language

According to the 2006 Canadian Census, 20% of the population (or just over 6 million people) do not speak English or French as their first language (Statistics Canada, 2006a). In one study, participants (consisting of Chinese and Tamil seniors) reported that they were regularly required to bring their own language interpreters to appointments which often included their family members (Sadavoy, Meier, and Ong, 2004, p. 195). This is problematic as they may not wish to disclose personal information in front of their family members or perhaps their family members were unable to properly interpret the information correctly (Donnelly et al., 2011, p. 283). Wang (2007) found that 88% of Chinese participants reported choosing a Chinese-speaking family physician (in Toronto) and being able to converse in a Chinese language was one of the most important factors in choosing a health care provider (p. 4).

O'Mahoney and Donnelly (2010) write that for immigrant and refugee women who are unable to converse in English or French, training may not be an option as they may need to stay home to look after children, have insufficient income to attend classes, and a lack of social support (p. 924). Lai and Surood (2010) reported that 37% of South Asian participants found language barriers to be a factor in seeking mental health services (p. 254). As demonstrated, the literature clearly shows that immigrants who are unable to speak English or French well are less likely to receive care for a mental health problem. Furthermore, the literature illustrates that the mental health care system is not adequately providing interpreters or translators for clients unable to converse in one of Canada's official languages.

Awareness of services and knowledge of the Canadian healthcare system

Studies show that some immigrants may not be aware of mental health services available to them, or perhaps do not understand how the mental health care system works (SAFE, 2003). Beiser, Simich, and Pandalangat (2003) found that 21% of Tamil participants wanted to seek mental health care but were unsure where to go (p. 241). This study also reported that participants had a mistrust of the healthcare system due to prior negative experiences. Donnelly et al. (2010) found that Sudanese and Chinese participants were more likely to seek help if they trusted "Western biomedicine" and its ability to treat mental illness (p. 282). For many participants, they did not seek help until their condition was relatively severe perhaps requiring hospitalization. These women expressed a fear of being diagnosed with a disorder and the consequences of this (e.g. deportations, separation from family, etc.) (p. 282).

Sadavoy, Meier, and Ong (2004) found that among Chinese and Tamil participants, there was a low level of awareness of available formal mental health services however, there was more knowledge about community-based programs (p. 195). Only when participants were in severe need of mental health care did they consult a hospital. There appears to be a gap between the services immigrants require and the services and programs they are aware exist. Reitmanova and Gustafson (2009) conducted an environmental scan of mental health care providers that cater to immigrant populations in St. John's, Newfoundland and found that there were almost no services available (p. 617). They also write that the pamphlets used to describe available services were only written in English and French and that none of them "considered that immigrants may hold beliefs about the meaning and management of [mental health problems] differently than the Canadian-born population".

Socio-economic barriers

Although in Canada there are provincial insurance programs which cover the costs of most medical (including psychiatric) services, there are services it does not cover and there are additional expenses that are incurred which can prevent new Canadians from seeking help. For example, many provinces impose a three-month delay after arrival into Canada to receive health insurance. Therefore, depending on the province someone may have moved to, they will have to pay out-of-pocket should they require health care. For some newcomers, they may be excluded from healthcare altogether if they are in Canada as a temporary worker, foreign student, visitor, or undocumented migrant (Oxman-Martinez, 2005, p. 252). The Canadian Research Institute for the Advancement of Women (2002) report that new immigrants are ten times more likely than Canadian-

born individuals to identify barriers such as transportation and costs related to seeking help (no page). Costs may include childcare or medication expenses. Similarly, Lai and Surood (2010) reported that 27% of their participants identified that costs related to services and transportation were significant barriers to seeking care (p. 254).

Cultural Beliefs

The mental health system in Canada privileges Euro-centric values and practices and this may conflict with new Canadian's belief systems. For example, immigrants may prefer to be treated by natural therapies (which are not covered by provincial health plans) or perhaps they understand their mental health problems in a non-medical way. Reitmanova and Gustafson (2009) wrote that there is a lack of recognition and accommodation of spirituality and religion in the biomedical mental health treatment model (p. 620).

Additionally, Caplan et al. (2011) reported on the instance of religious and supernatural causal and treatment beliefs in Latino immigrants. This study found that about a quarter of participants believed that supernatural items such as the Evil Eye and witchcraft caused mental health problems (p. 599). Similarly, Viladrich (2007) reported that spells and hexes for the purposes of retaliation may be understood by some Latino immigrants to cause mental health problems (p. 315).

Cultural beliefs may also be related to a client believing that a health practitioner does not understand their culture or cultural practices and therefore may be unable to provide help. Lai and Surood (2010) reported that 36% of their participants felt that mental health professionals did not understand their culture and this acted as a barrier to care (p. 254). Participants in another study found diagnostic instruments to be irrelevant to their cultural understanding of the world and family relationships (Reitmanova and

Gustafson, 2009, p. 620). Chen, Kazanjian, and Wong (2009) write that traditional Chinese culture often encourages the “suppression of individual feelings in order to maintain collective harmony” and this may conflict with a Western approach that emphasizes individual identity or medical treatment (p. 635).

Stigma

Stigma can be defined as feelings of shame or embarrassment about suffering from a mental health problem which many entail negative stereotyping about one’s mental health (Caplan et al., 2011, p. 592). Stigma can be felt within society-at-large or within one’s own family. In one study, immigrants often downplayed the severity of their mental health problems and were too embarrassed to visit with a mental health professional (Reitmanova and Gustafson, 2009, p. 619). Participants in this study also found that the diagnosis of having a mental illness further marginalized them. Donnelly et al. (2011) reported that participants avoided seeking help due to a fear of discrimination and stigmatization by people from their own ethnic community (p. 282). A fear of being shunned or ostracized by one’s community was described.

Finally, Chen, Kazanjian, and Wong (2009) wrote that stigma in the Asian community is a deterrent to seeking mental health help (p. 635). In this group, mental illness may be linked to punishment for offenses committed either by the patient or family and results in significant shame and is considered “moral weakness”. Seeking treatment only reaffirms that failure and the client risks being rejected by their family

Chapter 3: Methodology and Methods

Methodology

Case Study Methodology

This thesis used a case study methodology as a way of learning about how racialized newcomers to Canada have experienced coming to Canada, living with mental health concerns, and entering the mental health system. Case studies are ideal when a “holistic, in-depth investigation is needed” (Tellis, 1997). According to Yin (2003; as cited in Baxter and Jack, 2008, p. 545), case study design should be considered when the researcher wants to “cover contextual conditions because they believe they are relevant to the phenomenon under study”. This study is mainly interested in the barriers to mental health care that new, racialized Canadians face, however these barriers are explored within the context of their immigration experiences as well as how social determinants such as income or discrimination may have influenced this process.

Tight (2010) writes that a case can be “just about anything” (p. 336). For this project, the cases are the three participants as it is their stories that are reviewed and analyzed in depth. Although the topic of interest and overarching theme are the barriers to care, this is explored by conducting a detailed analysis of each participant’s interview. An important concept of case study research is defining the case(s) in addition to determining whether the project will utilize a single or multiple case approach. This project used a multiple case approach in that it predicts contrasting results (between the participants) but for predictable reasons (Baxter and Jack, 2008, p. 550). Therefore the

case study is still about barriers to mental health care, but the experiences of each participant can be contrasted.

In traditional case study methodology, multiple sources of data are used to bring out the details of each case. Data sources may include documents, interviews, archival records, physical artefacts, and direct or participant observation (Baxter and Jack, 2008, p. 554). For the sake of this project, only in-depth interviews were conducted as other sources were not deemed to add much substance. For example, one possible data collecting tool could have been providing surveys or questionnaires to racialized, new Canadians to determine what barriers to care they may have encountered within the mental health care system. However this information would have missed the context of their life experiences that the interviews provided. Other data sources such as observation or archival records were not applicable for this study.

Robert Yin and Robert Stake have each worked and written extensively about case study methodology. Yin identified some specific types of case studies: exploratory, explanatory, and descriptive (Yin, 1993 as cited in Tellis, 1997). Explanatory case studies are used if the researcher wishes to answer a question that explains causal links in “real life interventions that are too complex for survey or experimental research” (Baxter and Jack, 2008, p. 547). Exploratory case studies looks at situations when the “intervention being evaluated has no clear outcome” (p. 548). Finally, descriptive case studies – which includes this thesis – describes a “real life context in which it occurred”. In essence, this project uncovers some of the experiences new Canadians have had in Canada and especially as these experiences relate to accessing the mental health care system. This

project does not seek to understand any kind of cause and effect relationship but rather a description of people's experiences and how they perceive these experiences.

Stake (1995; as cited in Tellis, 1997) adds three additional types of case studies: intrinsic, instrumental, and collective. This project utilizes an instrumental approach in that it seeks to provide "insight into an issue". In other words, the participants provide information that increases our understanding of an immigrant's experience moving to Canada and requiring mental health services.

This thesis differs from some other research about barriers to mental health care because the interviews were not only concerned with the barriers to care, but also the participant's experiences before migration and how the events in their life have led them to require mental health care. Rather than asking participants to complete a checklist of barriers, this thesis is more interested in the stories each participant tells about their encounters with the healthcare system and the context that brought them to Canada. As personal story-telling is now an accepted method of data collection and knowledge production, using such an approach for this project was determined most appropriate (Fraser, 2004, p. 180).

Methods

This project used methods aligned with a qualitative approach. Fossey et al. (2002) writes that qualitative research includes methods which describe and explain a participant's "experiences, behaviours, interactions, and social contexts" without incorporating statistical or other numeric analyses (p. 717). Qualitative research tends to answer the "why" whereas quantitative describes the "what". Although often pinned against each other both are very valuable and can offer tremendous insight. Additionally,

qualitative research attempts to authentically represent the participant's views as well as the interpretation of the results (p. 723).

Interviews

As a goal of using case study methodology is to learn in-depth knowledge about the participant, interviews provide a forum for exploring a participant's story. Interviews are also a common tool within case study research as a way of seeing beyond quantitative measures of statistical results. Statistics, although useful, may seek to categorize or generalize people's experiences with numerical criteria while interviews reveal more depth of participants' experiences according to their understanding of events. For example, we may use a statistical number to understand how many new Canadians utilized the mental health system this year, but this information does not tell us why some people utilized services while others did not nor does it explain the process or perhaps barriers to seeking services. Gathering this information through interviews is a vital step in understanding experience.

The interviews were semi-structured with questions acting as a guide (see Appendix D). Esterberg (2002) writes that the interview guide should not be a set of questions that must be answered in a certain order, but rather help to maintain focus of the interview (p. 94). This document is a guide in the sense that questions may be added if necessary and others may be omitted. For example, I did not ask Asad (participant #3) questions about his children because he did not have any however, I did add questions about understandings of mental health and illness in Somalia since he articulated a story about this. Despite this, interview questions can be about the participant's experiences or

behaviours, opinions or values, feelings, factual knowledge, sensory experiences, and personal background (Esterberg, 2002, p. 95).

The questions were divided by topic (e.g. immigration, life in Canada, health, etc.) although the order was not as important during the interview process. I typically began each interview (after explaining the project and consent process), by asking participants to tell me about the country they were originally from. This open-ended question allowed participants to begin forming the foundation of the interview as I learned about where they were from as well as what they determined was important for me to know about where they were from. It allowed me to probe further into questions about their life in their home country and to gain further insight into why and how they immigrated to Canada. For two participants, it also allowed me to learn about the political violence they encountered in their country of origin which directly impacted their mental health while in Canada.

The goal was to keep the questions as open-ended as possible to ensure participants were not lead in a set direction. Context was determined from the literature however, participants were free to speak to events or experiences that were not found in the literature. For example, I would ask questions about ways the participant copes with a mental health problem but allowed them to develop this story as their own. To demonstrate, Geetha speaks to the importance of eating fresh, healthy foods as a way of preventing mental health problems but also highlights the cost of such foods as a barrier:

Respondent 1: It's in the food. They mix it. So why people are more sick here? Why people are not more sick in religious country? So because there's a lot

of chemicals used in the food here itself, that's why you get sick. So you would get fresh vegetables every day [in India].

(Geetha interview; lines 2052-2059)

Respondent 2: We cannot afford to buy all organic food otherwise we would love to buy all organics. But we're trying as much as possible to go natural organic food as much as we can afford to. I was talking to my brother-in-law and he's like why is it so expensive to buy good food? I'm like yeah. Like it should be ... It should be a right for us. You eat it but the chicken or the beef, there's all chemical in that. Like why do you have to do that?

(Geetha interview: lines 2109-2117)

Recruitment and Eligibility

Tellis (1997) writes that within case study methodology, selecting cases (or participants as per this project) must be done so as to “maximize what can be learned in the period of time available for the study”. To accommodate this, participants were recruited from a mental health agency in Toronto, whose clientele is predominantly ethno-racial and new to Canada. This agency specializes in working with newcomers that have mental health problems often related to migration and pre-migration stressors. Eligibility for this study included men and women over the age of 18 who have been in Canada for ten years or less and who self-identify as a person of colour. They also had to

be able to converse in English and provide informed consent. Issues that younger people face are unique and out of the scope of this study which explains the age limitation. Speaking with participants that are able to converse in English is necessary for the purpose of the interview and analysis. Important information during an interview can get lost if using a translator therefore only participants able to speak English were eligible.

Informed consent is a complicated component of research. It is defined by the researcher as a process to protect the participant while in actuality it typically protects the researcher and funder from any liability (Fine, 2003, p. 177). Furthermore, informed consent assumes all participants understand their rights and what providing consent means, however in some populations, particularly those where English is not the participant's first language, this may prove untrue. There is also a question as to whether participants actually believe or understand they can withdraw from the research as they might think objecting will interfere with their mental health care or perhaps immigration status. All participants were provided with an informed consent form which was signed by them prior to beginning the interview. If they were unable to consent, they would not have been able to be part of the study. All participants in this study were able to read the consent form and it was reiterated to them that they could withdraw at any time and that the interview would not be shared with their healthcare providers. Furthermore, it was emphasized that they would not be identified in the thesis or any other report. All participants received a copy of the consent form.

