Beyond Displacement: Understanding the Intersection of Cultural Variables on Mental Health Service Utilization among Newcomers

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Abstract

Existing literature regarding mental health and mental health service access reveals disparities between the experiences of newcomers and their native-born counterparts. Previous studies have mainly focused on how the immigration process and displacement from one’s country of origin influence mental health. Comparatively, few researchers have explored the association between these contributing factors and culture in how immigrants and refugees understand their mental health and approach available services. The goal of this study was to understand newcomers’ perspectives on mental health service access and utilization in order to ultimately meet their mental health needs using a phenomenological approach to inquiry. Interviews and a focus group were conducted with 10 newcomers and 5 support staff at a newcomer community organization in the Greater Toronto Area. A thematic analysis of the narratives was used to identify themes among the data. Findings from interviews with newcomers revealed the following themes: (1) perceptions of mental health challenges are influenced by internal and external pressures, (2) cultural beliefs influence if and when newcomers seek medical intervention, and (3) expectations and experiences of accessing services within the Canadian healthcare system. Additionally, findings from the support staff focus group revealed the following themes: (1) the influence of undocumented status and financial difficulties on newcomers’ mental health challenges, (2) tension between newcomers’ openness with mental health challenges and stigmatization from others in their cultural communities, and (3) barriers and facilitators associated with help-seeking and mental health service utilization. The dissemination of these findings for restructuring current mental health services and providing efficient and effective support for this vulnerable population is discussed.

Keywords: mental health, immigrants, culture, service use, newcomers
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# Table of Contents

Introduction ........................................................................................................................................ 1
  Research Aims and Goals ............................................................................................................... 7
  Research Questions ..................................................................................................................... 7
Method ............................................................................................................................................. 8
Procedure ....................................................................................................................................... 11
  Trustworthiness of the data. ........................................................................................................ 14
Results ........................................................................................................................................... 14
Discussion ..................................................................................................................................... 37
  Limitations ................................................................................................................................. 41
References ....................................................................................................................................... 43
Appendices ...................................................................................................................................... 50
Introduction

According to the World Health Organization (WHO) in 2014, health has been defined as, “…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Mental health, one of the components of health and wellness, has been defined as being, “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (WHO, 2004, p. 10). Difficulties with mental health in particular are considered to be a growing global concern affecting approximately 1 in 5 individuals every year (Smetanin et al., 2011; Smetanin, Stiff, Briante, & Khan, 2012). Studies by Kessler, Greenberg, Mickelson, Meneades, and Wang (2001) and Verhaak, Heijmans, Peters, and Rijken, (2005) have found that mental health difficulties were more prevalent than any other category of chronic conditions. Given the prevalence of mental health challenges, treatment needs have also been examined. Alegria, Bijl, Lin, Walters, and Kessler (2000) and Bijl et al. (2003) surveyed adults in the United States, Ontario and the Netherlands who identified as having mental illnesses and found that the majority of mental health challenges were untreated. These findings suggest that unmet mental health needs may lead to worsening conditions in the future. North American research has also shown that 75 percent of all mental health challenges occur between childhood and the end of young adulthood and are highest among those between the ages of 18 and 25 years (Broad, Sandhu, Sunderji, & Charach, 2017; O’Connell, Boat, & Warner, 2009; “Substance Abuse and Mental”, 2009). General research on mental health in North American adults has been growing. Relatively less research appears to focus on the mental health of immigrant adults specifically, who may be even more vulnerable to mental health challenges. This is important to consider given that immigrants to Canada make up a growing
proportion of the population. Recent statistics have indicated an immigration rate of 21.9%, which is the second highest it has been in over a century (Statistics Canada, 2017).

Among the available literature, research has shown that immigrant adults have unique mental health concerns compared to non-immigrant adults. Mental health challenges are as prevalent among immigrants as they are in the general population (Kataoka, Zhang, & Wells, 2002). Although newcomers are at a particularly high risk for an assortment of mental health challenges, Wood and Newbold (2012) found that the most frequent diagnoses were depression, anxiety, and post-traumatic stress disorder (p. 389). It is possible that these diagnoses are high as a result of feeling shame and experiencing stigma associated with mental health from their families which then limits their service utilization (Wood & Newbold, 2012). Furthermore, O’Mahony and Donnelly (2007) found that immigrant women suffered from intense mental health illnesses such as schizophrenia, depression, and post-migration stress disorder, with depression and anxiety being the most common. Lasry (1977) also found that anxiety levels were higher among Canadian immigrants compared to native-born individuals. These findings suggest that immigrants may experience unique mental health challenges and factors associated with these difficulties merit further attention.

Challenges associated with migration, such as limited employment opportunities, financial difficulties, and language barriers, may have a substantial impact on newcomers, making them particularly vulnerable to new and/or continuing mental health challenges. Displacement (i.e., relocating from their country of origin) is likely to impact mental health, mental health seeking behaviour, and successful treatment (O’Mahony et al., 2012). According to Wood and Newbold (2012), mental health is negatively impacted when immigrants are displaced into low-income areas, which often appears to be the case, beginning a cycle of
poverty for generations to follow. Similarly, an individual’s current immigration status and the uncertainties that accompany awaiting a final decision on residency status has been shown to be linked to poor mental health. Findings from a study by Kim, Schwartz, Perreira, and Juang (2018) revealed that adolescents from families whose members were undocumented newcomers were at an increased risk of experiencing anxiety compared to fully documented families. Furthermore, the professional credentials of newcomers are often not recognized in their new country, meaning that they may qualify for fewer jobs and may experience high levels of anxiety around their financial security (O'Mahony, Donnelly, Raffin Bouchal, & Este, 2013). Being exposed to perceived discrimination based on financial status, language, and other factors, may contribute to everyday mental health experiences for newcomers. Additionally, due to the limited perceived resources available to newcomers immediately upon their arrival, immigrant women were shown to be at higher risk of developing mental health disorders than other immigrant populations. This is because they are more likely to be uninsured, unemployed, and lacking the strong, social communities that existed in their country of origin (Miranda et al., 2005). This may lead to declining health conditions and the need for more crisis-oriented care (Miranda et al., 2005). Newcomers have attributed their lack of service utilization to healthcare providers’ limited language proficiency and lack of training in cultural sensitivity, little suitable professional feedback, and restricted availability of ethno-racial, elderly and mental disorder programs (Thomson, Chaze, George, & Guruge, 2015, p. 1898). These migration-related difficulties may present challenges to how newcomers adjust to the services available.

Various social-environmental factors may negatively influence how individuals perceive their mental health and experience and utilize related health services. New immigrants are less likely to report and acknowledge mental health challenges partially due to its conflict with the
perceived admissions criteria, termed the “healthy immigrant effect” (Newbold & Simone, 2015, p. 53). This effect typically occurs through the migration screening process whereby immigrants are less likely to declare their chronic conditions/disabilities and more likely to report good health (Newbold & Simone, 2015). This may relate to heightened experiences of fear and stress during the intake process. Following the migration process, the way that treatment is offered to newcomers compared to native residents may differ once a mental health challenge has been identified. Research has shown that care providers were more inclined to simply offer medication as the primary way of managing the problem and less likely to encourage psychotherapy, which was the opposite for their native-born counterparts (Yorke, Voisin, Berringer, & Alexander, 2016). Because too few health professionals are fluent in multiple languages, this makes it especially challenging for immigrants to receive proper attention and care for mental health symptoms (O’Mahony, Donnelly, Este, & Bouchal, 2012). Furthermore, the separation of the family through the strict immigration process may leave newcomers feeling isolated in their mental health experiences, and without loved ones to support them in finding or receiving help from healthcare providers (Yorke, Voisin, & Baptiste, 2016). The deficits highlighted suggest the need for greater personalized support and services for immigrants, as well as a societal level change in sensitivity and awareness of their individualized needs.