Participants were recruited by a poster that was put up throughout the mental health agency with the researcher's contact information. Interested participants contacted the researcher to gain more information about the study and the researcher determined

their eligibility. Following this, a time and location was determined to meet for the interview. The participants had the option of having the interview conducted on-site at the mental health agency for their own comfort; however, all participants requested the interview take place in a public space at a location of their choice within Toronto.

Although it is not necessary to have a fixed number of participants in order to get the best data, “sufficient depth” of data needs to be collected in order to fully describe overall experiences (Fossey, 2002, p. 726). This study recruited three participants who all met eligibility. Two of the participants were male and one was female.

Data Collection

All interviews took place in a neutral location decided by the participant. This is to ensure confidentiality and comfort for the participant. Although participants had the option of completing the interview in two sessions (each lasting one hour), all participants decided to complete the interview in one two-hour session. It was noted that stress may occur as a result of the interview. All participants were informed that the interview would stop at any time they felt uncomfortable or stressed and if there were any questions they did not feel comfortable answering. Only one participant refused to speak to some events as they triggered stressful feelings for them.

The interviews were semi-structured and questions were only asked to ensure clarification and to set minimal direction. Note-taking and tape-recording were used to document the interviews. This includes taking note of the time, place, and emotional climates of the interview as suggested by Fraser (2004, p. 186). All participants received an honorarium in the amount of \$50 at the completion of the interview.

Data Analysis

Transcription was conducted by a third party professional who typed up all interviews numbering each line to allow the researcher to conduct thematic analysis. No participant names were used during the interview to ensure anonymity from the transcriptionist. Part of the analysis not only encompasses interpreting what participants have said but also determining how this compares and contrasts with what others have said. Finding similarities and differences between participant's stories is an important way of learning about their experiences as well as comparing with what has been documented in the literature.

This was conducted during the coding process when I would use the same codes for similar experiences between participants. One way of understanding how the interviews were compared is using the coping theme. Coping with a mental health problem can encompass many strategies and often speaks to one's cultural background, socio-economic status, or severity of the mental health problem. All participants were asked about coping techniques and this information was compared to one another to get a sense of the different strategies used.

Table 3.1

Coping	
Substance Use	
Both Asad and Narith reported using substances to cope with their mental health problems	Asad consumes excessive amounts of alcohol in order to be able to sleep. Narith has tried marijuana and ecstasy in the past but did not become dependant. He

	has also been prescribed sleeping medication in the past but was concerned he would become addiction so discontinued.
Suicidality	
Geetha and Asad spoke to suicidal behaviour.	Geetha reported cutting herself as well as admitting herself to the hospital for fear she would attempt or complete suicide. Asad attempted suicide while in Ethiopia by cutting his wrists. He continues to think about suicide but has not attempted to hurt himself again.

In addition to recording the words that are said, it is also useful to record what is not said including writing notes on body language, facial expressions, tone of voice, etc. These nuances can provide insight into the ways participants think and feel about what they are speaking to. As all interviews were tape-recorded, notes were not taken regarding body language because it would become too difficult to ascertain what body language was conveyed at precise point in the transcript. However, notes were taken both during the interviews and when reviewing the audio to capture tone of voice and aspects such as laughter or hesitation. These observations were written in the margins of the transcripts themselves.

What may be most important about the analytical component of this project is reflecting on participant's experiences and relating these to political and structural systems. Newcomer's barriers to mental health care may reflect a gap in service that is not being addressed in policy or program development. Deconstructing systemic and political discourses is a crucial activity for understanding the complexities associated with the challenges faced by new Canadians.

Thematic Analysis

Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data and is considered to be a "foundational approach to qualitative analysis" (Braun and Clarke, 2006, p. 79). Thematic analysis may be an essentialist or realist method, which means that it reports on the "experiences, meanings and reality of participants", or it can be a constructionist method, which looks at the ways in which "events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society" (p. 81). Therefore, thematic analysis can be a method that works both to reflect reality and to unpack or unravel the surface of 'reality'. In order to conduct a thematic analysis, once all interviews were transcribed, I began this analysis by utilizing a line-by-line approach to establish themes. A theme encompasses a key concept or idea within the data which is related to the main research question, and represents some level of "patterned response" or meaning within the data (p. 82). There are different ways to code using a line-by-line approach: inductive and theoretical. Inductive coding is a process of coding the data without trying to fit it into a pre-existing coding frame or research question. Often times while using an inductive approach, new research questions formulate making the process very "data-driven". In contrast, the theoretical approach

seeks to be driven by the researcher's question and codes are identified based on the research question(s). For this project, I used a theoretical approach as the questions I asked and the themes I identified were based on my research question directly. The questions were specific to participant's experiences of migration, living in Canada, and accessing the mental health care system and as a result, my coding resembled these topics. Braun and Clarke (2006) produced a set of six steps when conducting thematic analysis which I will outline here and demonstrate my process within these steps.

Familiarizing yourself with the data

This step involves creating, reading, and potentially re-reading transcripts to become knowledgeable about what was said during the interview process (p. 87). Each interview I conducted was audio-taped and I also took notes of key concepts I wanted to highlight during the interview. Following the interview, I had the interviews transcribed by a professional transcription organization. Although there is an argument that interviews are best when transcribed by the researcher, in the interest of time, I opted to have this done professionally. I listened to the audio recordings of each interview at least twice and took additional notes as needed pertaining to areas I wished to explore further as well as to ensure accuracy of the transcription. I also read each transcript in its entirety prior to beginning the coding process to become more familiar with the information provided.

Generating initial codes

This is the stage that occurs following familiarization which includes reviewing the data to establish initial codes (p. 88). This does not necessarily mean identifying themes but rather codes that may need to be explored later. For example, in this project when I began this phase, some of my initial codes included 'filing for bankruptcy', 'parent's death, and

‘advocacy work’. Please see below for the sections which were coded as such. All codes were highlighted using a pen highlighter and I wrote in the margins the code I had developed.

Table 3.2

Data extract	Coded for
<p>Respondent: But we had to file bankruptcy. Interviewer: Bankruptcy? Respondent: 2008. Yeah, in 2008. Interviewer: And what happened there? Why did you have to file for bankruptcy? Respondent: The loans weren't paid up and I [Geetha] stopped working. Like we got some money ... We bought a new car. So it was like car payment, it was like loan payments and a lot of things piling up quickly (Geetha interview; lines 809-827)</p>	Debt/Filing for bankruptcy
<p>Interviewer: Did you have a family in Somalia? Respondent: I had my parents, my father and mother, but they passed away. Interviewer: In Somalia? Respondent: Yeah. Interviewer: By a violent way? Respondent: Yeah, the father by a violent way. (Asad interview; lines 49-59)</p> <p>Interviewer: Did [your mom] witness your father dying? Respondent: Oh yeah. She was there. Interviewer: Did they hurt her? Respondent: No. He was defending her. They come to find me to ask for advice and I was outside of the city at nighttime. They find out and my father was in the house, then my mother come and told to these guys, why you looking my child? Then my father come and they hit him with a bag on the back and he was dead. Interviewer: So how did your mum die? Respondent: After six months she was sleeping, she never woke up. (Asad interview; lines 1239-1262)</p>	Parent's death
<p>Interviewer: So when you say that you were doing social research over there, can you give me an idea of what kind of research? Respondent: Oh, all kind of things; with minority, for example;</p>	Advocacy work/employment

<p style="text-align: center;">with children, women...poor people, you know; gay, lesbian... everything, you know. People who have less opportunity, like less dignity, you know, everything low... I tried to help those people.</p> <p>(Narith interview; lines 84-91)</p>	
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Developing initial codes allowed me to think about what aspects of the interviews I wanted to highlight further in the analytical process and when interpreted, how these codes aligned with the research question. I chose these codes to highlight my analytic process as they encompassed three different ideas for each of the participants. These particular codes are not related to accessing the mental health system but do speak to some of the events that lead to participant's eventual mental health problems.

Searching for themes

This phase is conducted when all codes have been identified and the broader level of themes takes place. This is when codes are sorted into potential themes as well as possibly combining codes to produce one theme or a sub-theme within a larger theme (p. 89). When reviewing each of my three transcripts, it became evident that several of the codes I had developed could actually be combined into one theme. Please see below for the examples of codes that were combined to formulate this sub-theme. Many of the themes identified in this project overlapped with what has been reported in the literature so I decided to keep many of these themes as a way of aligning my findings with the literature in order to enhance the importance and consistency of such themes. After reviewing the transcripts in detail, I decided to sort through the codes and compile the findings into the themes mentioned above or by the social determinants of health. Sub-themes were developed (e.g. income, education, etc.) as well to explore these themes in more depth. This exercise was also completed by hand using different coloured pens to

highlight the potential themes and sub-themes. A table with each theme was developed and consisted of potential sub-themes and corresponding codes. An example of this process is below.

Table 3.3

Data extract	Coded themes and subthemes	
	Theme	Subtheme(s)
	Coping with a mental health problem	
<p>Respondent: I used medication from the prescription, but not now... not now.</p> <p>Interviewer: So you take nothing now?</p> <p>Respondent: Yeah, I told my psychiatrist – my doctor – I said, I want no medication.</p> <p>Interviewer: Okay, how long have you been off medication?</p> <p>Respondent: Like a year... like a couple of years. But that medication doesn't really help.</p> <p>Interviewer: It didn't help for you, no.</p> <p>Respondent: If I took those medications I cannot even talk, you know. It's more depressing (Narith interview; lines 852-861)</p>		Medication
<p>Respondent: I drink a beer and vodka.</p> <p>Interviewer: And how much would you say you drink a day?</p> <p>Respondent: I don't get every day but at least 15 days of the month I go.</p> <p>Interviewer: Would you say that you're dependent and you need the alcohol now?</p> <p>Respondent: When I drink and I go to bed, I don't have nightmares, it makes me sleep.</p>		Substance Use

<p>Interviewer: So when you drink before sleep, you don't have nightmares.</p> <p>Respondent: Yeah. (Asad interview; lines 1017-1036)</p>		
<p>Respondent: [Alternative medicine and treatment] costs money. I'd better choose remedy, you know. I'd better choose those things, you know, because medicine, through my own experience, you know, I think it's... I don't know, some are good, yeah... there's always something, like pros and cons about anything... about anything, you know. But to me, I choose nature, you know, as long as it had been like permitted... like... I mean, like what to say? Like... well, though scientific way, right, like not just go and pick up some tree and eat, no. I mean, the combination of scientific and nature, you know.</p> <p>(Narith interview; lines 1086-1095)</p>		<p>Alternative Treatment</p>

Reviewing themes

After the themes have been identified, the purpose of this phase is to determine which themes should remain in the thesis and/or which should be divided into sub-themes or which should be discarded or coupled with another larger theme (p. 91). This phase is conducted in two stages. The first stage includes reviewing all of the identified codes and determining whether or not they “form a coherent pattern” (p. 91). If they do not, it may

be necessary to decide whether or not the theme is appropriate or problematic. There are several codes in this thesis that I needed to review as they could fit into different themes and I wanted to ensure they were being represented in the right one. Additionally during the review process, I re-coded several lines to better reflect the analysis.

Table 3.4

Data Extract	Themes and Codes
<p>Respondent: I meet [people] in the library or when we are in the lines when everybody goes to eat. It's not that kind of connected friendship.</p> <p>(Asad interview; lines 376-377)</p>	<p>Theme: Social support Codes identified: Friendship/Making friends/Connection/Support Final code: Making friends</p> <p>‘Making friends’ was decided because the ‘social support’ theme can encompass both the practice of making friends and not finding a ‘connection’.</p>
<p>Respondent: But now I love my house to be clean. Like I’m as [curious 00:55:31] about cleaning my home as any other woman would be, keep her house clean. But it was my depression wasn’t letting me doing anything.</p> <p>(Geetha interview; lines 1316-1318)</p>	<p>Theme: Mental health Codes identified: Chores/Daily activity/Gender roles/Mental health Final code: Mental health</p> <p>‘Mental health’ was decided because the quote speaks more to Geetha’s meaning-making process of her mental health impacting her ability to conduct daily activities.</p>
<p>Respondent: Oh, it’s a walk-in clinic. Oh, sometimes, you know... sometimes I feel like fever, sleeping problems. Maybe I’m looking for sleeping pill prescription... something. Now I no longer take it.</p> <p>(Narith interview; lines 709-711)</p>	<p>Theme: Access to healthcare/Coping with mental health problem Final theme: Coping with mental health problem Codes: Substance use/physical health/coping/access/medication Final code: Substance use</p> <p>The theme was determined to be ‘coping with a mental health problem’ as many of the codes identified are geared towards coping rather than seeking services. ‘Substance use’ was decided because Narith later speaks to taking too many</p>

	and fearing he was developing an addiction.
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The second stage of this phase is to review the themes throughout the entire data set. This process includes reviewing all themes and codes and coding information that may have been missed prior. There was very little in my data that was missed but this process did allow me to discard information that I determined was not useful to the overall thesis.