Internalized negative stereotypes of visible minorities may create barriers to understanding and managing mental health and accessing services. Samuel (2015) interviewed African American male adolescents about their experiences regarding mental health and found that they attributed challenges to experiences of unequal treatment through racism, prejudice, and discrimination. It is plausible that societal-level experiences of stigma and stereotypes may be internalized by the individual, creating distress and feelings of helplessness. Comparatively,
research has shown strong relationships between cultural identity affirmation and positive mental health which have also been shown to lessen the harmful effects of discrimination and inequality (Kim et al., 2018). Research has also shown that, among Asian immigrants, culture played an important role in their service utilization by associating their illness with a supernatural power or by asserting that it was caused by another individual through “magical means” (Fung, & Wong, 2007, p. 217). Salami, Salma, and Hegadoren (2019) interviewed service providers at various immigrant serving agencies in Alberta to explore their observations of the most influential contributors to mental health service access and utilization for immigrants (p. 153). The results revealed feelings of internalized stigma surrounding the notion of mental illness, community understandings of mental health, and ambiguity regarding potential negative implications of maneuvering daily life with a mental illness.

Cultural influences are important sources of socialization and have implications for how individuals interpret experiences in their lives. O’Mahony and Donnelly (2007) conducted in-depth interviews with immigrants from three different cultural backgrounds and found that their families often encouraged them to hide their illnesses out of fear of rejection from their cultural community, which led to exacerbated symptoms by the time they were ready to go against their family/community and address the problem. Cultural beliefs and limited multicultural representation within the current health care structure may also lead to emotional challenges within this population. In other studies, newcomers have felt that they were unable to appropriately address their emotional issues because of their mental health status (O’Mahony et al., 2012). Cultural stigma strongly affected whether immigrants believed that they should access professional services for their mental health (O’Mahony et al., 2012). Even when newcomers recognize a worsening of their own mental health, cultural views of the issue being a family
problem that should not be raised with anyone outside of the family, including friends and care providers, ultimately influence their help-seeking behaviours (Yorke, Voisin, & Baptiste, 2016). Researchers have also begun to incorporate health care providers’ perspectives of the effectiveness and influences that affect service delivery. Olcoń and Gulbas (2018) analyzed the perspectives of Latino immigrant youth service providers who acknowledged their attempts to overcome sociocultural disparities while utilizing discourses that mirrored biases, assumptions and stereotypes. This complex intersection of factors influencing mental health service utilization creates obstacles to alleviating the elevated rates of mental health challenges within newcomers.

*Kleinman’s explanatory model* was used as the theoretical framework to guide the current study. This model has been used to examine how beliefs based on culture, values, and knowledge explain how an individual interprets, understands, and copes with illness (Kleinman, 1978). According to this model, different cultures have unwritten rules about how wellness is understood, interacted with, experienced, and managed, which are systemically intertwined within various social institutions (Lin, 2013; O’Mahony, Donnelly, Bouchal, & Este, 2013). Kleinman (1980) wrote that, from the perspective of the “ill individual”, professional support should not only address physical manifestations but also incorporate cultural understandings of symptom origin and how people interpret these experiences. This model focuses on how cultural variables intersect with various experiences of wellness, and how people view their health (Kleinman, 1980). Additionally, the model provides an ideology to incorporate belief systems when explaining symptoms related to their mental health experience and to inform a plan to address it (Hallenbeck, Goldstein, & Mebane, 1996).
Research Aims and Goals

Although there has been some empirical attention given to help-seeking trends among adult newcomers, gaps remain regarding the role that culture, and other social factors, play in facilitating or impeding help-seeking behaviour. The purpose of this study was to add to the existing literature regarding the influence that culture and other social factors have in facilitating and hindering mental health service utilization among newcomers. The goal of this study was to understand the positive and negative perspectives on mental health service accessibility and utilization by newcomers in order to ultimately meet their mental health needs. This is important for the development of accessible, comprehensive, and specialized approaches to mental health care among newcomers in Canada.

Research Questions

Four research questions were addressed in the study: (1) What are the mental health help-seeking experiences of young adult newcomers? (2) How do cultural socialization and upbringing facilitate and/or create barriers to seeking and accessing mental health support? (3) What other social factors facilitate and/or create barriers to seeking and accessing mental health support among young adult newcomers? (4) What are some recommendations to mitigate the identified challenges and gaps?

Kleinman’s explanatory model (1978) was used throughout the study from project conceptualization to data analysis and interpretation. The model was used as a framework to prompt newcomers to describe their mental health challenges and the cultural belief systems that influence their decision-making regarding intervention (Hallenbeck, Goldstein, & Mebane, 1996; Kleinman, 1978). According to Waite and Killian (2009), this model highlights both compromises and bargaining between an individual’s cultural norms and Western culture’s ideas.
of illness treatment. As culture underpins a belief system, this may also influence how individuals perceive their mental health, whether they seek intervention for associated difficulties, and how they manage others’ responses to their course of action (Waite & Killian, 2009).

Method

Participants

A convenience sampling method was used to recruit 10 newcomers from minority backgrounds and five support staff at a multi-service settlement agency supporting the diverse needs of immigrants and refugees through settlement and integration services in the Greater Toronto Area. This centre is located in a region that is home to a large and growing population of immigrants. The organization provides settlement, counselling, English language training, newcomer childcare, and employment support for anyone who identifies as an immigrant.

Two groups of participants - newcomers and support staff - were interviewed about their experiences of the phenomenon of interest.

Newcomers. The term newcomer was used throughout the study as individuals who identified as immigrants or refugees. Young adult men and women ages 18 to 30 years who had migrated to Canada within the last 10 years and had either been experiencing a decline in their mental well-being within the last 12 months or were interested in sharing their cultural views on mental health were invited to participate. The young adult population was defined as individuals between the ages of 18 and 30. This age group was chosen as research supports increased disparities in mental health experiences during this developmental period (Broad et al., 2017; O’Connell, Boat, & Warner, 2009; “Substance Abuse and Mental”, 2009). Additionally, the primary researcher had access to this group within the recruitment organization. The participants were required to have basic oral English communication skills. Initially, recruitment was
achieved through convenience sampling. The executive director compiled a list of clients who met study inclusion criteria. The amount of time that newcomers had been living in Canada was not a criterion for participation in the study. This was to provide an opportunity to incorporate a variety of perspectives on mental health and related service experiences to newcomers who had moved to Canada in the recent as well as not so recent past. The primary researcher verbally informed the first 10 newcomers from the list who were present at the centre on one of the scheduled interview days about the study and invited them to participate. Newcomer participants were members of various racial and ethnic groups including (but not limited to) Hispanic/Latino, East Asian, and Middle Eastern backgrounds. All newcomer participants identified as first-generation immigrants to Canada. See Table 1 for newcomer demographic characteristics.

Table 1

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age (years)</th>
<th>Gender</th>
<th>Ethnicity/Religion</th>
<th>LoT in Canada</th>
<th>Employment Status</th>
<th>AHI (Thousands/CAD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>30</td>
<td>F</td>
<td>Islam</td>
<td>2 years</td>
<td>Unemployed</td>
<td>10-30</td>
</tr>
<tr>
<td>2</td>
<td>26</td>
<td>F</td>
<td>Muslim</td>
<td>3 years</td>
<td>Unemployed</td>
<td>31-30</td>
</tr>
<tr>
<td>3</td>
<td>26</td>
<td>M</td>
<td>East Slovic</td>
<td>9 years</td>
<td>Student</td>
<td>31-50</td>
</tr>
<tr>
<td>4</td>
<td>28</td>
<td>M</td>
<td>--</td>
<td>2 years</td>
<td>Unemployed</td>
<td>71-90</td>
</tr>
<tr>
<td>5</td>
<td>27</td>
<td>F</td>
<td>--</td>
<td>1 month</td>
<td>Unemployed</td>
<td>--</td>
</tr>
<tr>
<td>6</td>
<td>28</td>
<td>F</td>
<td>Muslim</td>
<td>2 years</td>
<td>Unemployed</td>
<td>10-30</td>
</tr>
<tr>
<td>7</td>
<td>21</td>
<td>M</td>
<td>Catholic</td>
<td>8 months</td>
<td>Part-time</td>
<td>10-30</td>
</tr>
<tr>
<td>8</td>
<td>25</td>
<td>F</td>
<td>--</td>
<td>5 months</td>
<td>Unemployed</td>
<td>--</td>
</tr>
<tr>
<td>9</td>
<td>29</td>
<td>F</td>
<td>Muslim</td>
<td>8 years</td>
<td>Part-time</td>
<td>--</td>
</tr>
<tr>
<td>10</td>
<td>24</td>
<td>F</td>
<td>Islam</td>
<td>1 year</td>
<td>Unemployed</td>
<td>--</td>
</tr>
</tbody>
</table>

Note. LoT = length of time; -- = not reported; AHI = annual household income.
Support staff. Staff from the newcomer organization who had been employed for at least six months and supported this population were invited to participate in a focus group to share their experiences. Support staff participants were required to have basic oral English communication skills. Convenience sampling was used to recruit support staff as the executive director informed staff across various departments about the research study. The researcher invited interested support staff to participate to provide alternative perspectives on the barriers and facilitators of newcomers’ mental health help-seeking behaviour by distributing a recruitment email. See Table 2 for demographic and employment characteristics for support staff and Appendix A for the recruitment e-mail.

Table 2
Support Staff Demographic Characteristics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Highest Education Completed</th>
<th>Role/Title</th>
<th>Type of support offered</th>
<th>Years with Organization</th>
<th># of clients supported</th>
<th># of newcomers supported</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>College Diploma</td>
<td>Settlement counsellor</td>
<td>Housing, Mental Health, Language, Employment</td>
<td>1-5</td>
<td>300+</td>
<td>300+</td>
</tr>
<tr>
<td>2</td>
<td>Masters</td>
<td>Crisis Intervention worker</td>
<td>Mental Health</td>
<td>1-5</td>
<td>350/year</td>
<td>All</td>
</tr>
<tr>
<td>3</td>
<td>Masters</td>
<td>Settlement counsellor</td>
<td>Housing, Employment, Language</td>
<td>1-5</td>
<td>100/month</td>
<td>All immigrants</td>
</tr>
<tr>
<td>4</td>
<td>Bachelors</td>
<td>Settlement Counsellor</td>
<td>Housing, Mental Health,</td>
<td>1-5</td>
<td>350</td>
<td>All</td>
</tr>
<tr>
<td>Participant</td>
<td>Highest Education Completed</td>
<td>Role/Title</td>
<td>Type of support offered</td>
<td>Years with Organization</td>
<td># of clients supported</td>
<td># of newcomers supported</td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------</td>
<td>------------</td>
<td>-------------------------</td>
<td>-------------------------</td>
<td>-----------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Information, Employment</td>
<td>5 Post-graduate Certificate Program Manager Housing, Mental Health, Language, Employment</td>
<td>10</td>
<td>1000+</td>
<td>80%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Procedure**

Written consent was obtained from each participant prior to beginning data collection. All procedures received clearance from Brock University’s Research Ethics Board. Please see Appendices B and C for the newcomer and support staff consent forms.

Individual interviews and a focus group were used to explore experiences of cultural and social barriers or facilitators in addressing mental health concerns and service utilization. The director distributed the recruitment flyer to support staff and facilitated the primary researchers’ discussions with the staff responsible for recruiting newcomers. The researcher’s supervisor assisted with the formulation of both interview guides and co-facilitated the focus group. An interview guide was created to ensure that relevant questions were addressed and to assist the primary researcher with additional question probes for clarification. The interview guide included a series of open-ended questions to facilitate dialogue directly influenced by questions posed by Salami, Salma, and Hegadoren (2019). These questions highlighted experiences related to mental health experiences, access to services and facilitators or obstacles when accessing mental health services (Salami, Salma, & Hegadoren, 2019). Participants were encouraged to
share what they were comfortable with regarding the influence that their culture and various social factors had on their mental health experiences and concerns. Questions focused on culture, immigration processes, displacement, mental health services, stigma, community, perceived settlement resources, cultural inclusion and recommendations for change. Mental health stigma was defined for participants as “the labeling and devaluing of a person based on negative beliefs, attitudes, and perceptions about mental health issues that results in status loss, discrimination, or stereotyping” (Crumb, Mingo, & Crowe, 2019, p.143). All interviews (i.e., individual interviews and focus group) were audio recorded. The primary researcher subsequently listened to each recording and transcribed the narratives into written form. Please see Appendix D for the newcomer interview guide and Appendix E for the support staff interview guide.

A phenomenological approach was used to convey the meaning of daily experiences expressed by the participants while investigating the awareness and complex intricacies of the phenomenon. Phenomenology can be defined as “the philosophical belief that, unlike matter, humans have a consciousness. They interpret and experience the world in terms of meanings and actively construct an individual social reality” (Bowling, 2009, p. 467). This researcher utilized the framework to guide the study by attempting to understand the meanings that the solicited experiences hold for the individual. Furthermore, the phenomenological approach made use of a focus group and in-depth interviews to gain insight into the effects of social factors, such as culture and socialization, on how individuals interpret mental health experiences in their personal lives.

**Data analysis.** An inductive approach (i.e., the researcher relies on data from participants to create broad themes regarding the phenomenon) was used to understand newcomer perspectives (Braun & Clarke, 2006; Patton, 1990). Within this study, the themes were not
derived by the researcher prior to collecting data and analyzing each of the participant’s narratives. Thematic analysis (Braun & Clarke, 2006) was used to organize the data. This approach was used to organize the results from face-to-face interviews and the focus group responses to identify patterns within the data. The processes involved in utilizing this analysis as outlined by Braun and Clarke (2006) include six distinct phases. The first phase required the researcher to become acquainted with the narratives from within the interviews or focus groups which researchers called familiarizing yourself with your data (Braun & Clarke, 2006, p.87). To achieve this, the research re-read each of the narratives several times and kept track of potential codes that may be used at later stages within the analysis. Secondly, generating initial codes consisted of creating an initial set of codes from the data. This involved grouping similar data with their corresponding codes in a systematic way while keeping note of potential higher-order themes that may be of interest (Braun & Clarke, 2006). The researcher chose a key term or phrase for each quote from participants which were all color coded differently using the transcription software. Next was searching the themes which included conducting a broader review of the data, grouping the codes and all applicable data into larger, potential themes (Braun & Clarke, 2006) Within this study, these themes were coded in a new color and included topics such as origins of mental health challenges and language barriers to service accessibility and effectiveness. Following this phase was reviewing themes where the researcher conducted two levels of review which began with examining the themes to see if they created a coherent pattern and then doing the same thing but examining the entire data set to confirm that the themes and patterns accurately depicted the content within the narratives (Braun & Clarke, 2006). During this step, the researcher grouped codes into patterns of narratives and revised theme names to accurately depict the quotes within them. The fifth phase was defining and
naming themes by identifying exactly what it was that each of the themes portrayed (Braun & Clarke, 2006). The researcher ensured that specific quotes from the participants were representative of the narratives and altered theme naming to encompass narratives as necessary. The last step was called producing the report wherein the researcher conducted a final analysis of the themes that had been created and then wrote a report disseminating the results of the analysis including examples from the narratives to strengthen the validity of the themes (Braun & Clarke, 2006). NVivo 12 software was used to organize the data while the primary researcher conducted a step-by-step analysis of the narratives expressed by the newcomers and support staff.

Trustworthiness of the data. Methodological rigour of the data was established (Creswell, 1998; Lincoln & Guba, 1985). Thick description was utilized as the narratives of experiences and accounts provided by newcomers and support staff reflected the experiences of these populations and their perspectives on the topic. Next, prolonged engagement was achieved by the collective experiences of the organization’s director, primary researcher, and supervisor (i.e., experience researching and/or supporting immigrants with various cultural and mental health statuses). Finally, consideration of negative case analysis through identification of disparities across the narratives between and across participants were investigated over the course of the study.

Results

Newcomer Themes

Participants highlighted the importance of understanding the role that culture and other social factors played in facilitating and hindering mental health service utilization. Analysis of the newcomer interviews revealed the following themes: (1) perceptions of mental health
challenges are influenced by internal and external pressures, (2) cultural beliefs influence if and when newcomers seek medical intervention, and (3) expectations and experiences of accessing services within the Canadian healthcare system.

**Theme 1: Perspectives of mental health.** Newcomers held many beliefs regarding mental health challenges including internal and external pressures that affect mental health. Internal pressures included perceiving mental health as a curse from God or as an inherent sickness; external pressures included experiencing war and financial instability due to immigration.