Table 3.5

Data Extract	Discarded information
<p>Respondent: Yeah, you don't have to go and, you know, buy medicine just to make yourself strong; you just eat properly, or you know, something from the... what you call? The food stall, it'll be good. You don't need to inject like... what you say? I see a lot of water boy... we call it water boy in Thailand.</p> <p>Interviewer: Like drugs?</p> <p>Respondent: No, they inject something in their body, like hormone or something.</p> <p>Interviewer: Oh, like... oh, steroids.</p> <p>Respondent: Yeah, to make it big.</p> <p>Interviewer: Yeah. Do they do that in Cambodia?</p> <p>Respondent: I think in Thailand. A lot of, you don't look cool, you know. You know some guy friends, they were skinny like me...</p> <p>Interviewer: Yeah</p> <p>Respondent: After I went back to Cambodia, I come back to Thailand, I don't recognise them, you know; big face, big muscle.</p> <p>Interviewer: Yeah.</p>	<p>This data was discarded as it did not add any substance to our discussion or provided further information about Narith's experiences of mental health problems or healthcare access. It also did not add anything to our discussion about social determinants that can impact someone new to Canada.</p>

<p>Respondent: Well I mean, if it make them happy, I mean, good for them. (Narith interview; lines 1113-1129)</p>	
<p>Respondent: Yeah, they are drug dealers, they are... they sell children... orphan children they sell, prostitution, all those things. And I understand that it's not Cambodian people for... Interviewer: Of course. Respondent: It's a big country involvement, like United States, China... they're involved too much down there. So yeah, it's their business, so... Canada doesn't really involve much in my country; they had some business down there, but not much. The US the most, their business down there, so it's good, you know, to have a crazy government and then you make money. (Narith interview; lines 1028-1037)</p>	<p>This quote was discarded because it was a discussion about the socio-political climate of Cambodia and although it provided some context around Narith's country of origin, the information given did not add anything to the thesis.</p>

Defining and naming themes

This phase essentially requires the researcher to review each theme and ensure they are coherent and are not trying to “do too much” (p. 92). This phase is also when sub-themes are finalized. Braun and Clarke (2008) write about the importance of conducting a detailed analysis of each theme and making sure each theme tells a story. They write that in order to test whether or not a theme requires refinement, one should “see whether or not you can describe the scope and content of each theme in a couple of sentences” (p. 92). If not, further refinement is required. As I decided that the larger themes should

complement the literature, I did not need to spend as much time with this aspect.

However, I did spend considerable time determining what the sub-themes should be and ensuring these themes corresponded appropriately to each larger theme. In order to determine what the sub-themes should be, I analyzed the text within each theme to find similar codes or discussion. For example, two of the participants spoke about suicidal thoughts and behaviour therefore, this was made a sub-theme within the 'Coping' theme.

Producing the report

The sixth and final phase of thematic analysis is when one should produce the actual report. Braun and Clarke (2008) write that it is important during this phase to "tell the complicated story of your data in a way which convinces the reader of the merit and validity of the analysis" (p. 93). It is important that many data extracts are used to convey this story especially ones which capture the essence or point one is trying to make. The data extracts should be coupled with an analytic discussion to produce a report that is meaningful and important.

Social Location

I am a White, able-bodied, English-speaking female from Canada (born and raised) who is well-educated. Although in a Canadian context I come from a low-income family, I recognize that in many cases, I still had more than the participants I met with. Most newcomers to Canada from the last 20 years identify as people of colour and furthermore, many come from low-income countries. Therefore, it was important for me to continually acknowledge both during the data collection process as well as during analysis, the privileged lens by which I view the world.

It was also important to recognize that issues may arise as a result of my social location such as trust and a willingness to participate. It was important to know that male participants may feel uneasy discussing their stories with me because of my gender or all participants feeling discomfort because of my ethnicity. Furthermore, it was critically important for me to continually examine my position of authority as a researcher and to reflect on how this may impact the data.

Credibility and Trustworthiness of Data

One strategy I used of ensuring credibility and reliability was reviewing information with each participant to ensure the information I understood was accurate. This involved asking participants to elaborate and then repeating what I believed they were saying. This was especially important since the participants did not speak English as a first language. Asking them to repeat information or for me to repeat information ensured that I understood their thoughts accurately. I also went back to prior topics to ensure all information about that topic was covered especially if participants began speaking about other things without finishing one subject. For example, when interviewing Asad, even though we had spoken about where he grew up in Somalia earlier in the interview, I decided later in the interview that I wanted more information about that so initiated the subject again later in the interview.

I also maintained an audit trail at all points of my research process to help ensure credibility (Brun, 2005). This included digital recordings of the interview sessions, typed transcripts, and hand-written notes from the interviews. This audit trail helped ensure that

the information I used during data analysis could be traced back to specific sources and originated from the interviews I conducted.

Case study methodology recommends conducting a triangulation of the data to ensure construct validity (Tellis, 1997). Essentially this entails bringing together all data sources to determine the validity of the data. For example, survey data may be compared with the interviews to determine if the information is the same or perhaps by reviewing archival documents one can assess if the information from other sources is accurate. Comparing data is called data source triangulation and could not be utilized for this thesis as there was only one source of data (i.e. interviews).

Chapter 4: Findings

Study Sample

In total, three participants were interviewed for this study. All had been in Canada less than ten years with the most recent being two years. One participant was from India, one from Cambodia, and one from Somalia. All but one was male. The youngest participant was 33 and the oldest was 54 years of age.

Summary of participant's backgrounds and mental health care experiences

In order to gain further insight into the experiences of the three participants and their pathway to mental health care, it is first important to understand the circumstances each person came from in order to understand their experiences in context. Themes will be deconstructed later in the thesis; this section is to provide a brief overview of each participant's journey to Canada and to identify what life has been like thus far in Canada. This section will also provide a summary of mental health care experiences. For the purposes of confidentiality, all names have been changed.

Geetha's story

Life in India

Geetha is a 30 year old woman from a mid-sized city in India. Although she was not raised in poverty, she described her family as lower income. Her father owned a grocery store and her mother stayed at home.

“My dad used to run a grocery store. It's kind of like a grocery store. Like a convenience store kind of thing.

But he was not a very well to do businessman. Like he

was not a very good businessman. And every time we had to stock up in the store we had to ask money for him. And there was time when everybody had some issues like in their own life they needed money and stuff like that. So then there was a point where nobody could lend us money anymore”.

(Geetha interview; lines 233-241)

She notes that she had a happy childhood and that she and her family have always been close. Geetha says that she was always taught to be an independent thinker and to speak her mind freely.

“... like in my home the normal was like nobody’s the leader. Like okay, my dad was the head of the family. But you have the freedom to say whatever you want, to speak up your mind. And it’s not going to be like we’re going to enforce something on you which you do not want to do”.

(Geetha interview; lines 368-373)

Marriage and Co-Dependency

In her very early 20’s, Geetha fell in love with a man named Sandeep. He was from her community but had significantly more money. Geetha’s family did not want her to marry Sandeep because he was considered a “wild man” with few career aspirations. Her mother would have preferred her to marry someone who was more successful.

When I was getting to married to him, my mom didn't like him. Like she wanted me to marry some other guy. He was a nice guy but I didn't love him. So I said to my mom, I'm not going to marry him.

(Interviewer) And how come she didn't want you to marry him?

This guy was like into woman in the beginning and he was very naughty. He was not studious and stuff like that. So she didn't like him. But to me it was like I knew he had a good heart so that was important for me. I told her like I'm not giving up no matter how much you try so why don't you just give it up. She told me okay, you want to marry him, you marry him, but if something goes wrong don't come and blame me. I said okay, I won't come and blame you. But today she's happy with him because he treats her so respectfully as a mother and whatever, you know. Like something like that. She's happy for us today".

(Geetha interview; lines 373-405)

In the year 2000, Sandeep moved to Canada with his family. Sandeep's parents decided to immigrate to Canada in hopes of more opportunities for themselves and their

children. Sandeep was the only boy and had a sister who was much younger than him. After spending two years in Canada, Sandeep returned to India to marry Geetha. Although they were both happy with the marriage, Geetha recalls it as being one of the worst days of her life. She described her new in-laws as being very over-bearing and controlling and she felt they made her wedding day and honeymoon uncomfortable.

“When we came to India to get married, his dad got diagnosed with MS, multiple sclerosis. So most probably he was not in his own self. So he didn’t know what was going on and he didn’t take full responsibility of the wedding. So he put some of the responsibility in his brother’s hands and he messed up the wedding completely. And in our home my mother was like an independent person. So a lot of people ... A lot of men don’t like that. So they tried to pick fights with my mother. They wanted her to bow down to them, do this and that, and my mother refused. So they made a big mess out of the wedding. [His family] made sure that the [wedding] film doesn’t contain my mom and dad.

(Interviewer) You got married in India, right?

Yes, in India. And it's our worst memory. And even in honeymoon his parents came with us. His parents came with us, his aunt came with us.

(Interviewer) Was that in India?

Yeah. Yeah.

(Interviewer) Is that common?

No, that's not common. It was just his parents".

(Geetha interview; lines 1713-1753)

After they were married, Geetha moved to Canada to be with Sandeep in 2003. She admits to being very excited about moving to Canada although knew little about the country prior to arrival. She was excited and eager to begin her new life as Sandeep's wife in Canada.

Since arriving, Geetha has been unable to make any friends in Canada. She says that Sandeep is her only friend and essentially the only one she speaks to, "I depend on him a lot and he's my only friend here" (Geetha interview; line 1362). Geetha gave birth to their only child (a son) in 2007. She loves her son very much but reports that she finds it difficult to spend too much time with him as she finds it overwhelming. As a result, her son spends every day in day care and is home in the evenings.

He [Geetha's son] goes to full time day care and will be in senior kindergarten in September. I send him to daycare because he is better off there than with me. He has two weeks off for summer vacation from the daycare and it was going crazy for me because I just can't take it for the full day. I manage to stabilize myself and I somehow I managed to get through the time.

(Geetha interview; lines 1660-1664)

She also states that Sandeep no longer has many friends as he is concerned about leaving Geetha alone in case she hurts herself, and therefore stays home with her, "There was a time when I was so dependant on him he could not have a social life at all. His social life was completely over because of me and my depression" (Geetha interview; lines 1385-1388).

Living with Extended Family

When Geetha arrived in Canada, she moved in with Sandeep who was living with his parents. She reports that in Indian culture, it is not uncommon to stay with the family of the groom after getting married. Although this did not bother her initially, she soon became distraught as she was expected to conduct all the household chores and take care of her new in-laws.

"When I came here his family thought 'we are like God'. They are thinking we are like God. Whatever we say goes, no matter what. If you think it's wrong or

right, you have to do it. And to me that was not acceptable. I was completely modern thinker. And I told [my husband], I'm not trying to make a fight with them, but I was just trying to be like having a family tradition that maybe we can make some changes for better. They didn't like it. They're like you're not supposed to argue with us. You're not supposed to say anything about it. And I could not keep my mouth shut. So that created a lot of flak and initially he was with them".

(Geetha interview; lines 407-434)

Geetha, who was university educated, wanted to pursue further education in Canada to upgrade her knowledge and to gain some Canadian educational experience. She said she found this difficult as she was in school full time and expected to also complete all household duties.

"And then I got into university, full time. I was working fulltime and then I was going evenings to fulltime courses. And then I had to come home and [her in-laws] expected me to do all the housework for them. His mom's thinking was like now I have a daughter-in-law, now I rest. And so I couldn't manage everything together. Then they come back to me and say "Oh, you are our daughter-in-law. We want to spend time with

you. You don't give time to us." Okay, I'll give time to you. And then I had no time to study".

(Geetha interview; lines 596-608)

The stress of this reality began to take an emotional toll on her and she describes that at this point her feelings of depression and anxiety began. Unlike Sandeep who had his family with him, Geetha had no family or friends in Canada and began to feel isolated. Although she complained to Sandeep and begged for them to move to their own home, he initially sided with his family and refused to leave.

Geetha says that during the period of living with his family, they would say mean things to her and treat her poorly. After two years, Geetha had finally convinced Sandeep that it was time to find their own home. Part of the reason for Sandeep's decision to leave was that he was reportedly dealing with his own issues with his family. He had some traumatic events happen to him in his younger life and his family's indifference to these events led him to question their integrity. After Sandeep and Geetha moved out of his parent's home, they made a decision to no longer speak with his family, "For one year or so [after we moved out] we didn't talk to his parents, no communication, nothing"

(Geetha interview; lines 512-513).

Mental Health

"Like I was very confident person and I thought nothing would ever happen to me. I didn't have any health problems, nothing like that. But this was like ... living with [the in-laws] was like every day I had to

*struggle for myself just to be living a respectable life.
So that led to my depression”.*

(Geetha interview; lines 566-570)

Throughout the years of living with her in-laws, Geetha would speak with her own family every few weeks by phone but had not seen them. Geetha was struggling with her own increasing feelings of loneliness, depression, and anxiety and decided to speak with her family doctor (who was also from India) about it.

“So then I went to [the doctor] and I said I’m feeling sad and I’m crying a lot and stuff like that. So I think he put me on pills. I’m not sure. I think he put me on pills”.

(Geetha interview; lines 1142-1144)

The doctor prescribed anti-depressant medications and referred her to a psychiatrist at her local hospital. After being on medication for a year, she began to feel better and decided to take a trip to India to visit her family. Upon returning from this month-long trip, she learned that she and Sandeep were expecting their first child. After their son was born, Geetha says that her mental health quickly deteriorated.

“But then what I did is after my son was born I didn’t go for the [follow-up] appointment and I stopped my medication abruptly so things came back to me. I think it was postpartum depression as well. So then I didn’t go for like three or four appointments so my psychiatrist stopped seeing me. Then after a few

months I got worse... like I just couldn't take it one more day. I went to the emergency room one day and I said to them, you know what? Keep me in the hospital. I cannot take one more day at my home. I don't know what I will do".

(Geetha interview; lines 1199-1208)

Due to an intense fear of possibly hurting herself, she voluntarily admitted herself to the emergency department of a local hospital where she stayed for 24 hours. She found this experience frightening as she had never felt such strong feelings towards suicidal behaviour before. Following discharge, she was sent back to her psychiatrist who continues to work with her by providing medication.

Geetha heard about a community-based agency that specializes in mental health treatment for racialized people, and has been with them for six months. She finds their staff and programs helpful but lives too far to access their services regularly, "They have good programs for us to go everyday but like my worker, she comes all the time and we'll sit here and we have a chat over coffee" (Geetha interview; lines 1435-1438).

Narith's story

Life in Cambodia and Political Violence

Narith, a 34 year old man from Cambodia, has been in Canada since 2006. Narith worked for a human rights agency in Cambodia and engaged in social research that promoted equal rights for women, LGBT groups, and other marginalized communities. As this type of research did not align with government values, he was jailed in 1998 where he was severely abused physically, sexually, and emotionally.

“I was doing a lot of research down there, right. I mean social research and you know, this is no good for government, right. So then I was jailed in 1998. And I was a victim of torture too, by police”.