**Origins of mental health challenges.** The majority of newcomers described contributors to mental health that were separate from social factors. Some newcomers said that individuals with mental health challenges were born “psycho” or “crazy” (Newcomer 1) and were cursed. One man directly spoke to the segregation of those considered “sick” once they began displaying mental health challenges stating that, “People feel like you are not normal because you are crazy, you are sick and uh like they don't accept you in that group. They don't want you to be with them because you're, I mean you have this problem” (Newcomer 2). Newcomers often mentioned that mental health challenges were inherent to the individual and therefore incurable. Newcomer 3 stated, “Uh like you can keep [it] in your family only, not outside because outside [it's] like they still like you but you are sick you know [they] they don't tell people around them you know”. Another newcomer with limited English skills struggled to explain her experience but stated, “No, maybe it’s uh how do you say its maybe uh something we cannot do so how can I say it. Something you cannot fix it” (Newcomer 1). Comparatively, few participants discussed the possibility of alleviating mental health challenges through practicing religion and higher education. A newcomer who identified as Muslim articulated, “Yeah but they think it's like the
God punishes you like this, like if you do something. You have to read Quran or go to the mosque or pray … some people they think like the punishment from God like you did something wrong” (Newcomer 7). Similarly, Newcomer 8 described being questioned about her academic choices due to the apparent illegitimacy of these experiences. She explained the following:

Like when I decided to study psychology, all of my family like even my family said so you want to study crazy people? You want to go to the hospital to see those, those crazy people? You will be like them if you listen to them, but I was intent to study psychology.

(Newcomer 8)

**External stressors that affect mental health.** Newcomers described a variety of stressors that affect mental health. For example, some participants described the experience of war as a distraction hindering individuals in their country of origin from acknowledging challenges. A newcomer discussed the distress resulting from living in a country stricken by war saying, “[Mental health] It's a good thing and a bad thing too. You have a lot of war [so] we can't study well and that is our culture… There's a lot of wars and bomb blasts so every day we are scared on how to go” (Newcomer 10). Another participant explained the impact that increasing service costs in their country of origin has on worsening mental health challenges. Newcomer 3 reflected on a time where he would have accessed support if prices had been more affordable:

I did know where to go but to see somebody like this you need to pay money and at that time I didn’t have that much money and also too, I didn’t tell my family about this so because I knew they would have to do extra things to get the money so ya. So I had to do it on my own and it made things bad…It’s tough for people, especially if you don’t have money so it’s really tough for those people.
Related to the reality of environmental and social distractions, displacement and the settlement process were often mentioned by newcomers as contributors to mental health challenges. Most newcomers expressed the difficulties associated with moving to a new country and attempting to assimilate into their new cultural surrounding. A female newcomer acknowledged these hardships by saying:

It was like too hard for us because I was studying there at the university, faculty of [inaudible]. It was my last year at the university. Because of the war, we move to [country]. I live there to for 2 years and then I move to Canada because I wanted like [a] safe place for my kid, my child but I became depressed and alone. (Newcomer 2)

**Theme 2: When to seek professional help, if at all.** Newcomers described difficulties regarding the decisions to seek medical intervention for mental health challenges. Newcomers minimized the potential seriousness of symptoms, referred to their beliefs that intervention is only for severe problems, and some newcomers deemed intervention for mental health challenges to be unnecessary.

*Minimizing the potential seriousness of symptoms.* Newcomers articulated that mental health challenges and associated symptoms were temporary, and that they would “grow out of it” eventually (Newcomers 3, 5, and 6). It was commonly reported that experiences commonly associated with illnesses such as anxiety and depression were temporary and did not require medical intervention. A male newcomer reiterated that his culture regarded unpleasant mental experiences as challenges that lasted only a short while and did not require any additional thought or action to alleviate symptoms. He stated the following:

I don't know, if I can explain it like depression, but I was worried [a] little bit and maybe it last[ed] for 1 month maybe…And I rather to deal with it myself because I didn't see-
knew that was going to pass. The period, the period will pass, and I will feel relief and I didn't find I need to go to doctor or something. (Newcomer 4)

Newcomer 6 referred to temporary feelings of loneliness by saying, “Even right now, when I have no friends here I have no opportunity to speak my language or even improve English skills because I don’t know anyone but I try to keep myself positively like okay it’s just temporary it will be good it will be okay. Things are always temporary.” Some participants expressed that addressing anxious or sad feelings was minimized compared to their reality of war and prioritizing the safety of their loved ones. Therefore, mental health was disregarded until it began to limit the individual from effectively contributing to society through employment or their family fulfilling various roles. A male newcomer spoke of the cultural taboo surrounding the normalization of negative mental health when his social network of family and friends say:

You have stress everybody has the stress it's okay. Take multivitamins, melatonin, you will be okay don't worry, everybody in Canada has stress yeah because you are a newcomer with new language you have to start from the bottom. You're studying, work and yeah. (Newcomer 7)

**Intervention is only for severe mental health challenges.** Newcomers expressed that intervention for mental health challenges should only be accessed if they pose a “big problem” (Newcomers 5, 6, 9). Strategies to manage “big problems” included meditation and participating in a hobby. Most of the newcomers mentioned the importance of an individual recognizing concepts that lack a definitive definition such as “big problems” and serious issues (Newcomer 1, 2, 4, 5, 6, 8). Newcomer 5 mentioned, “…I guess ya sure, if I have like- if I will have kinda like big problems like big depression ya sure I will go but if I just have little bit anxiety or like if I’m sad I just like can handle [it] by myself like try to meditate, think positive [or] read
something”. However, when probed further, participants were unable to further elaborate on what distinguishes a big problem from others and so forth. An idea was illustrated by a participant which referred to ambiguity saying, “Before my cousin really liked to sit alone. She didn’t talk to anybody because her depression was hard. Now everybody knows what is a depression. Before she really liked to sit alone but she didn’t like to talk with anybody” (Newcomer 10). Another newcomer commented on the cultural differences between their country of origin and Canada while eluding to how culture influences their opinions on when to seek medical intervention for specific mental health symptoms. The following perspective was shared:

In my country, goes to severe problems and then we go to the doctor but in here, if you face small problems or small stress, we can go to the doctor but in there, not like that. If I have [a] severe problem about mental health we have to admit in my back home in my hospital and they treat it like our house like they can admit there but in here I don’t know. If I have health card, we can easily reach the doctor and we can get [help]. If we have severe problem about mental health, we can get medicine free in here. (Newcomer 6)

A few participants stated they thought they should seek medical intervention but were unsure if their symptoms were severe enough. Newcomers did not clearly articulate the specific signs that people needed to show in order to seek intervention but spoke to uncertainty as a legitimate reason: “…yes these kinds of things. If there is a cause of your depression this means that you can just pass by without any treatment, but if you get depression from out of nowhere, this is the issue. You have to go to doctor and ask him why do I have this depression and why is this happening to me and he can take a look and tell you the cause and give you treatment” (Newcomer 4). A participant had a clearer idea of what warrants seeking medical intervention as
a severe issue, “Hurting someone else and hurting yourself and not understanding that you were doing this and that it's wrong. This is the major [problem]. Especially when you hurt someone right and you don't really recognize that it's wrong” (Newcomer 1).

**Intervention for mental health challenges is unnecessary.** Newcomers referred to beliefs that mental health challenges were “small problems” (Newcomers 6, 9) that should only be discussed with family and close friends. They discussed attempts to keep conversations regarding mental health limited to immediate family members. One newcomer commented on the distinction between immediate family and extended relatives when these challenges are present stating that, “They don't accept it like even [if] I want to [go to] the counselor like my family they don't tell my relatives. For my neighbors they don't talk like they keep it like a secret like they don't tell on us that you made it to the doctors, or you have a problem like they don't talk about this” (Newcomer 7). Similarly, a participant echoed this idea when reflecting on segregation with this comment: “They changed but before no. I know some families they have some of - like they have one daughter and I think she has depression and they didn't take her to the counselor or the doctor. They just stay in the home, give her medicine and don't talk about her like they don't show us to her” (Newcomer 6). Comparatively, some participants explained that they received exceptional support from their family members and friends during times when they experienced a decline in their mental health. Newcomer 2 commented on an experience: “I have friends here, of course they help me and sometimes I call my mother. She helps me a lot and my sisters also are helping me so I know how to manage that time”.