(Narith interview; lines 41-45)

He was released from jail and began to think about the possibility of moving to a new country to escape officials that disapproved of the type of activist work he was part of. He initially thought about moving to Holland but as he does not speak the language, decided not to. He put moving on hold until he was hurt again by authorities. In 2004, he was injured in a motorcycle accident which he describes as a “set-up”. Narith reports that the individuals who hit his motorcycle on that day did so on purpose with an intent to injure or kill him.

“I was on a motorbike from my friend’s home and there was one car and three motorbikes with a lot of men inside. Basically they just want to crash and kill, right. So I don’t remember how it happened actually. Like I don’t exactly... but I woke up in hospital”.

(Narith interview; lines 545-548)

Following this incident, Narith decided to finally move to a new country. As there was a conference in Toronto related to his work, he decided to leave Cambodia and move to Canada. Narith said that his family in Cambodia have been threatened many times by individuals who want to know where he is however, he never told his family that he was

going to Canada (in order to protect them) so his family did not know his whereabouts. No one in his family have been harmed as a result of Narith leaving the country.

Marriage and Children

Prior to arriving in Canada, he learned that his girlfriend was pregnant with his child. Although he still felt he needed to leave the country, he married his girlfriend and stayed in touch with her while in Canada, “I have one wife. Basically we are just friends, but we decided to have one kid” (Narith interview; lines 114-115). Six months prior to interviewing Narith, he was successful in being able to get his wife and daughter (who is now 5 years old) to Canada. They both arrived and Narith got to meet his daughter for the first time, “I was crying a bit [when I first saw my daughter] you know...can’t say anything. Just hugged.” (Narith interview; line 165). Although he and his wife are no longer a couple, he says that they are very close and speak daily, “They are happy here. They are my best friends and they are all I have” (Narith interview; lines 145-147).

Arrival in Canada

Upon arrival in 2006, Narith claimed refugee status and has been in Canada ever since. When Narith arrived in Canada, he says he felt free. He looked on a map of the world and realized how far Cambodia is from Canada and felt that he was finally safe.

“First of all, I felt freedom. I feel like no one going to hurt me, or no one going to search for me here, you know. And then I looked at the map, I said, ‘this is impossible for them to follow’”

(Narith interview; lines 220-222).

Since being in Canada, he has suffered from fear that officials from Cambodia will find and hurt him and he finds himself looking behind him when in Toronto. He does say that he does this less often now that he has been here for six years.

I always look over my shoulder; maybe someone spy on me and... Finally I think I'm not that much, you know, important.

(Narith interview; lines 227-228)

The Canadian government told him they would pay for him to stay in a hotel for the first month he was here but he refused and stayed in a downtown shelter instead. He said he did not wish to stay somewhere there were so many people and would rather be alone. He also felt guilty and did not want to spend the government's money this way. He has stayed in a few shelters and apartments since being in Canada and found many of them to be unsafe and/or noisy. Although Narith has only been in Canada for six years, he has already resided in 15 different homes. He said "The landlord says, 'why do you stay home? When you stay home you use more water'. That's what they think... more electric heating. Why do you stay home? Because they don't understand my situation, right; they don't know, and you know... maybe I look scary to them, or something, I don't know" (Narith interview; lines 382-386). His living condition in Cambodia was quite good. He had money and a home and he has found it difficult being in Canada where he needs to survive on very little income each month.

"It was a struggle because the way I spent money back home is much more than here. I had a good salary [in Cambodia] and everything to buy is cheap and fresh so

when I come here I struggled. Meat here is cheap but vegetables, especially organic vegetables are expensive”.

(Narith interview; lines 327-334)

Mental Health

Although Narith started having symptoms of a mental health problem while still in Cambodia, it has become much worse since arriving in Canada. “Maybe [in Cambodia] I had more friends, or something, I don’t know. But when I came here, I feel like... what’s the right word to say? Hopeless.” (Narith interview; lines 595-596). He relives and thinks about much of the trauma that he encountered while in Cambodia and has had difficulty sleeping and doing daily activities. He has been to see several doctors in Canada but felt that none of them listened to him – they were more concerned with why he came to Canada. One doctor did put him on medication for his mental health concerns but Narith did not like the side effects he was experiencing so stopped taking them.

After a few years of being in Canada, Narith did eventually find a doctor he likes and has been working through some of his mental health problems with him. To help him cope with the symptoms of his mental health problems, he spends a lot of time ‘with nature’ by going on walks and spending time in parks.

Asad’s story

Family Life

Asad grew up in a mid-sized city in Somalia where he says he had a happy childhood. He was an only child and lived with both his parents. When a civil war began in the 1970’s,

he says everything changed and a country that was peaceful turned into a frightening place.

“The civil war; just running for your life. The last 25 years, Somalia’s situation is very bad. So when this religious organization took over, they hang the people, they hurt them for their ideology. So you live in hiding and you see a lot of killings, a lot of punishment, cutting hands, legs”.

(Asad interview; lines 39-43)

Living in Somalia Among Political Violence

As an adult, Asad witnessed many acts of violence at the hands of various militant groups including a beheading. This event has had a long-lasting impact on Asad and he admits to having regular nightmares about the incident.

“(Interviewer) Did you know the person who was beheaded?”

No. But we were forced to watch it. No one wanna see that. But they forced us to watch. It's kinda like giving you an example. Everybody say something but they are saying he don't wanna join terrorist organization, he don't wanna fight. They say pick someone else. You never know. Because they never say nothing and this people, they bring him, they are distressed, condemn

him to death, they read something and then they kill him. That was like eight years ago. A young guy, 24 years old. [Afterwards] they take him. And then you see guys, they cut the hand off the limb. Almost they do this every Friday after Friday prayer in front of the mosque. That's what they do”.

(Asad interview; lines 562-593)

Shortly before Asad came to Canada, his father was killed in violence in front of his mother. She passed away shortly after by what Asad calls, a broken heart. Asad feared for his own life and decided it was time to move to a country where he would be safe from this violence.

Journey to Canada

With money that he had saved as well as savings from his family, he fled on foot to Kenya where he was to make contact with a person who would assist him in getting to a safe country.

“I just walk in two days and one time I walked it to another day and then I get ride. You go from the small village to village to ride, then from this village to another one, we walk. Because even together, ride is by chance and it's expensive.”

(Asad interview; lines 618-621)

It took several weeks to both walk and get occasional rides to Kenya where he met a woman who, for a fee, would supply him with a passport and documents that would get

him to a new country. It wasn't until he met this lady that he learned he was coming to Canada. He knew very little about Canada prior to arriving other than the cold winters and that people were supposed to be friendly. "I heard it was a big country and that as a refugee you can go there and they will help you" (Asad interview; lines 140-141).

Arrival and Life in Canada

Asad arrived in Toronto from Somalia in 2010 when he was 52 years old. When he arrived he saw snow for the first time and left what he described as a country in turmoil. "I was very surprised and very scared the first time [I saw snow]. I went to walk on the snow and I needed two or three jackets and socks my feet. That's beside the shoes you must have. All that was serious." (Asad interview; lines 198-200). He arrived in Canada and claimed refugee status when he got to the border. Initially he resided in a shelter in the downtown area and says he felt unsafe there. There was quite a bit of fighting and tension so he spent the night in the shelter but would spend the days in other parts of the city. While staying at the shelter, he was given \$30 a week by the government to cover any expenses he had. It was later arranged by the Canadian government for him to live in a shared house in Toronto which he did for a year. He currently resides in an apartment that is government subsidized. He uses food donation services for his meals as the money he receives is not enough to cover all his food expenses. He is able to cook traditional Somali dishes once a month as the ingredients are more expensive.

"It's so expensive I cannot cook [traditional food] every day but there's Somalian groceries. There are Somali restaurants but it's expensive too. But I eat every day,

like corn meal, it costs you \$10. People say it's very cheap but to me it's very expensive."

(Asad interview; lines 342-345)

Mental Health in Canada

Asad has not worked since being in Canada as his physical and mental health have been poor. Asad's mental health condition began while still in Somali but has worsened since being in Canada. He suffers from regular nightmares and admits to crying daily. "It's the experience of the civil war and the beheading. And then I get nightmares; it's too hard to sleep". (Asad interview; lines 517-519). Just prior to coming to Canada, he attempted suicide by cutting his wrists. Although he has not attempted to take his life again, he says he thinks about suicide regularly and has contacted the suicide hotline for help. Due to the trauma Asad has faced in his life, sounds such as sirens, fireworks, or cars backfiring are frightening to him and make him think about his life in Somalia.

While staying in the shelter, a worker from a local hospital met with Asad and told him to come into the hospital for one of their clinics to help him with some of his issues in adjusting to life in Canada. He was also referred to a community-based mental health agency where he participates in programs. Asad is not on any medication and does not wish to be as he did not like the side effects of the mental health medication he was taking. One way Asad copes with the nightmares and other symptoms of mental illness is by drinking alcohol before bed. He finds that if he is intoxicated prior to sleeping, he does not have nightmares (or any dreams). During the day, Asad goes for long walks and spends time (approximately four hours) on the internet where he reads the news and plays

online chess. Asad does not have any plans for his future but does say that if the civil war ended in Somalia he would consider going back.

Chapter 5: Study's participants barriers with accessing mental health care

Racism and Discrimination

Each participant reported experiencing racism either in the healthcare system or during the daily lives. Both types of experiences can impact one's mental health as well as whether or not they will seek or receive appropriate care.

Racism and Discrimination in Society

“It's not about like [a mental health agency] has to be Asian, because here is diversity, but I just can't go anywhere... mix with people. It doesn't have to be Asian, as they don't discriminate, because personally, I talk to you as a person, but I don't know what you're thinking; that is the core of the psychology. How can I know what people are thinking? That's why I say, the policy is multiculturalism and diversity, but hey man, you don't know what people are thinking, you know; that what makes me unstable, you know?”

(Narith interview; lines 802-810)

Geetha spoke about racism and discrimination in society both in terms of her husband being discriminated against at work as well as feeling discriminated against by different government bodies who treated her poorly because she was new to Canada.

When [my husband] was sick the first time, like he was working [at the bank. So first time he got sick he stayed home and then he couldn't go, right? Because he got

fibromyalgia. So he was home and his manager would call all the time, saying come back, come back, why are you doing this? Then one day I got so frustrated and I was like 'what is this all about?' and then [the manager] said if he went back in then he will just get the sick days and not get insurance or any benefit for it, right? She was like come back, come back, what are you doing, we are busy.. I got so frustrated, then one day I just called up his workplace, his manager, but I called up in the evening. I knew she wouldn't be there. I got so frustrated, I yelled in the phone. I left a message, a bad message. Like this guy's suffering. If he was suffering from cancer would you ask him to call back? Like if you were suffering cancer would you go back to work? And I yelled so much and I said okay, you know what? Tomorrow I'm calling you back, I'm getting your manager's number and I'm complaining. You can't just force him to come back. How dare you force him to come back!

So next morning the manager came in the branch for the message and she was so frigging ... like she was so scared of me. They said she never call back. And then the company sent a bouquet of flowers. Like this is what

you have to do to survive? Like I had the courage to do that but people like him didn't have the courage to do that. He will actually go back even if he was like 100 degree fever. Like I gave him a lot of courage to fight whatever he needed to fight. That kind of discrimination happens a lot. It's like, you know, you are from India and all these people and they just start to use you. They know that you're going to come if they say something. Unless you speak up for yourself, people are going to use you.

(Geetha interview; lines 1872-1922)

Asad recounts being called a 'nigger' while staying in the shelter when he first arrived in Canada. This was upsetting to him but was something he repressed and tried not to think about.

[In the] the shelter, people using the word 'nigger'

(Interviewer) Towards you?

Towards me. It's upsetting of course.

(Interviewer) Was it predominantly white people that would say these things?

Yeah.

(Asad interview; lines 920-934)

This was Narith's first experience with racism in Canada which occurred two days after his arrival:

[When I first arrived] I didn't know the TTC [public transit] system and one day when I walk into the

subway I had one transfer. I asked people and they said I could still use it but when I tried to use it to get onto the subway [transit personnel] called the police. I apologized and said that I didn't know the system and that today is the second day that I'm in Canada. And then [the police officer] scolded my mother and called me a 'mother fucker. Why did you come to Canada?' He saw my paper that I am a refugee. The other police officer was a good guy because he tried to cool him down. I just smiled – what could I do?

(Narith interview; lines 437-450)

He states that he does not think this is a reflection on Canada necessarily as “every country there are people like that” (line 468), but this early event did have a negative impact on him. Narith also says that while in Canada he has been called a racist when strangers have said hello to him but he did not reply to them.

Racism and Discrimination in the Healthcare System

As stated earlier, racism and discrimination can act as a health determinant as well as a determining factor to seeking care. Narith described experiencing both types during his time in Canada and says that he has found many healthcare providers as well as Canadian Immigration Services to be quite racist and discriminatory. Narith saw several doctors who also asked why he was in Canada. Whether or not these doctors were asking as a way of making conversation or being condescending, because of Narith's earlier

experience in the subway, it likely painted a negative view of what he believes people think of him and why he is in Canada.

“So I feel like I come to see a doctor to get help with medical... with whatever problem is, and not to hear ‘why you come here?’, ‘why Canada?’, you know. ‘Are you working?’ I just feel disappointed and I say whether I will end up in this country, like that, or will... will they send me back... deportation?”

(Narith interview; lines 611-615)

Narith also talked about the discrimination he felt by not being heard when accessing healthcare. He felt dismissed by most health professionals he has visited and states that when a doctor does not truly listen or do something to resolve your concerns, it is discrimination because they are choosing not to help.

“Like at the Canadian Centre for Victims of Torture or something like that, they’re saying yeah, yeah, and then they ignore; they don’t address the problem... they ignore. They treat you like, okay, you are a victim of torture... okay, you are crazy people, you have mental health issues, you are there; you are down there in that circle. You can voice your concern, but be ignored, because you aren’t belong there; you understand what I mean? And [what I learned in school is to connect the community and the agency]. You cannot ignore them,

because you're supposed to work close with them to address the problem. But here they do it different, you know; whatever you told them, okay, then disappear, you know. They don't address it, so you can spot that is racist. If not a racist issue, this is discrimination, or stigmatisation... absolutely. When you ignore someone, that means that you put them down, you understand what I mean?"