Newcomers managed their mental health issues without intervention because of fears regarding the stigma of mental health challenges and accessing support. Participants mentioned
the negative connotations associated with conversations pertaining to mental health challenges and accessing support for these experiences. For example, one newcomer said,

If they can uh like open[ly] talk about it, it’s like a stigma on them [and] on their reputation or something like that it’s like kinda you[re] weak like weaknesses but for me, I think if you have some bad uh situations or bad like obsessive thoughts. (Newcomer 6)

Furthermore, participants discussed that individuals within their culture pitied those who openly discussed their mental health challenges, seeing them as “less-than”. The newcomer stated the following:

Ya and when they know that you have this kind of mental issues, they say maybe very sorry you and it’s they think its hurt you. I’m a normal person. I know I have a problem but I’m a normal person. I finish my degree and I get married and I have kids but many people they do not understand these things may be a lack of knowledge they have but its just still cultures things. (Newcomer 1)

Instead, participants described strategies such as distracting themselves with hobbies and praying to God to rid themselves of these symptoms. Many cultures encouraged the use of alternative interventions to alleviate mental health challenges rather than seeking intervention. This was common in narratives among Muslim participants. For example, Newcomer 2 who was Muslim stated,

It's like that: you have to pray, and we say like make wishes to manage uh the time. Yes, like that… my religion as Muslim you have... like... If you are feeling depression and then you have to do uh like to believe that God and pray. Like have to pray and make wishes and he can be treated, and God will treat you.
Theme 3: Expectations and experiences of help-seeking. Newcomers referred to their initial expectations of help-seeking in Canada prior to and once they arrived. They also described their experiences accessing available supports.

Perceptions of the Canadian mental health care system. Newcomers discussed general positive perspectives of Canada’s mental health care system. Participants articulated that people in Canada cared about residents more than professionals in their country of origin based on their perceptions from the media (e.g., television). One participant attributed the affordability of services in Canada compared to their country of origin to the government and professionals caring more about citizens:

So out here they more care about people, they more care about your health and they don’t really care about money here. It’s very different because you get more services here than back home… Actually, [in] Canada they care about those stuff [and] mental health and I would say they more care about people like this out here than back home. (Newcomer 3)

Referring to the differences between Canada and other countries, some newcomers also stated that services were easy to find in Canada compared to their country of origin. Specifically, they discussed the accessibility of resources through other supports and the media within Canada. Newcomer 6 expressed his opinion saying,

I mean, it’s easy you know. I can just walk into a walk-in clinic and ask for information or some other places that I can ask for information that are there for those services, so I think it’s pretty easy here. Definitely ya easy. They care about that stuff out here.

Comparatively, through various media outlets, participants believed that diagnosis was common in Canada, professionals were more accepting of mental health issues, and that individuals were encouraged to access services once they experienced mental health challenges.
One newcomer compared his perception of Canadian mental health culture to the Ukraine:

“What I noticed in Canada [is] it’s much more people with mental illness, officially mental issues than in [the] Ukraine. I don't know what the consequences are or what's the connection between this but that's what it is” (Newcomer 4). Another participant echoed a similar narrative saying,

Here in Canada, it's like you have to go to the doctor does not believe in God. But here I know that's different culture so it's no problem. I can go to the doctor and ask for help. I don't have any problems. Totally different than my country. (Newcomer 2)

Newcomer 2 believed that religion was not a significant factor in help-seeking decisions and intervention options for native-born Canadians experiencing mental health challenges. Alternatively, another newcomer spoke about possible negative consequences associated with belonging to a culture that is too accepting of mental health challenges. She expressed:

People with mental health here have less accountability. I don't know about back home because I was seventeen when I left. I had nothing. I didn't study law or something but here we know these people have less accountability. They have more options like for treatment and stuff and I think it's right. It's supposed to be like that. (Newcomer 1)

Experiences accessing services. Few newcomers felt supported by their families when expressing their desire to seek intervention in Canada. Participants expressed their satisfaction with the support they received from people in their social networks. One newcomer spoke about his mother saying that she “always support[s] me. She would say if I want, then go and if you feel really bad. I don't have a lot of friends and you feel very bad, go to doctor. So, I would go to the doctor” (Newcomer 10).
Most participants described positive experiences with Canadian healthcare providers after migrating to Canada. Newcomers believed that professionals addressed their concerns appropriately and completely. For example, Newcomer 9 had a chronic illness and discussed her experiences meeting with a variety of doctors and specialists to receive necessary support. She stated,

I just go to the doctor and I ask him because I already take the medication, so they just wrote me a prescription. After that, I have seizure recently uh so he told me that you should go to the specialist and we will decide whatever he will do for you. That's it. Actually, from November I wait for the specialist yeah and now we are in January. (Newcomer 9)

Another participant paralleled this comment by sharing her experience in accessing services when they first migrated to the country:

Actually, it’s good. At the beginning, I was in [city] I went to the doctor and she told me It's okay we know about this uh this kind of disease and we have this kind of medicine for it. Back home, we use different names because it’s different companies uh. She still looking for something similar and they give it to me and I still just use it and when I came here, I also went to the specialist and he wrote the prescription for me. But actually, I have it sometimes when I don't sleep well uh my husband to travel and I stay with my two kids uh so it makes me tired so even if I take the medicine, it makes me tired so I have the troubles. (Newcomer 1)

**Support Staff Themes**

Support staff described their experiences supporting newcomer clients with their mental health needs and service utilization. The data revealed three themes: (1) newcomers’ mental
health was negatively impacted by undocumented status and limited finances; (2) beliefs about whether mental health is real and, if it is, facing stigma from the newcomer’s cultural communities, and (3) factors that facilitate or hinder mental health service utilization and help-seeking behaviours.

**Theme 1: Factors that contribute to mental health challenges.** Support staff discussed newcomers’ difficult experiences upon arrival in Canada. Participants described newcomers’ anxieties while waiting to hear news from the government regarding permanent residency or citizenship. They stated that government assistance is inadequate, leaving newcomers with relatively little money to afford mental health supports, if required.

**Stress associated with undocumented status.** Support staff described their newcomer clients’ feelings of anxiousness, worry, and fear regarding whether or not they would become permanent residents and, if so, when it would happen. Support staff recalled meetings in which newcomers made direct links between undocumented status and mental health. For example, Support Staff 2 said,

Some of them are still waiting for the papers. Even if they are not refugees, other refugees like refugees in protection are still waiting for the PR [permanent residency] so a lot of people are waiting, making them anxious about it no matter how you speak to them. Immigration status also plays a role in the type of services they can access. So that is actually important because those programs out there are for everyone but actually just for selected people.

Other support staff believed that having documented status provided newcomers with opportunities for settlement into Canadian society by accessing incentives such as reduced
academic tuition rates and increased government-funded services. In addition, a support staff shared an experience from a client that she supports who noted that,

So for example, I have many youth [who] are in their senior year but their issues are graduating high school. [Some say] I want to go to university but at this point, I would need to apply, and I may be charged as an international student because I cannot receive my status so it's really that competition that exists. It's a pressure that they face but in the case of youth, they don't have any choice in many instances because of their financial situation. (Support Staff 4)

**Restricted finances.** When asked about pressures affecting mental health challenges, support staff recognized that some newcomers were eligible to receive financial assistance from limited sources through Canadian government assistance programs. A discussion around the consequences of the negative intersection of financial status, waitlists and service efficiency began with Support Staff 2 stating:

We refer them to services, but do they help them? Those with autism and those with disabilities [realize that] other than referring them, it's all for money unless they wait 6 years. [They] cannot wait for 6 years to get good service so [there are] very limited services and it is creating tension on the family who are newcomers [in] very small houses, [with] no support, no family support. They used to get support from family here [but now] they're not getting it so there’s financial suffering. I believe that mental health is an issue but what is really affecting them is loss of the day. It's holistic. Financial needs is hard and a lot is happening around them.

Financial assistance covered necessities and left little additional money for other needs. Support staff suggested that discussions regarding money were based on issues of uncertainty of
residency status, which is a major concern for newcomers and, therefore, impacts mental health. A support staff commented,

I want to add also about status. For refugee claimants, they claim refugee status and are waiting for a hearing. They are waiting for long, I have clients for three years and this is affecting their health because they are only allowed to get help from Ontario Works [and] there is no baby bonus for them so they can only get the minimum which is rent and rent is going up. (Support Staff 1)

Other support staff suggested that newcomers were unable to pay out-of-pocket for services and supports which may negatively affect mental health. For example, one support staff said, “They can only get money from [government program] which does not cover expenses and on top of that, they are waiting which affects their mental health and their children's mental health” (Support Staff 5).