(Narith interview; lines 816-838)

Narith reported another incident when he went to a local hospital to have blood drawn, and experienced discrimination.

"There is one nurse who took my blood and she said like a disaster, or something, you know, to help me. She's Canadian, right, and yeah... I don't look at minority, but she's African community, right... with her friend and they laughed. Because when I go, I don't really speak, so they think maybe this guy no English. At least I understand something. So it's just from time to time, it's building up, you know."

(Narith interview; lines 652-662)

Both Geetha and Asad have accessed predominantly non-White healthcare providers which may factor into why they have not felt or experienced racism in the healthcare system. They both utilized services designated for racialized people with mental health

problems and found these programs non-discriminatory. Geetha does speak to an incident however when her social service worker at the hospital did not inform her about provincial disability insurance.

“Like you know, when I was speaking to the social service worker, nobody told me about OSDP. It’s like they don’t want to come and tell you about it. You are supposed to know about it. Like how am I supposed to know? I’m new to the country.”

(Geetha interview; lines 713-718)

All three participants reported experiencing some kind of discrimination and/or racism both in the healthcare system and in society-at-large. These negative experiences demonstrate the added layer of difficulty when seeking services that non-racialized people would not experience. Racism and/or discrimination can be experienced by a person at various levels including overt experiences (such as Asad being called a ‘nigger’) and subtle or systemic experiences (e.g. most doctors representing the dominant ethnic group). Discrimination and/or racism can also impact one’s either directly or systemically. For example, some of the systemic issues may include income inequities or a lack of foreign credential recognition.

Language

According to the literature, language is cited as one of the most common barriers to mental health care (Lai and Surood, 2010, p. 254). This study is rather limited in speaking to this experience as all participants had to speak and understand English in order to be interviewed. Therefore for study participants, language has not been as

significant a barrier as other new Canadians because all participants spoke and understood English very well. Although all participants could speak English upon arrival into Canada, Asad took classes to improve his skills. In addition to English, he also speaks a Somali dialect that is spoken in his village back home. He notes his English has improved since being in Canada. Narith is fluent in Thai, Khmer, and English. As he spent many years in Thailand as a young person, his ability to speak Thai is very good and he worked in Canada as a Thai-English translator for a period of time after arriving. In addition to English, Geetha is also fluent in Punjabi.

Access and healthcare experiences

Knowledge of the Healthcare System

The information that all participants have received about the Canadian healthcare system has been minimal and all information they have learned has been established by direct experience or by asking questions. Asad was unaware that there are in fact two health cards that he possesses – one is for provincial health and the other a drug benefit card he receives monthly with his assistance funds. He noted that he has been turned away from several doctors who told him that they won't accept his card. This was because he was showing most doctor's offices his drug card and did not know what the other card was for. This interview was the first time he had learned the difference between the two cards – as well as learning that he is entitled to visit any medical doctor in Ontario with his provincial insurance card.

Service Effectiveness

An outreach worker met with Asad at the shelter he was staying at and offered healthcare services from a program at a local hospital for New Canadians. He reports that when he

visits this program, he typically sees a different doctor each time, therefore he is unable to establish trust or rapport with his physician.

“I [see] nurses. I don't know, every time they send different people. Not the same person. But they know everything about me, they prepare themselves with the computer or with the file. Sometime I see the same person in three weeks or sometimes different people”.

(Asad interview; lines 973-977)

This program also referred Asad to a community-based agency to assist in his mental health needs. He accepted this help but notes that his health (mental and physical) have only minimally improved since attending these programs.

“[I feel] sometimes better, sometimes the same, sometimes bad. It depends on the situation that we have that time. So it's good they are helping me. They do all they can. All they can do”.

(Asad interview; lines 826-831)

Narith became very frustrated with the healthcare system when he arrived in Canada. After a month of living in Toronto, he decided he needed help (physically and mentally) and was quickly distraught with the way he felt he was treated by healthcare providers. He reports that doctors were typically more concerned with why he was in Canada rather than listening to his symptoms and helping to resolve his difficulties.

Feeling Heard

All participants expressed a concern that they did not feel heard by the healthcare system. Narith says that he has even worked with an agency that specializes in trauma and although they would listen to his story, they did not help him in overcoming the tremendous impact this trauma has had on his life. As a result of mental health challenges, Geetha regularly visited a psychiatrist at her local hospital for help. Her psychiatrist was not interested in the reasons she may be feeling unwell but rather continued to prescribe her medication. This did not work long and as a result, she had to admit herself to a hospital for help.

“For a long time [the psychiatrist] gave me the same medication, just the dose he changed. And he would keep asking me how I was doing. Every week I was going there. I was not an open person before. I wouldn’t open up. I was very quiet. So I would go and I would say yeah, I’m doing okay and he would take my word for it. He thought I was doing fine while actually I was feeling miserable but I would just go and say yeah, I’m fine. Then six months or a year later then [my husband] started to come with me and then he told the doctor, you know, don’t take her word for it. She just keeps saying fine just because she wants to, but she’s not fine. And then [the doctor] realized that I was actually doing much worse than what I was saying. And then he changed the

medication and this new medication seems to be helping me a lot better than the other one”.

(Geetha interview; lines 1167-1179)

Until recently, she has not had a space where she can talk about the stressful events that are perpetuating her feelings of depression and anxiety.

Narith admitted to seeing several doctors before finally finding one that he felt listened to him. He said in order to find help, he would enter walk-in clinics or other offices that had a ‘doctor’ sign out front and tell them that he needed to talk to someone. Rather than referring him to a mental health practice, he was told that they were unable to help him, so he would leave feeling disappointed.

“Sometimes I just decided to walk in, if I see like a doctor’s office, or something, that kind of place, I just walk in and ask them, you know, can I be your patient? What’s the problem with you? I said, I just need someone to talk to. But it seems like after one experience to another hell... I just try to avoid them, you know. I stepped back from them, because I don’t see any help. All they say, why do you come to Canada? They’re interested in my life, like why I’m here, more than my sickness”.

(Narith interview; lines 740-752)

He also reports that even when he had a chance to speak with a healthcare provider, he did not always feel heard because they appeared distracted.

“Or maybe when they talk to you, they use their iPhone or Blackberry to do something else. They don’t really pay attention, you know”.

(Narith interview; lines 729-730)

He says that his current doctor listens to him and also tries to help relieve some of the mental health problems he has been facing. Narith also highlights that a lack of Asian-centred agencies can be problematic, “At the mental health agency, I don’t really see Asian people” (lines 777-778). Perhaps a Cambodian or other Asian doctor or healthcare provider would be better able to understand his needs as a patient as well as be able to understand his concerns. Although he is fluent in English, he may be better able to express his symptoms in his native language however, he does not have an opportunity to do this.

Social Support

Making Friends

Since Geetha arrived in Canada, she has not made any friends nor has any of her family moved to or even visited Canada.

“You know what happened? When I came new to Canada, I tried to make friends at my workplace and stuff like that, but my situation at home was so bad. When I would try to tell them something about myself they’d be like why you living with this guy? Just think of divorce and live happily and all these things. So that was like against my Indian culture and thinking, you know. So I would never think of leaving him and going

by myself or something, you know. So that scared me to... not to make any more friends. So even till today I don't have any friends here. I depend on him a lot and he's my only friend here. But there is one of his cousins here who I'm more comfortable with so I talk to her a lot. Once a weekend I'm going to her place because she has a son now who's like three years old and my son is four and a half years old so they play together with each other. So I go for couple of hours. And she's the only person who like I feel comfortable talking to about things. But other than that I don't have any friends, no".

(Geetha interview; lines 1349-1369)

Upon arrival into Canada, Narith entered a restaurant that was owned by a Cambodian family. They did not treat him well and thought he was in the restaurant to steal. He says that at that time he did not look as healthy as he does now so thinks he may have scared them. He also went to the Cambodian-Canadian Association to meet new people and although the people were friendly, he decided he was not ready to befriend Cambodians as he was concerned word would get back to Cambodia that he was in Canada and that his life or that of his family would be in danger.

"I went to the Canadian Cambodian Association; they are friendly, but I try to have less contact as much as possible, yeah. I just want to go see quick... I don't

have to tell them I'm from Cambodia; you know, I can speak Thai and other languages”.

(Narith interview; lines 246-250)

Narith also says that he will often greet people in the street but that he rarely gets a positive response. Narith admits to feeling ‘rejected’ and notes this impacts his mental health negatively as he has no one to speak to.

“People are afraid of me. Sometimes I say hi and they just walk”.

(Narith interview; line 428)

In Cambodia Narith reports that he had an active social life and stayed in touch with his family. Although he was beginning to suffer the symptoms of a mental health problem prior to coming to Canada, it was not until he arrived that these symptoms became much worse.

“Maybe down there I had more friends, or something, I don't know. But when I came here, I feel like... what's the right word to say? Hopeless?”

(Narith interview; lines 595-596)

Since Asad arrived in Canada, he has also been unsuccessful in making friends. Asad has met people here whom he refers to as acquaintances such as people he meets while waiting in line at the shelter. He has not made any connections and admits to feeling very lonely.

“I meet [people] in the library or when we are in the lines when everybody goes to eat. It's not that kind of

connected friendship. Sometimes it's good not to rush to the people if you don't know them good. But sometimes it's good too to have some friend that you can talk and socialize with people. I feel lonely.”

(Asad interview; lines 376-387)

Sometimes when people arrive from other countries, they instinctively place themselves in an area and atmosphere that is surrounded by people from their home country. They may move to a neighbourhood with others from their country or join clubs or associations where others can be found. Similarly to Narith not wanting to join any Cambodian associations, Asad also does not want to have any contact with Somali people in Canada. Asad indicated that even though many new Canadians prefer to live in areas that have higher populations of people from their home country, there are many new Canadians that, for a variety of reasons, do not wish to be in contact with members of their own community or culture. Asad experienced such trauma in Somalia that the mere discussion of the civil war triggers him and significantly impacts his mental health.

“The way they [Somali people in Canada] talk, they talk about the civil war and they remember bad things. I don't wanna talk about the civil war or tribal conflict.”

(Asad interview; lines 987-989)

Asad noted that since being in Canada, he has run into people that were from his village in Somalia who also arrived in Canada as refugees, and although he may say hello, he makes no attempt at staying in contact with them. Although it has been reported

in the literature that ethnic-matching (between a client and healthcare provider) is important (Snowden et al., 1995, p. 466), some new Canadians may not seek care due to stigma within their own communities as well as mainstream society (Schreiber et al., 1998, p. 515). Therefore they may deliberately wish to receive services from a provider that is not from their country or part of their culture.

Supports from Home Country

Until six months ago, Narith was completely alone in Canada without any friends or family. Due to the nature of his escape from Cambodia, he was not able to speak to his family often as a way of protecting their safety. He does speak with his parents more often now but has not seen them nor does he think he will see them again. The family Asad was closest to in Somalia were his parents and he refused to leave Somalia while they were still living, “As long as they were living, I was not leaving [Somalia] (line 1275). When they passed away is when he made the decision to leave. Since he has arrived in Canada, he has not had any contact with friends or extended family in Somalia. Both he and Narith spoke about the expense of phoning overseas so this is very limiting.

“Before I avoided calling [my family], because I don’t want the government to know anything they knew, you know, so... But now it’s okay; I just use public phone or something and just call. [I get a] long distance calling card [but I don’t call] too often. Also, you know, I’m not employed, right. It costs money.”

(Narith interview; lines 167-176)

Geetha speaks to her family in India but reports that her mother has difficulty understanding her mental health problems and is unable to be supportive.

“Maybe a couple of months ago [my husband] told her about like I was having suicidal thoughts and couple of times I had wanted to do something but I always would give him a chance but I would tell him I’m not feeling well and I [might] do something bad, can you do something about it? He would leave his work and he would come running for me and every time I would be okay after that, you know. So [my mother] had very hard time understanding this and after I phone her now I realize that ... how bad she was feeling about it and how bad the situation must have been because when you’re there you don’t realize anything.”

(Geetha interview; lines 194-205)

Supports in Canada

Having the support of friends and/or family are strong protective factors against mental health challenges and stressors. Supportive friends and family (or lack of) played a key role with each participant. Geetha’s only supporter is her spouse.

“Like [my husband’s] the best person who can understand me. Other than that there’s nobody around me who can understand me well, you know, and so forth. Because he has been through depression himself so he

knows what is depression is all about and he can try to understand.”

(Geetha interview; lines 162-166)

The only family she has in Canada is that of her husband's and that relationship is strained at best. Her spouse also has few friends as a result of feeling he needs to stay with her in case her mental health deteriorates requiring assistance.

“But I even find nowadays when he goes out and I'm there for like four, five hours on my own with my son in the evening, I'm fine. And he comes home and he's like “You didn't call me once. Are you okay?” And I'm like yeah, I'm fine. I'm fine. And I know where he's going so I don't need to call him. But before that I used to call him a lot. It's like please come home. I cannot take care of this, that, whatever.”

(Geetha interview; lines 1697-1703)

Geetha admits that her spouse is her best and only friend and said that if one of them was not doing well, the other ceases to do well also. Her husband is a strong supporter in terms of her recovery as well and drives her to all her appointments. She admits that if he does not drive her, she will not go on her own however she does have the desire to learn.

“I cannot go to some of the appointments. Like when I wanted to go to some school to inquire but he could not take me there because he wasn't feeling well. So there

*are small things that make me realize that I should learn
and now I'm feeling more motivated to learn."*

(Geetha interview; lines 1628-1632)

He also assists in childcare and meal preparation when she is not doing well enough to cope with these tasks on her own.

Once Narith's daughter and former wife arrived in Canada six months ago, he reports that his mental health has improved and he is very pleased to have his 'best friend' near him. He and his former wife speak every day and he sees her and his daughter more than once a week and he admits that they are 'all I have' (line 147). He says that he was very frustrated that it took so long for them to be able to come to Canada. He asked immigration when he first arrived if they could also come and was told they could not.