Support staff shared disparate perspectives and experiences regarding whether culture could be parsed apart from other social factors when examining mental health. For example, Support Staff 3 spoke to the impossibility of separating cultural influences from other factors, such as education, when supporting newcomers in alleviating mental health symptoms through mental health service utilization saying,

… It's not only culture and socioeconomic backgrounds. It can be the same culture, but you can see two totally different situations. Some people come out and ask for help and some people are against it that's why it's so important when talking about mental health. We can't generalize things like that…We are focused on education [and] I see that there's a gap in the younger kids that are going through a lot of stress.
Comparatively, a support staff discussed that, in addition to other challenges, culture played a significant role in mental health challenges because:

They are stigmatized but I want to talk about the other end. The service provider. I think the hardest barrier is in a financial piece…not all health services are provided for free so even though I put my kids’ wants first and foremost, the resources are limited they need to be referred and also the prices are so high… so how do you imagine an immigrant family can afford that? They try so hard, but they can't. (Support Staff 4)

Theme 2: Newcomer attitudes toward mental health. Support staff participants expressed tension between newcomers’ openness with mental health challenges and whether they were real. Additionally, support staff discussed observing the stigma newcomers experienced from their cultural communities once accessing intervention.

Is mental health real? Support staff perceptions of newcomers’ cultural beliefs about mental health were shared throughout the focus group. Common newcomer narratives indicated that mental health challenges were fictional and therefore did not require the individual to access supports. When support staff were asked why newcomers believed that mental health was not real, one support staff replied, “they may not believe it or supported or it may conflict with their cultural beliefs and what a parent's role is and their support may not be like they are back home for them” (Support Staff 5). Support staff also stated that many cultures did not have a term for mental health which made the topic difficult to explain to clients. For example, one support staff said, “Well I think that even in some cultures and languages, there isn’t a word for mental health and there isn’t a word to translate it to them even. Talking about support in Arabic may be a negative thing” (Support Staff 4). Another support staff echoed this point when stating,
… From my end, I'm saying these great and welcoming things but (there’s) not an exact way to say that in their language or if there's no word for it or if the meaning is different. It is tricky to have those conversations, but a lot of my role is even doing [that]. (Support Staff 3)

One support staff commented on cultural evolution which is not accepted or supported by its older generations. They referred to mental health being perceived by newcomers as a generational belief formed by Western culture meaning that the new generations of the culture’s population are further integrated into Western medicine. Support staff expressed this perception as:

…to the whole idea of mental health but I think the new generation, but I have been seeing having a different understanding and I think it's because they come with a different education. They are engineers and, in some way, coming as they are aware of what they are coming from because of their situations back home with the family.

(Support Staff 2)

**Stigmatization from others in the culture.** Support staff acknowledged newcomers’ feelings of wanting to access mental health supports but were fearful of what others in their cultural networks would think and how they would be treated. One support staff explained their experiences hearing about culture and stigmatization by saying,

…and that is associated with cultures because we are all human beings and there are some common ways that [individuals] react and deal with mental health. We see resistance from certain cultural backgrounds, not really specific to certain cultures but it's basically really common there. More like people based on their own stigma and cultural
practice and also fear because mental health definitely means different things for different people. (Support Staff 5)

Support staff highlighted the willingness of some newcomers to take action to resolve mental health challenges despite potential cultural stigma and ridicule. For example, faith was mentioned as helping newcomers to access services:

…depends on the level of faith they have in the service that they were trying to access. Whether they are actually motivated enough to go there and the stigmatization piece is constantly on their mind wondering about who is going to think what, who is going to know and if they know what are they going to say, what is their opinion going to be. (Support Staff 1)

Support staff discussed that newcomers were overcome with fear which hindered mental health service utilization. An additional factor included in culture is religion which plays a role in whether service is accessed. Support Staff 4 reflected on an experience with individuals with a particular religious background stating:

I also think because I work with mostly Arabs [that] the religion plays a role in the mental health. You know many of them have commitment to something and they have a tool in which they use to overcome mental health issues and things like that. Many times, for them it can be stigma or if you can focus on religion [thus] resulting in the issues that they have.

**Theme 3: Newcomers’ attitudes toward mental health service utilization.** Support staff stated that newcomer attitudes toward professional services were impacted by their socioeconomic status and difficulties communicating with service providers as a result of language barriers. Comparatively, support staff stated that belonging to a similar cultural
background to their client established quicker and deeper professional relationships with newcomers.

**Barriers and facilitators to service utilization.** Support staff explained barriers and facilitators that impacted newcomers’ abilities to access services necessary to promote mental health. Participants described two major barriers: socioeconomic status and language barriers. More specifically, professionals were not trained in different languages and newcomers did not have the money to pay for a translator. For example, Support Staff 1 shared an experience of a newcomer accessing supports in Canada and having a negative experience:

> There are no interpretation services. They keep telling them to bring somebody, but we cannot bring somebody, you have to provide them, and I have to fight for them. Many of my clients do things without knowing what it is.

However, Support Staff 5 spoke to the conscious effort she made when meeting new clients to address this barrier saying,

> I always offered different references and referrals and I offer, if they are more comfortable, to have more services in their own language because I only speak English, but I have to work for my team as well to provide translations.

Regarding socioeconomic barriers to service utilization, newcomers may be faced with financial expectations that they are unable to meet. Support Staff 4 discussed the cost of services sharing, “A financial piece is huge [as] not all health services are provided for free … the prices are so high. One session for CBT [cognitive behavioural therapy] is $200-500 so how do you imagine an immigrant family can afford that”.

Support staff shared experiences of newcomers being misdiagnosed by physicians and psychologists because front-line support staff were unable to understand pressures of the
settlement process and other variables leading to traumatic experiences. These experiences affect future help seeking through experiences such as in the following example:

…providing services that the girl doesn't want to eat and is losing weight but it's about stress, so we referred them to someone who just thinks the girl wants image and that's not the case. That can create more trauma for the girl through the service where they sent her to a group with substance addictive people but the girl is in high school, she's not experience[d] to that at all so when she's in that group it's a huge challenge for her. We see sometimes yes, we are for them [and] yes there's two services but don’t do a follow-up to see what kind of services they got and if it's working. (Support Staff 2)

Additionally, some support staff described experiences where they related to their client’s perspectives as they shared the same culture. Understanding the client’s needs and referring them to an appropriate service was simplified when they shared similar cultural backgrounds. For example, one support staff said,

It help[s] in a way to change the process of the work. To an extent, I find it a little easier to relate, it's easier for them to relate…I am Multicultural because I was raised dual cultural home So I find it easier to deal with pretty much any culture because it does not affect the way I work as long as you follow the process but when it comes to the [country] in specific, there are some things that you can relate to and they can relate to which makes the process a little different. [I] don't have to go over all of the information or you can deliver the information in a different way that they can relate to and understand. (Support Staff 1)

A few of the support staff agreed that sharing cultural relationships enhanced the services that they were able to provide to newcomers. Alternatively, there were also positive experiences
from native-born Canadians who did not share cultural backgrounds which provided a different perspective. One support staff stated, “So in my experience, I was born and raised in Canada and a lot of my clients have voiced that they like that because they can speak to me about issues that are stigmatized within their own culture and they willfully voice like ‘you are a Canadian so I can talk to you about divorce and I can talk to you about [the] LGBT community’” (Support Staff 2). Support staff noted that feeling comfortable to share experiences in a judgement-free environment facilitated further mental health service utilization.