*"I just feel disappointed, you know; I said look, why did
it take so long, you know? I called the embassy, I
called Canada, you know; there is something wrong
about Canada, you know."*

(Narith interview; lines 157-159)

The people in Cambodia that threatened his life also threatened the lives of his former wife and daughter and this caused significant stress to Narith. Since they have been in Canada, he has found that his stress levels have decreased knowing they are safe.

*"All I wish is just they are good, so I consider them
more than for myself. Well, I have less guilt, you know,*

when they are here. I couldn't even smile before. Yeah, they are here, that's all I need, you know."

(Narith interview; lines 942-949)

Employment and income disparities

Socio-economic Status

All three participants are living with a very low-income and all noted that their current income is not enough to cover their expenses. Geetha and her husband had to file for bankruptcy in 2008 due to being unable to pay their expenses. At that time, Geetha's husband was working but due to his own physical and mental illness, had to quit his job. Geetha did not have any income and he was only earning government assistance which was not enough to pay for their growing family.

"[We were in debt]. Credit card, we are full \$1,000.00. Both of us they are full. So we pay every month like one to \$200.00 and then I guess we use again. Then in 2008 we filed for bankruptcy. The loans weren't paid up and I stopped working. We bought a new car so it was like car payments, it was like loan payments and a lot of things piling up quickly. My husband quit his job because of the fibromyalgia. Everything came rapidly and I couldn't manage it."

(Geetha interview; lines 806-839)

Assistance

All participants are currently receiving support from the government which they all state is not enough to maintain a healthy lifestyle in Toronto. Since 2008, both Geetha and her husband receive provincial disability income which does not allow them to save money, but does cover costs such as food and rent. Geetha has also received some second-hand clothing from her husband's cousin which has been helpful. Geetha said they were frustrated with their financial background not only because they have not been able to cover their expenses, but because the social worker at the hospital Geetha stayed in never told them about the Ontario Disability Support Program (ODSP).

“I wasn't working and I wasn't earning anything for one and a half year, no income. So it was only [my husband's] income that we were going on. And then after that somebody at his work told him that depression is considered a disability. And she said you should apply for ODSP [provincial assistance]. Actually, I'm very surprised that my doctors, my social service worker knew I wasn't working, he never asked me about ODSP. So nobody ever told me. But when one of his friends told us, then we apply for disability and I got disability.”

(Geetha interview; lines 681-688)

When Geetha contacted ODSP, her case worker told her that she should have known about this assistance program. ODSP covers the costs of most medications however, Geetha and her husband are unable to afford childcare and admit that they currently have

significant credit card debt. Narith is also receiving ODSP and insists the amount is not enough to cover living costs.

“They don’t give much, because the rent they give like three fifty, but I pay like four fifty for that place, so the money from the food may be like fifty dollars... sixty dollars a month. I go to the food bank and they give you some food, but... It’s free food; I don’t expect fresh or anything, but some of them is out-dated. When I read I say, why people do this, you know? It’s out of date, make people sick. Well, I complained a bit and then I went to Daily Bread food bank; I said I want to volunteer here. So finally I met some people and I said, this is nonsense, you know; can’t do this to people. I mean, they are poor, but they don’t deserve to die or something, or to be punished --- because the food here, you had to put something to preserve with and when they say it’s expired, it’s expired – you’ll kill people. And then they said they will look into that, something like that.”

(Narith interview; lines 343-372)

When Asad arrived in Canada and began living in the shelter, he was provided with \$30 a week for his expenses. He said that this amount was not enough to pay for expenses such as food so he regularly visited food services including the local food bank and soup kitchen. After he moved into his first apartment, he was provided with Ontario Works

(government assisted income) which covered the cost of rent and left him with \$200 a month. Although this was more than he was receiving initially, it was still a small amount and barely covered expenses.

Employment

None of the participants are currently working nor do they believe they are capable of working at this time due to their mental health conditions. Geetha has a degree in accounting but does not feel ready to work at this time due to her mental health problems. Her husband suffers from mental health problems as well as fibromyalgia so is also unable to work. Geetha states that her husband became frustrated with his work environment as he was there a long time but saw new employees (predominantly white employees) promoted ahead of him. She says this was very difficult for him and impacted his mental health negatively.

“When he was working at the bank he never used to get a transfer [or promotion] in work. And he would see like white people and they’re like coming, going; coming, going. And he could see that right in front of his eyes. I know why they are doing it, what they’re doing it for.”

(Geetha interview; lines 1857-1861)

He also does not wish to return to work until symptoms from his illnesses subside.

Since being in Canada, Asad has not been able to work due to his health but also due to the challenges that getting a job can include:

“No, [not working] is not my choice, it's the work itself because of my health. And being new to the country, they

ask you for résumé, something like that. I don't have it. So it's a lot of obstacles to overcome.”

(Asad interview; lines 354-356)

Asad would like to return to work if his mental health became more stable and if he was able to get assistance in creating a resume and job searching. As noted, Narith worked extensively in Cambodia as a researcher and activist and has many skills that can be important in the Canadian workplace. He has worked as a translator since being in Canada and has also volunteered at several community agencies. He discussed the importance of gaining Canadian work experience and he is concerned that he is not currently employed. Although he would like to work, he is not well enough and does not want to risk the progress he has made, “If I get a little bit better mentally I hope [to work]” (line 360)

Coping with a mental health problem

Medication

Everyone finds different ways to cope when suffering with a mental health problem. Two of the participants in this study are not currently taking any medications nor have a desire to as they did not like the way the medication made them feel.

“Well, I use medication from the prescription, but not now... not now. I told my psychiatrist – my doctor – I said, I want no medication. But that medication doesn't really help. If I took those medications I cannot even talk, you know. It's more depressing...you know, sometimes want to throw up.”

(Narith interview; lines 852-863)

There was also confusion from all the participants as to what the medications were prescribed for. They were given little information (or did not understand the information they were told) about the medication, its uses, side effects, and dosages, “I stopped [taking medication] because I got itchy from that, give me overweight” (Asad interview; line 839). Therefore, other ways to cope with their respective mental health problems were employed.

Substance Use

In addition to going for walks and spending time online, Asad also drinks a significant amount of alcohol to cope.

“I drink a lot. You know, I have drinks because it makes me sleep. I drink a beer and vodka. I don't get [alcohol] every day but at least 15 days of the month I go. When I drink and I go to bed, I don't have nightmares, it makes me sleep. When I drink, I pass out. Then as soon as the alcohol is in my system, I sleep. I don't really understand that but that's the way it is. I don't know.”

(Asad interview; lines 1003-1042)

Narith experimented with street drugs but reports he never used them regularly and has not used them in several years.

“I used to smoke marijuana once in a while, just for parties. I don't addict to them, no. And maybe one happened in a year or something like that. And I used

to try Ecstasy... they're good; if you do it properly, they're good, but I don't do it. I just want to see why my friend, neighbour... you know, always addicted to it. I just want to see how it feels. If you use it properly, I think that, you know, it's better than having drug busts. It just makes you happy. I know how to make myself happy".

(Narith interview; lines 405-416)

Due to nightmares and other issues that were causing him not to sleep, he was regularly prescribed sleeping pills but stopped taking them as he was concerned he would become addicted.

"Oh, sometimes, you know... sometimes I feel like fever, sleeping problems. Maybe I'm looking for sleeping pill prescription... something. Now I no longer take it. They were helpful, but it's no good. I know it's no good, like an addiction, so I used to take, but now no longer. Now I sleep okay... not the best, but I can sleep."

(Narith interview; lines 709-715)

Suicidal thoughts and behaviour

Two participants reported having suicidal thoughts, attempting suicide, or engaging in self-harm. One study in the literature found that Chinese and Indo-Asian immigrants have higher rates of suicidality than their European counter-parts (Kennedy et al., 2005, p. 354). For example, 47% of 1st generation Chinese and 52% of Indo-Asian immigrants

thought about completing suicide compared to 36% of the European immigrants. However 3rd generation Europeans have higher rates of suicidality than their 3rd generation counter-parts. One study did find that refugee girls (ages 13-19) reported higher rates of suicide attempts than males (5.7% compared with 1%) (Tousignant et al., 1999. p. 1429). Both Geetha and Asad expressed that they had inflicted self-harm both prior to and after arriving in Canada. Asad reported that he attempted suicide while living in Somalia and still thinks about it today.

“I tried [to end my life] in Somalia like four years ago. I tried to cut my wrists. Someone took me to a clinic, there was no doctor, she put a little bit things in it. But no medicine, nothing. Luckily it went good. [I still think about suicide] from time to time sometimes when I'm depressed, like that. [I think about it] every three months. I told the doctor at [the community agency]. He wrote me something to take but that doesn't help me. Even I get kind of—how do you call it—bad side-effects. Something like that. He give me a phone number, emergency number to call [but I've never called it].”

(Asad interview; lines 765-813)

Geetha also spoke about a desire to hurt herself after her son was born.

“I went to emergency room one day and I said to them, you know what? Keep me in the hospital. I cannot take one more day at my home. I don't know what I will do.

[My son] was very young. Three, four months maybe. Like I would just do something, you know. Like run against the wall or something.”

(Geetha interview; lines 1212-1239)

“I got cut. I got cut like three, four times you can say. I was like in a position that I would actually cut myself. I never went through with it [suicide]. I didn’t have a plan what to do. But I was just so frustrated like I wanted to get lost somewhere. I wanted just to leave my home, go outside and never come back. I would call [my husband] first at work and I would say I’m having these feelings and I don’t know what to do. He would leave his job and come to me and try to console me.”

(Geetha interview; lines 1292-1302)

Alternative Treatment

All participants stated that if natural medicines were covered by their insurance plans, they would almost definitely use them instead. None of the participants were able to afford natural medicine or therapies so were unable to purchase.

“[Natural medicine] costs money. I’d better choose remedy, you know. I’d better choose those things, you know, because medicine, through my own experience, I don’t know, some are good, yeah... there’s always something, like pros and cons about anything. But to me, I

choose nature, you know, as long as it had been like permitted. Like... well, though scientific way, right, like not just go and pick up some tree and eat, no. I mean, the combination of scientific and nature, you know. Yeah, for sure [I would use natural medicine if it were covered by OHIP], because I trust in nature. Honestly, everything is from nature, but we've tried to walk away from them. You don't bring those medicines from Mars; they're from the ground and from the trees, but we walk away, you know".

(Narith interview; lines 1086-1105)

Narith opted to spend time with nature and admits to speaking with nature when he feels lonely.

"I talk to the trees. If I talk to people, they ignore me, so I talk to the trees. It's better for me. Yeah, I know how to make myself happy; I just go out, you know, just try to forget everything."

(Narith interview; lines 416-419)

Staying busy was also noted as a way of coping not only for mental health problem, but with loneliness in general. Narith says "I try to keep myself busy to conquer my depression, but I never win" (lines 189-190). Daydreaming and going for long walks were also noted by participants. Geetha stated that she and her husband have stopped eating meat and try to eat an all-natural diet which she says has helped with their depressive symptoms.

Cultural beliefs about mental health and illness

Culture-specific Beliefs

All three participants come from three different countries but that have similar beliefs (or disbeliefs) about mental health and illness. Therefore, seeking services in Canada may not occur until the symptoms are severe enough to warrant a visit to a doctor or hospital. General practitioners in Somalia (especially smaller communities) are difficult to find. Before the civil war, Asad reported that it was not so difficult to see a doctor but many have been killed during the war.

“Really there is no healer but it was very difficult to get the doctors, too, because the doctors, they run and there's no pharmacies to get medicine, some organizations like Doctors Without Borders, if you find them, that's good. Most of the time you live by painkillers, something like that. [You get medicine from the] black market or if you have some family from outside the country, some of the pills they send them. We share with that. That's the way it is. We take a chance. There's not regular health care. There used to be hospitals open everywhere. There were Russian or Italian doctors, Somalian doctors. That was good. It's the experience of the civil war and seeing the banishment and the management adding these things.”

(Asad interview; lines 494-519)

Stigma

How mental health and illness are understood in one's country of origin plays a pertinent role not only in whether or not they will seek help, but what kind of help as well. Unlike other illnesses, mental illness continues to be heavily stigmatized around the world and most countries contribute little (financially or otherwise) to mental health care or policy – especially compared to physical health initiatives. Asad recalls having a neighbour whose son had mental health problems. This young man was chained to a tree behind the house and he was someone the neighbourhood feared.

“I saw neighbors [with mental health problems]. I remember one guy, he was shackled into chain to a tree. That was not fair. That time I was young I don't understand. But now when I look back it's a very bad thing to do to someone. But his family was doing it so no one can say nothing about it. They feed him but 24/7 he's shackled to it. The chain isn't too long, he can go up to the washroom, come back, sit under the tree, inside of the house. Because they don't him that other people see that he was there. Very difficult situation. [My parents said] oh, he's crazy, don't go near him.”

(Asad interview; lines 884-907)

Mental illness in Somalia is something to be embarrassed about and depending on the illness, often requires the family to keep the individual locked in the house. If this is all Asad knows about mental illness, his eagerness to seek care when in Canada would likely be low.

Geetha did say that in the bigger cities, it is “getting better” and mental health and illness are being better understood and treated but reported that in most parts of India, one is either crazy or not. It is not spoken about and as in Somalia, is quite stigmatized.

“Like one of my uncle’s wife, she had a little bit mental problems. I don’t exactly know what kind of mental health problems. So she was getting help that way. But everyone’s perspective of looking at her like she’s sick or more like she’s crazy. But now things have changed [in the cities].”

(Geetha interview; lines 2018-2036)

She recently admitted to her mother that she has thought about suicide in the past and her mother had difficulty understanding this because it would mean that Geetha was “crazy”. Narith reported that mental health terms such as depression, do not exist in Cambodia. There are almost no supports in place in Cambodia for people with mental health problems and the stigma associated with having a mental illness are great.

Trauma

Both Asad and Narith have been diagnosed with Post Traumatic Stress Disorder (PTSD) since being in Canada which includes symptoms of reliving the traumatic event causing panic, avoiding anything that may remind one of the trauma (e.g. Asad avoiding crowds or being fearful of sirens), and symptoms of “increased arousal” (di Tomasso, 2010, p. 248).