**Newcomer and support staff recommendations to improve services.**

Recommendations were offered by both newcomers and support staff to increase help-seeking behaviour and effectively support newcomers. Participants focused on service accessibility commenting on the lack of bilingual healthcare professionals and limited supports in place to assist individuals in following through with medical recommendations (e.g., childcare assistance in order to attend appointments). One newcomer stated,

> If I know that there's someone who speaks Arabic and can help me I will see more. Like they told me here in [newcomer organization] on the fourth level but I don't see her. I asked if she's Arabic or native speaker but she’s not Arabic so. (Newcomer 7)

Support staff also commented that newcomers’ initial experiences of having difficulty understanding and being understood by a physician or psychologist reduced the likelihood of future help seeking saying:

> There are no interpretation services. They keep telling them to bring somebody but we cannot bring somebody, you have to provide them and I have to fight for them. Many of my clients do surgery without knowing what is the surgery. They went into the surgery
and because they were embarrassed to say they don't understand, they just did it. (Support Staff 5)

When asked about potential recommendations for the Canadian healthcare system, a newcomer who had been referred to a follow up consultation with a specialist said, “…Maybe uh like for my situation. If I called the doctor or whatever organization, just I want someone to stay with me yeah in case I have [symptom] so my kids and me will be safe. yeah that's it” (Newcomer 1). This newcomer alluded to wanting a consistent case manager for family needs to establish trust around her kids and herself. Additionally, newcomers were not informed upon arrival to Canada about services that are accompanied by very long waitlists. Newcomer 8 commented on the lack of information provided to newcomer that made help seeking increasingly difficult:

Ya maybe I tell people about these services because many people they don't know. Like me at the beginning, when I came many services here I don't know about it. Just sometimes by accident I know or some of my friends they told me about it but it's easier maybe for me because my language is better than others but it's very hard or difficult or maybe some people, they will never know about it because they don't have the language.

The affordability of services and supports offered to newcomers was a common theme for newcomers and support staff. Both groups recommended that more government-funded supports be increased for this population to aid in the settlement process. Support Staff 2 noted that funding for all services that newcomers are referred to should be subsidized: “… they are stigmatized but I want to talk about the other end. The service provider… a financial piece is huge [because] not all health services are provided for free even though they should be. So even though I'm open to what kids want first and foremost, the resources are limited and also the
prices are so high”. This is consistent with newcomers who commented on added financial stress. One newcomer said, “Yes. Yes. Because can you imagine it for the people who do not really have money, it’s a lot of money for them so sometimes they have to do extra stuff to get the money. The government should help” (Newcomer 3).

**Consolidating Theme: Loss of Everyday Stress**

Newcomers and support staff expressed a re-occurring narrative of mental health regarding experiences of distress. As previously noted, The WHO (2004) defined mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (p. 10). However, newcomers often mentioned that they experienced elevated levels of daily stress. Participants described stressful experiences they faced prior to the migration processes that dulled their experience of ‘everyday stress’ as a newcomer to Canada. For example, Newcomer 10 articulated the daily intense distress he faced resulting from previously living in a war-stricken country saying, “[Mental health] It's a good thing and a bad thing too. You have a lot of war [so] we can't study well and that is our culture… There's a lot of wars and bomb blasts so every day we are scared on how to go”. This comment highlights this newcomer’s previous regular experiences of heightened feelings of anxiousness and overwhelming distress related to living in constant conflict and upheaval in his home country. Similarly, once arriving to Canada, newcomers felt that they were alone and lacked strong, social connections that assisted them in dealing with daily stressors. One newcomer described her loneliness once in Canada and of the challenges one faces on their own saying,
We don’t have any kind of help… And uh my kids. It's a big problem for me. Should I leave them, and I don't trust anyone uh and my younger baby, he will be almost two so before this time he's a baby so It's hard for me to leave him with anyone. (Newcomer 1)

Although the researcher attempted to ask impartial questions framing mental health as encompassing both positive and negative experiences, all of the participants narratives were focused on the negative aspects of mental health. See Table 3 for a summary of newcomer and support staff themes and subthemes.

Table 3

*Newcomer and Support Staff Themes*

<table>
<thead>
<tr>
<th>Themes Subtheme</th>
<th>Newcomers</th>
<th>Support Staff</th>
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<tbody>
<tr>
<td><strong>Theme 1</strong></td>
<td>Perspectives of mental health</td>
<td>Factors that contribute to mental health challenges</td>
</tr>
<tr>
<td><strong>Subtheme 1</strong></td>
<td>Origins of mental health challenges</td>
<td>Stress associated with undocumented status</td>
</tr>
<tr>
<td><strong>Subtheme 2</strong></td>
<td>External stressors that affect mental health</td>
<td>Restricted finances</td>
</tr>
<tr>
<td><strong>Theme 2</strong></td>
<td>When to seek professional help, if at all</td>
<td>Newcomer attitudes toward mental health</td>
</tr>
<tr>
<td><strong>Subtheme 1</strong></td>
<td>Minimizing the potential seriousness of symptoms</td>
<td>Is mental health real?</td>
</tr>
<tr>
<td><strong>Subtheme 2</strong></td>
<td>Intervention is only for severe mental health challenges</td>
<td>Stigmatization from others in the culture</td>
</tr>
<tr>
<td><strong>Subtheme 3</strong></td>
<td>Intervention for mental health challenges is unnecessary</td>
<td>Newcomers’ attitudes toward mental health service utilization</td>
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### Themes

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<th>Subtheme</th>
<th>Newcomers</th>
<th>Support Staff</th>
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<tbody>
<tr>
<td>Theme 3</td>
<td>Expectations and experiences of help-seeking</td>
<td>Newcomers’ attitudes toward mental health service utilization</td>
</tr>
<tr>
<td>Subtheme 1</td>
<td>Perceptions of the Canadian mental health care system</td>
<td>Barriers and facilitators to service utilization</td>
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<tr>
<td>Subtheme 2</td>
<td>Experiences accessing services</td>
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#### Recommendations

Participants focused on service accessibility commenting on the lack of bilingual healthcare professionals and limited supports in place to assist individuals in following through with medical recommendations.

#### Consolidating Theme

Loss of Everyday Stress

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### Discussion

The findings from this study revealed several positive and negative mental health experiences by newcomers and support staff working with immigrants at a local settlement organization. Both newcomers and support staff discussed that culture plays a role in whether or not and how mental health services are accessed. Mental health help-seeking behaviours were influenced by cultural beliefs about the origin of mental health symptoms, if and when to seek help, and expectations about mental health services in Canada. Both newcomers and support staff provided recommendations to improve service access.

### Newcomers

According to Kleinman’s model, individuals from different cultures have various beliefs regarding the reason for their symptoms which impact their course of action (Kleinman, 1980). Cultural beliefs regarding the origin of mental health challenges that affect mental health were discussed by newcomers. This is crucial to understand because circumstances such as precarious
work and low-income housing due to displacement play a large role in service utilization. Therefore, both culture and socio-economic status may impact a person’s decisions about accessing mental health services (O’Mahony et al., 2012; Wood & Newbold, 2012). Newcomers mentioned that several cultures regarded changes in mental health as resulting from a curse or being chosen by God. These findings closely aligned with the Fung and Wong (2007) study in which the authors explored help-seeking among Asian immigrant women. Researchers found that mental health challenges were associated with “magical means” from a spirit-type individual (p. 217). As many newcomers within this study considered themselves to be refugees escaping war-ridden countries, some participants mentioned that mental wellness was less of a priority than, for example, being physically safe while living in a war-torn country. Therefore, additional attention to mental wellness may be an important focus in newcomer settlement services.

Newcomers had difficulties expressing whether mental health challenges were “real” and if and how to determine when seeking intervention was appropriate. They discussed that several cultures did not endorse that mental health challenges were real and, if they were, they were temporary and minor. However, research emphasizes the increased prevalence of mental health challenges in newcomer groups especially depression and anxiety (O’Mahony & Donnelly, 2007; Wood & Newbold, 2012). Unfortunately, symptoms may be undiagnosed or mistreated resulting in mental health challenges and individuals experiencing chronic, worsening conditions. Although, in the current study, the researcher did not differentiate whether newcomers understood the severity of their symptoms and ignored them or believed that symptoms were not a concern, research by Newbold and Simone (2015) also showed that immigrants were more likely to report good health and ignore their chronic conditions when migrating to their new country. Participants in the current study also stated that intervention was
never necessary as these challenges should only be discussed among immediate family members. According to Kleinman’s (1978) model, the decision whether to seek medical intervention is dependent on the individual’s social community, past experiences of illness and cultural belief system. These findings were consistent with qualitative studies by O’Mahony and colleagues (2012) and Yorke and colleagues (2016a) who found that a fear of experiencing stigma within their cultural community deterred newcomers from accessing supports and increased the likelihood that challenges were only discussed with family members. Newcomers require health care professionals to provide a safe environment where trust can be established, and the client is able to completely share their experiences.