“It starts if I see a lot of people, I avoid the crowd and I am becoming more isolated. I don’t socialize with this. Fire, a fire truck having the sirens on—I get scared at that. Or when car

backfires, it's scary too. Some days is good, some days is bad. I don't know. But the nightmares are getting worse somewhat."

(Asad interview; lines 528-548)

According to Bemak and Chung (as cited in di Tomasso, 2010, p. 250), PTSD among the refugee population is 50% or higher and depressive disorders can range from 40-90% (p. 250). It has been reported that during the process of immigration as well as settling in a new country, refugees do not get the professional support needed and this can lead them "vulnerable to mental breakdown". Geetha's trauma stemmed from living with and experiencing abuse from her mother-in-law, while Asad and Narith suffered from political danger and violence.

Narith noted that although mental health professionals would listen to him, little was done to help him recover from his trauma. Di Tomasso (2010) writes that by framing the problem within the individual, mental health professionals as well as society at large are 'absolved of the responsibility' to address some of the social determinants or 'socio-political' issues that played a role in developing such a problem (p. 252). Some researchers have argued that by labeling people with a PTSD diagnosis and by framing their suffering using a medical model, it may actually reduce their ability to heal and to deal with their suffering and pain (p. 252). As many believe the symptoms of PTSD are natural responses to a frightening event, labeling this response as a mental illness may impede one's ability to recover. Therefore a new Canadian may not believe their symptoms to be the result of a mental health problem and therefore would not seek mental health care.

Once they do seek help, if they are not being counselled in such a way as to recover, they may discontinue using services until their symptoms have become more severe. Both Asad and Narith have received services for the trauma they have encountered, and both admitted that they do not feel much better than when they began treatment. There may be a need to have more counselors or peer-led programs with people who have suffered trauma themselves in order for people who are currently suffering to feel heard and to begin to heal.

Chapter 6: Discussion

This study looked at what barriers to receiving mental health care may be experienced by racialized new Canadians. There were some themes between the three participants that also correlated with findings from the literature review that will be highlighted here.

First, this thesis will explain why only racialized new Canadians were selected for this study. The last 20 years there has seen an influx of racialized people moving to Canada which is a shift from immigration prior to this period when most newcomers were from European countries (Statistics Canada, 2008). In Canada, racialized people are more likely to experience determinants such as poverty and racism which can significantly impact one's mental health. The term 'racialization' is the "social significance attached to perceived phenotypical or cultural difference among groups of people" (Creese, 2007, p. 93). In other words, racialization has more to do with social hierarchy than it does a biological trait.

Razack (2008) writes that 'race thinking' allows us to understand how a concept such as skin colour can become "virulent" (p. 8). Furthermore she writes that race thinking divides the world by deserving versus undeserving simply according to decent and can "mature" into racism. Similarly, Ladson-Billings (2000) writes that 'racial formation' is a social construction and is the process of developing racial meanings (p. 259). The experiences racialized people have when coming to Canada and needing mental health services are different from non-racialized groups. For example, racialized groups are more likely to encounter a language barrier, have experienced racism/discrimination (in and outside of the healthcare system), live in a low income

environment, and delay seeking services for a mental health problem (Beiser, 2004, p. S37).

Lack of access to and awareness of services was identified by all three participants. Upon arriving into Canada, none of the participants knew how or where to access services and since all came from countries that did not have national mental health policies or at the least, acceptance, seeking help was hindered. Nelson and Macias (2008) write about the experiences racially marginalized women encounter when faced with breast cancer information. They write that materials about breast cancer are typically developed for the 'ideal patient' which excludes women of colour almost entirely. Women of colour must 'conform' to 'dominant standards' in order to heal and to become the ideal patient (p. 20). To my knowledge, a similar study has not included mental health materials, but this example shows that medical information (when available) may be demonstrating what a patient should look and act like and one must conform to this image to receive care. This reminds me of what Narith was describing when he spoke about there not being any Asian people in the mental health agencies he attended. What people see whether it be in pictures or in the people at an agency, can all be determining factors in whether or not someone may feel comfortable receiving care.

All three participants encountered the mental health system through different pathways. Geetha utilized her family doctor and the hospital emergency department while Asad and Narith have used the services of community agencies and hospital programs. All three participants admitted to not receiving enough information from government services about help that was available to them. Geetha suffered from mental illness and low income for a number of years before leaning about ODSP. Asad did not know the

difference between the drug card he received or his provincial health card. He was told by several doctors that they wouldn't see him because they were unaware he had provincial health insurance and therefore care was denied to him many times. There was clearly frustration, especially from Geetha, about the lack of information they have received and how they all felt this was discriminatory.. As healthcare systems work differently in each country, the participants in this study as well as those described in the literature found their lack of awareness or knowledge was a barrier to care.

None of the participants interviewed were currently working or were able to work due to their illness. Geetha and Asad were educated and were qualified to work in positions in Canada but Asad noted that without a resume, there were many obstacles to face. As a result of not being able to work, all participants were being supported by government assistance and were therefore earning very little. Morrow et al. (2009) writes that as many as 90% of people with a mental illness are unemployed (p. 663). The participants admitted that their current income was not enough to sustain them and both Asad and Narith relied on food donation centres. Income can be a barrier to care in that one may not be able to afford the treatments they need (such as alternative therapies) or perhaps cannot afford all of the medication needed. Transportation was highlighted as a barrier to care in the literature and being able to afford public or private transportation was difficult for all participants. Narith noted that although there is a mental health agency in Toronto that works specifically with people from Asian countries, he is unable to afford the transportation costs to get there. All participants, especially Narith and Asad expressed a desire to work and were hopeful that their condition would improve enough that they would be able to work. Both said that memories of the trauma they experienced

prior to migration significantly impacts their ability to function and that much time is spent thinking about and becoming upset over what they experienced in the past. They noted that until these feelings have healed, they will not be able to function in a work setting.

Trauma was described by all three participants and the severity of this trauma and the inability of service providers to effectively deal with the trauma has acted not only as a barrier to receiving continued care, but prevents them from recovering and working through their mental health problems. The more an individual perceives they were in danger, the worse their symptoms may be (di Tomasso, 2010, p. 248). Beliefs about mental health and illness from one's country of origin or culture play a significant role in whether or not one will seek services for a mental health problem. All participants reported that mental health is not discussed or understood in their home countries and this knowledge determined how and whether or not they would seek help. When speaking about trauma, di Tomasso (2010) writes that while some of the "symptoms of PTSD may be experienced across cultures, it is the variance of world view that leads to the differences in mental health and healing" (p. 259). In essence, how one understands and experiences the world will impact their experience of living with a mental health problem. Geetha and Narith reported that mental illness was not understood or spoken about in their home countries while Asad said that in addition to it not being spoken about, he had a neighbour who was neglected and feared because of his mental illness. Therefore, a strong barrier to care would include one's own belief systems not only towards help-seeking, but also towards understandings of mental illness. As was

described in the literature, reasons for having a mental illness may include witchcraft or punishment for a wrong-doing.

The stigma associated with having a mental illness can be found in most parts of the world but may be heightened among people who are used to being from a place where mental illness is never spoken about. Geetha said that in her community in India, one was either “normal or crazy” with no other option. In some parts of the world, having a mental illness may mean that the individual (and perhaps their family) is ostracized from the community completely. Coming to Canada and living with the symptoms of a mental health problem is complicated in that seeking help may bring a sense of shame or fear to the person. As demonstrated in the literature, new Canadians often do not seek help until their symptoms are more severe and this may be a result of being too ashamed of seeking care earlier. Geetha, for example, did not seek care at the hospital until she had become isolated and believed she would hurt herself. There is a fear in seeking care that one may get deported back to their country of origin or that they may face significant social stigma as a result of being in care. This fear alone prevents many new Canadians from seeking care early on and campaigns aimed at overcoming stigma are one way of alleviating this.

A lack of culturally appropriate services was highlighted in the literature as a potential barrier to care and was found among the participants as well (Whitley et al., 2006, p. 207). Narith especially did not think that his providers understood the trauma he experienced or provided appropriate care. He reported that doctors told him to find other activities (e.g. attend university) and he found this frustrating and dismissive. Geetha said that she did not feel she was getting help until she began seeing a Somali case worker. Geetha noted that she is able to talk to this worker as if they are friends and that it is

easier because “she understands where I’m coming from as a woman of colour not from Canada”. Although having a provider that has the same (or similar) cultural background is not important to all new Canadians, it appears to be important to many and the lack of diversity within the mental health profession makes this difficult. For example, there are only 13 Hindi-speaking psychiatrists in Toronto but there are an estimated 12,000 Hindi-speaking people in the city (College of Physicians and Surgeons of Ontario, 2012). Additionally, there are no Somali-speaking psychiatrists in Toronto but there are a reported 11,500 Somali-speaking people living in Toronto (Statistics Canada, 2006b). This demonstrates that in Toronto (which has the highest number of people who identify as being born outside of Canada) there is a dearth of providers available. To compare this with another Canadian city, there are only six psychiatrists in the city of Calgary that speak Punjabi however there are over 20,000 Punjabi-speaking people living there (College of Physicians and Surgeons of Alberta, 2012).

All participants reported being discriminated against due to their ethnicity either within the healthcare system and/or outside of it, and this will certainly hinder one’s desire to seek mental health services. If a new Canadian has felt racist attitudes towards them by Euro-Canadians, they would feel less inclined to receive help from someone of that background. The literature shows that perceived racism impacts not only one’s mental health but also their ability to seek care (Noh et al., 2007, p. 1272). Racism may not be directly portrayed by a service provider, but rather may be the result of systemic structure in place. For example, within the healthcare system, senior staff (including physicians) are more likely to be of Euro-Canadian decent whereas nursing and maintenance staff more likely to include people of colour. Therefore the culture of a

hospital or other healthcare setting may indirectly relay to the client that people of colour are not in positions of power or authority. Furthermore, a racist system may also include the inability of healthcare professionals to find professional interpreters or translators (versus using family members of the client). It may also include valuing a western medical model over any alternative model which informs the client that their way of healing or treating mental health problems is not valued. Narith felt discriminated against when all the doctors he saw were more interested in why he was in Canada and Asad felt rejected that so many healthcare centres had turned him away without seeing him because he showed the wrong card. Many new Canadians (especially refugees) may not like to accuse healthcare providers of racism or discrimination as there may be a fear of authority, deportation, or guilt for living in a new country and receiving financial assistance.

Social support (or lack thereof) was a strong theme throughout all the interviews. Loneliness was expressed by both Narith and Asad as neither had any friends or family in Canada (until very recently for Narith). Geetha admitted that her husband was her only friend and spoke to the dependence she has on him not only for support, but also as someone who can drive her to appointments, provide food when she is unable, and bring in a secondary income. Social support is not only an indicator on one's mental health (more support often means better mental health), but is also an indicator of whether or not someone will seek care. If someone has a non-judgmental person in their life that supports their decision to seek care, they are more likely to receive services and get help.

Chapter 7: Implications for Social Work Practice

The barriers that prevent a new and racialized Canadian from seeking care varies from personal beliefs to a lack of professionals who speak one's language or are part of one's cultural and/or ethnic background. As social workers, it may not be possible to alleviate all barriers to care, but there is room to ensure that clients are receiving the best care they can once in treatment.

Practice Frameworks

Anti-Oppressive Practice

Establishing an anti-oppressive and anti-racist practice is crucial when working with racialized new Canadians to ensure all clients are treated fairly and equitably. Anti-oppressive practice (AOP) has been defined as “a form of social work practice which addresses social divisions and structural inequalities...” (Dominelli, 1996, p. 170). It continues that “AOP aims to provide more appropriate and sensitive services by responding to people's needs regardless of their social status”. By subscribing to an AOP framework, social workers are better equipped to work with people and to eliminate some of the barriers they face – both within and outside of healthcare.

Cultural Competence

Being culturally competent has been wrongly understood as being an expert about cultures other than one's own. Cultural competency has been defined as “understanding the importance of social and cultural influences on patients' health beliefs and behaviours; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-

making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations” (Betancourt et al., 2003, p. 297). Essentially what this entails is that staff at all levels of an organization should reflect the populations they serve, ensuring there are language services available, and being knowledgeable in the social determinants of health and how social factors can impact one’s mental and physical health. Furthermore, competence is not about being able to “develop ethnic-based skills and strategies” but to continually challenge oneself and reflect on one’s own “cultural biases and assumptions” (di Tomasso, 2010, p. 259).

Self-Awareness

Recognizing one’s social location is a key aspect of self-awareness. Social location can include one’s ethnic background, socioeconomic status, ability, education, nationality, and age. Understanding social location is crucial as this is the lens through which we see and understand the world around us. If someone is from the dominant culture, there will need to be a continued examination of one’s beliefs and values in order to ensure that a bias or judgment is not taking place. To counter the effects of discomfort being a barrier to care, being equipped with the skills of self-awareness can mediate any discomfort a client may have. It will not always be possible for clients to receive mental health care in an organization that has professionals that are the same background as them – especially in small communities. Therefore by engaging in self-awareness – which can be part of cultural competence – clients will feel a stronger sense of security and less so of discrimination. Heron (2004) wrote about her experience working with women in Zambia and how she became self-aware of her research methods following her work. For example, she wrote that she developed a work group which consisted for two Zambian

women and two white women believing this to be equal (p. 120). She did not take into consideration the privilege the white women (including herself as the researcher) held in comparison so although the group may have been equal, it was not equitable. Being self-aware in practice is important when working with racialized new Canadians for similar reasons and the recognition of location and privilege are essential to building an equitable relationship.

Structural Implications

In addition to ensuring translation services are available, there are other structural and systemic initiatives that can improve access to care for racialized new Canadians. There should be an increase in the number and quality of mental health services that are specific to a racialized population. Although most racialized new Canadians reside in Toronto, Montreal, and Vancouver, racialized people reside throughout Canada and services should reflect this. There should also be consideration for alternative therapies to be covered by provincial health insurance and provincial drug benefit plans. All participants in this study reported that if available and affordable, all would rather utilize alternative therapies. More research into the barriers to mental health care for racialized new Canadians should be implemented on a larger scale to better support the argument that barriers need to be understood and alleviated. Better supports should also be in place for new Canadians – especially refugees. Many refugees come to Canada having experienced significant pre-migration stress as well as possible conflict from their country of origin and if this is not addressed, symptoms of trauma, depression, anxiety, or other mental health problems may worsen.

Practice Implications

When a person immigrates to Canada they may experience extreme loss including the loss of home, country, culture, family, profession, language, friends and other supports, and a shared sense of belonging (di Tomasso, 2010, p. 253). The task for a social worker therefore is two-fold: helping new Canadians work through some of the experiences they may have had prior to coming to Canada as well as assisting them in establishing a life here. In keeping with the theme of multiculturalism that Canada is based on, social workers too must employ a diversity of strategies when working with new Canadians as ‘talk therapy’ may not suffice for everyone. Encouraging the use of alternative therapies (such as acupuncture or naturopathy) may be a strategy for helping people work through their mental health problems as well.

Di Tomasso (2010) writes that “getting to know the worldview of the client” social workers can adapt their practice in such a way that makes sense to the client’s cultural reference points (p. 259). Furthermore, when conducting an understanding of one’s social location, it should be determined whether or not an aspect of that location will be a barrier to care.

Chapter 8: Conclusion

This project utilized both the findings from the review of relevant literature as well as the interviews of three racialized, new Canadians to understand how the social determinants of health, such as income level and race, along with other barriers identified by participants affect access to treatment for mental health problems. The discussion highlighted that determinants such as income, language, and social supports can impact both whether or not someone will seek services as well as the pathway to getting that care. This thesis attempted to demonstrate some of the personal, systemic, and social barriers that can exist for racialized newcomers when accessing care such as racism and discrimination (both in and outside of the mental health care system).

In order to reduce or remove some of these barriers requires work at all levels including increasing diversity in the workforce and ensuring clinicians are properly trained in cultural competence. It also shows the importance of new Canadians receiving supports upon arrival to ensure their quality of life does not diminish to the point of a severe mental health problem. Adequate income and shelter were two key themes that were raised both in the literature and by participants. Research as well as policy development should be increased to counter some of the negative impacts immigrating to Canada may have. Additionally, ensuring diverse clients receive equitable services is paramount and funding services specific to their needs is a priority.

Limitations

Logistical limitations included having a project with only three participants. Although it is common not to have many participants in a qualitative project, it leaves

little room for generalizations or perhaps explanations. Future work should include more participants from various backgrounds to gain further insight. Although the participants reflected cultural diversity, their experiences cannot be necessarily generalized to the experiences of all immigrants and refugees. The reasons for and experiences of immigration may impact one's mental health (both in the short and long term) therefore, not all new Canadians will experience the same barriers to care. Additionally, as all participants volunteered to be interviewed, the experiences of those who did not want to participate have been missed. Their stories may demonstrate more or fewer challenges within the healthcare system.

This project only interviewed participants who have accessed the mental healthcare system and therefore those who have not were excluded. People that have not accessed the system may have ceased to do so for a variety of reasons including additional barriers not mentioned in this study. Additionally, this study only interviewed participants in the city of Toronto. Toronto is Canada's most ethnically diverse city and as such, does have some mental health programs geared towards new Canadians and especially new, racialized Canadians. Barriers for this group in other parts of Canada may be more extensive as they may reside in a white-dominated community with either few ethno-specific services or few services at all. Furthermore, most studies conducted in Canada about the mental health of racialized new Canadians have taken place in Toronto, Vancouver, and Montreal therefore the literature is only reliable for a select number of areas in the country. Although it can be assumed that the barriers highlighted in this thesis may apply to new Canadians in other parts of the country, it should be noted that

these Canadians may experience additional barriers not mentioned or perhaps those mentioned by to a more significant degree (e.g. racism or access to healthcare).

The most important limitation for this study was the cultural limitation including the role of the researcher's social location. As a white woman from Canada, the researcher's identity may have impeded participant's willingness to express complete discussions of their experiences. The researcher may (likely) have been viewed as an outsider as the researcher represents a dominant group and culture and this may have increased mistrust. Although none of the participants reported feeling any discomfort with the researcher as a result of her social location, when working with marginalized groups, one's social location may always play a role in how the participant perceives the research and research process. Narayan (1993) writes that it cannot be assumed that because the researcher is a member of the same ethnic or racial group that he or she has emic knowledge of that group (p. 677). Therefore the assumption should not be that if the researcher were racialized the participants would automatically feel more comfortable or that the researcher would have 'insider' knowledge into the community. One's experiences and background all shape a person and although some participants may feel more comfortable at the forefront speaking with someone who is reflective of their racial or ethnic community, that researcher's analysis would still be through the lens by which they see the world – and this could be significantly different from the participant's. Furthermore, although the researcher provided an opportunity for the participants to comment on the findings of the research, the analysis was still through the researcher's social lens and knowledge framework. Therefore, analyses of the results are based on the researcher's thoughts, ideas, and interpretations.

Although all participants spoke English during the interview, they may not have been able to express themselves freely as English was not their mother-tongue. Not being able to converse with the participants in their native language is a significant limitation and it may have impacted the information received. Additionally, not all words or concepts in English can be properly translated (and vice versa) therefore some meaning may have been lost as a result of the interviews being conducted in English.

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Appendix A – Recruitment Poster



**University
of Victoria**

School of Social Work
Human and Social Development Building Room
B302
3800 Finnerty Road (Ring Road)
Victoria, BC
V8P 5C2

RESEARCH PARTICIPANTS NEEDED

*Are you new to Canada, identify as a person of colour,
and receive mental health services?*

I am a Master of Social Work student at the University of Victoria conducting a study called “Barriers to Mental Health Care for Racialized Newcomers in Canada”. I am interested in speaking with people to hear their experiences of entering the mental health care system.

You are eligible to participate in this study if:

- You are over the age of 18 years
- You have been in Canada for 10 years or less
- You identify as racialized or a person of colour
- You have received services for a mental health problem
- You are able to speak, read, and understand English
- You are willing to provide up to 2 hours to be interviewed

You will be given the option to review a written analysis of the study’s findings. Total maximum time commitment (including review of the analysis) will not exceed 4 hours.

This study is being supervised by Dr. Patricia MacKenzie, University of Victoria, School of Social Work, (250) 721-8036. This study has been approved by the Research Ethics Board at the University of Victoria.

Interested? Please contact:

Emily Hansson, MSW Student

Appendix B – Participant Consent Form



University
of Victoria

Participant Consent Form

Barriers to Mental Health Care for Racialized Newcomers in Canada

You are invited to participate in a study entitled Barriers to Mental Health Care for Racialized Newcomers in Canada that is being conducted by Emily Hansson.

Emily Hansson is a Masters' student in the Department of Social Work at the University of Victoria and you may contact her if you have further questions by phone or email.

As a Graduate student, I am required to conduct research as part of the requirements for a Masters' degree in Social Work. It is being conducted under the supervision of Dr. Patricia MacKenzie. You may contact my supervisor at 250-721-8036.

Purpose and Objectives

The purpose of this research project is to learn about the experiences people new to Canada have when getting help for a mental health problem.

Importance of this Research

Research of this type is important because there are very few programs in Canada that work specifically with people new to Canada which may prevent people from getting the help they need. By learning more about the experiences people new to Canada have, more can be done to create more programs for new Canadians and eliminating some of the barriers or obstacles.

Participants Selection

You are being asked to participate in this study because you are new to Canada (i.e. you have been in Canada for 10 years or less), you identify as a person of colour, and have accessed mental health services in Toronto.

What is involved

If you agree to voluntarily participate in this research, your participation will include an interview with Emily Hansson that will last no longer than 2 hours. This can be in one session or if you prefer, the interview can be conducted over a period of two sessions. Screening questions will be asked to ensure you understand the research project and to determine whether or not you are well enough to participant. Questions will be asked about when you came to Canada, what mental health difficulties you have experienced, how you started getting help, and challenges you have faced when getting help. You and Emily Hansson will meet at a time and location that is convenient for you.

The interview will be audio-taped and transcribed and observational notes will be taken.

Inconvenience

Participation in this study may cause some inconvenience to you including the time it takes to complete the interview.

Risks

There are some potential risks to you by participating in this research and they include feeling stressed by speaking about your experiences of immigration and living with a mental health problem. If at any time you feel stressed or uncomfortable and would like to end the interview, the interview will end with no impact to you. If you would like to withdraw from the study, Emily Hansson will remove you from the study without repercussion. The staff at Across Boundaries will not be informed of your participation in this study and this study will in NO way impact the services you receive at Across Boundaries or anywhere else. To ensure your comfort, you will select a location for the interview to take place that is convenient and comfortable for you. If you would like to be interviewed at Across Boundaries, this will be arranged. If you feel any discomfort or stress during the interview, the interview will stop. If necessary, Emily will assist you in seeking help either from Across Boundaries, a local hospital, or by notifying family or friends if the interview has impacted you in a difficult way.

Benefits

Although you may not directly benefit as a result of participating in this study, your participation will help to learn about what the experiences and challenges are to getting care for new Canadians.

Compensation

As a way to compensate you for any inconvenience related to your participation, you will be given \$50 at the completion of the interview. If you agree to participate in this study, the honorarium must not be coercive. If you would not participate if the compensation was not offered, then you should decline.

Voluntary Participation

Your participation in this research is completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will be discarded and the information you provided will NOT be used.

Confidentiality

Your confidentiality and the confidentiality of the data will be protected. Only Emily Hansson will know the names of the participants. Your name will NOT be used in any of the analysis or reports nor will it be shared with Across Boundaries or any other agency. All information including audiotapes will be kept in a locked cabinet and only Emily Hansson will have access to it. A research assistant will be transcribing all interviews and will therefore hear the content of the interview. They have signed a confidentiality form and will not repeat anything they have heard in the interviews.

Dissemination of Results

It is anticipated that the results of this study will be shared with others by way of a thesis. If requested, you can also receive a copy of this paper when it is complete.

Disposal of Data

Data from this study will be disposed at the conclusion of this project. Audiotapes will be destroyed, computer files will be deleted, and notes will be shredded.

Appendix C – Questions to determine cognitive capacity

Questions to determine cognitive capacity

1. Repeat these words: Dog, tree, house, boat
2. What day is it today?
3. What is the current year?
4. Approximately what is the current time?
5. Count backwards from 10
6. Recall the words you were just asked to repeat (from question 1)

Appendix D – Interview Questions

Interview Questions

Immigration:

Please tell me about the country you come from and when you came to Canada.

Why did you decide to immigrate to Canada?

Did you immigrate alone or were you accompanied by friends/family/loved ones?

Do you still have friends/family/loved ones in your country of origin?

Have you ever spent time in a refugee camp or similar place?

What did you know about Canada before moving here?

When did you arrive in Canada?

Life in Canada:

What did you think about living in Canada when you arrived?

Did you have a place to live when you arrived in Canada?

Why did you decide to move to Toronto?

What was your immigration status when you arrived? (i.e. refugee, visitor, etc.)

What is your current immigration status?

Have you ever worked in Canada?

Does your spouse or other family members work in Canada?

Do you find it difficult to pay for things that you need (e.g. food, clothing, shelter, etc.)?

Family:

Do you have children? How many?

Are you married? How long have you been married?

Are your children and spouse in Canada? Do they live with you?

Do your parents live in Canada?

Do you have family in Canada? If so, who?

Health:

Are you physically healthy?

Have you ever seen a doctor or traditional healer in Canada?

What does 'mental health' mean to you?

Help-seeking for mental health care:

When did you decide to get help for a mental health problem? Did someone tell you to get help or did you decide to get help?

How did you first get help for a mental health problem?

Did you ever see someone in your country of origin for a mental health problem?

Where did you first get help for a mental health problem?

What treatments do you currently use to help with your mental health problems (e.g. medication, herbs, therapy, etc.)?

Have you ever had to stay in a hospital for your mental health problems?

Does your family know that you are getting help for a mental health problem?

What services do you receive in Canada for your mental health problems?

What do you like about the services you receive in Canada?

What do you dislike about the services you receive in Canada?

Do you think doctors understand your mental health problems?

Do you feel safe or comfortable talking to health care professionals about your mental health problems?

Have you ever felt discriminated against when getting help for your mental health problems because of your race, gender, ethnicity, or any other factor?

Do you think the care you have received has made your mental health problems better?

Appendix E – Transcription Confidentiality Agreement

Confidentiality Agreement Barriers to Mental Health Care for Racialized Newcomers in Canada

1. Confidential Information

The ‘Barriers to Mental Health Care for Racialized Newcomers in Canada’ Research Project hereby confirms that it will disclose certain of its confidential and proprietary information to their interview transcriptionist, Leah Handler.

Confidential information shall include all data, materials, products, technology, computer programs, specifications, manuals, software and other information disclosed or submitted, orally, in writing, or by any other media, to **Leah Handler** by Emily Hansson .

2. Obligations of Transcriptionist

A. **Leah Handler** hereby agrees that the confidential ‘Barriers to Mental Health Care for Racialized Newcomers in Canada’ research study and is to be used solely for the purposes of said study. Said confidential information should only be disclosed to employees of said research study with a specific need to know.

Leah Handler hereby agrees not to disclose, publish or otherwise reveal any of the Confidential Information received from Emily Hansson, research assistants or other participants of the project to any other party whatsoever except with the specific prior written authorization of Emily Hansson.

B. Materials containing confidential information must be stored in a safe location so as to avoid third persons unrelated to the project to access said materials. Confidential Information shall not be duplicated by **Leah Handler** except for the purposes of this Agreement.

3. Completion of the Work

Upon the completion of the work and at the request of Emily Hansson, **Leah Handler** shall return all confidential information received in written or tangible form, including copies, or reproductions or other media containing such confidential information, within ten (10) days of such request.

Any copies of confidential documents or other media developed by **Leah Handler** and remaining in his possession after the completion of his work need to be destroyed so as to protect the confidentiality of said information. **Leah Handler** shall provide a written certificate to Owner regarding destruction within ten (10) days thereafter.

With his/her signature. **Leah Handler** shall hereby adhere to the terms of this agreement.

Signature and Date