Expectations and experiences of help seeking in Canada were also important themes discussed among newcomers. Newcomers focused on beliefs based on media reports that organizations in Canada cared more about people and that professionals addressed issues holistically prior to immigrants and refugees arriving in Canada. Comparatively, newcomers faced financial insecurity and other circumstances that disproved these beliefs. This finding is consistent with Miranda and colleagues (2005) which highlighted the experiences of disadvantaged young black women who found that the inaccessibility of supports upon arrival in Canada was linked to increased mental health challenges. These participants were also at an increased risk of being unemployed and uninsured. Most newcomers in the current study described positive experiences with Canadian healthcare providers once they had migrated to Canada. This contrasts with research showing that newcomers felt that they did not receive quality care and adequate attention for their mental health challenges (O’Mahony et al., 2012). Newcomers also discussed that they were offered prescription medications more often than psychotherapy, which was the opposite for their native-born counterparts (Yorke et al., 2016b).
These findings align with McSweeny’s (1993) application of Kleinman’s explanatory model (1978) to correlations between perceived causes of myocardial events and their health behaviours. This article applied the model and found that each individual interpreted illness uniquely which changed over time based on that individual’s social environment, perceptions of past experiences and their ethnicity or culture (McSweeney, 1993).

**Support Staff**

Support staff discussed a variety of factors that contributed to newcomers’ mental health challenges. Staff alluded to a linkage between feelings of stress and anxiety due to newcomers’ undocumented citizen status and limited available finances. Support staff revealed that immigrants expressed feeling worried or anxious while waiting to receive citizenship. These findings were consistent with Kim and colleagues (2018) who investigated the influence of culture on stressors for mental health challenges in children of new immigrants and noted that these youth were at an increased risk of developing anxious feelings compared to families that were fully documented. Data from newcomers regarding restricted finances revealed that government assistance provided inadequate financial security which may negatively affect mental health. This was mirrored by findings in a study by O’Mahony and colleagues (2013). Creating additional financial supports that undocumented newcomers are eligible to apply for may decrease mental health challenges among this population.

As indicated by support staff, newcomers were conflicted about accepting mental health as real and experiencing concerns regarding potential discrimination and stigmatization from other members of their cultural communities. Similar to the newcomer participants, support staff suggested that people from certain cultures might not believe that mental health concerns exist, and if they accept this Western ideology, they experience stigma within their culture (O'Mahony...
& Donnelly, 2007; Olcoń and Gulbas (2018). This is important because researchers have found positive mental health to be correlated with cultural identity affirmation (Kim et al., 2018) which may be compromised once newcomers move outside of their cultural network by accessing service. Support staff participants discussed that stigma is one of the greatest influencers on help-seeking behaviours by newcomers they support. Salami and colleagues (2019) found that cultural understandings of mental health and its existence created barriers for newcomers to accept their symptoms as worthy of intervention. This information is critical as the first step in supporting this population should be educating newcomers about the existence of mental health concerns and how to identify when they are experiencing mental health challenges. This may facilitate further barriers to receiving the services this population may require, as it threatens their ability to articulately advocate for themselves and what they need in order to feel adequately supported. In general, cultural upbringing and related social-environmental considerations require attention in mental health services. The findings from this study suggest that mental health services should increase the availability of bi-lingual staff and provide free childcare to allow parents to access services and to meet appointment requirements. In addition, there should be increase in fully government funded mental health supports and professionals should follow-up with previous clients once they have received a referral to ensure that their needs are adequately met.

Limitations

There were several limitations to this study. Firstly, participants were invited to participate if they were available on the researcher’s scheduled interview days, and so it is possible that alternative perspectives were not captured. Additionally, in the current study participants represented multiple cultures and religious orientations. Future research might focus specifically on one or two cultures. This approach would provide a deeper insight into the
potentially unique experiences of these specific cultures. Another limitation was that individuals with limited oral English skills were exempted from participating in the study. Perhaps providing participants with the option of submitting oral and/or written answers in their native language to be later translated and then transcribed for analysis may have provided additional newcomers with an opportunity to express their narratives. Furthermore, the researcher was female and did not belong to the cultural and/or religious groups represented in the study. This may have caused discomfort to participants explaining the perceived positive and negative aspects of their culture in relation to mental health and service utilization since some religions have strong opposing gender roles and guidelines when discussing sensitive topics.

Conclusion

This study adds to previous research on the role that culture, and other social factors, play in how mental health is experienced by newcomers in addition to exploring their mental health service needs and their challenges when accessing appropriate supports. Through this study, newcomers and support staff revealed that culture and other social factors facilitate and hinder help-seeking behaviour and mental health service utilization. Participants provided insight into the challenges associated with relocating to Canada in addition to recommendations to improve service access upon newcomer arrival. Future research is needed to explore innovative ways to best support the unique needs of this underserved population. The feasibility of increased financial assistance and culturally sensitive support groups offered at settlement services should also be considered. Findings from this study may be used to positively impact the future delivery of effective and holistic care to newcomers to Canada and their families.
References


https://www.mentalhealthcommission.ca/sites/default/files/MHCC_Report_Base_Case_FINAL_ENG_0_0.pdf


Good Morning/Good Afternoon,

My name is Brittany Davy and I am a master’s student in the Department of Applied Disability Studies at Brock University. Under the supervision of Dr. Priscilla Burnham Riosa, I am conducting a research study on understanding the intersection of culture and mental health service utilization among immigrants and refugees. This study has been reviewed and received ethics clearance through a Brock University Research Ethics Committee (file #________).

We are reaching out to Newcomer Centre of Peel staff who have been working at the organization for at least 6 months to see if you are interested in participating in a focus group on staff perspectives of barriers and facilitators to mental health service utilization among refugees and immigrants.

The focus group is expected to take approximately 60-90 minutes of your time at the Newcomer Centre of Peel. The date and time of the focus group will be organized based on staff and researcher availability.

If you are interested in participating or would like more details regarding the study, please email Brittany Davy at bd14rr@brocku.ca or Dr. Priscilla Burnham Riosa at pburnhamriosa@brocku.ca.

Sincerely,

Brittany Davy

This study has been reviewed and received ethics clearance though the REB (file #______).

Principal Investigator: Priscilla Burnham Riosa       E-mail: pburnhamriosa@brocku.ca
Appendix B

BROCK UNIVERSITY

Consent Form - Newcomers

This study has been reviewed and received ethics clearance though the REB (file #____).  

Title of Study: Understanding the Intersection of Cultural Variables on Mental Health Service Utilization among Immigrants and Refugees

Researchers:

Principal Student Investigator: Brittany Davy, Department for Applied Disability Studies, Brock University and the Newcomer Centre of Peel organization, bd14rr@brocku.ca, 289 257-6455

Faculty Supervisor: Priscilla Burnham Riosa, pburnhamriosa@brocku.ca, 905 688 5550 ext. 6376.

Information about the Study: The purpose of this study is to understand how culture and other social factors impact refugees’ or immigrants’ views of mental health and mental health services. There is not a lot of research on this topic, and so we are doing this study to learn more about it. Interviews will take place with participants at a location that is convenient for them. The interview is expected to take 60-90 minutes and will be audio recorded by the researcher.

Name of Participant: (Please print) ________________________________________________________________

I understand that the purpose of the research project in which I have agreed to participate is to help professionals understand culture and mental health and the most effective ways to support
the mental health of newcomers to Canada. I understand that my data will not be anonymous, but it will be confidential. Results from the study will be kept 5 years and then safely destroyed.

I understand what this study entails and how I will be participating in it. I agree to participate in this study and I understand that I may stop participating at any time.

I agree:

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<td>• to participate in a research study that is exploring the effectiveness of mental health services for newcomers within Canada</td>
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<td>• that you may ask me questions</td>
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<td>• to allow people from your research team to meet me in a setting that I have chosen</td>
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<td>• to allow the researchers to talk to others and publish papers about my results, but never mention my name</td>
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<td>• to allow the information gathered from this study to be used in different ways in other studies to help improve mental health services</td>
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<td>• to be contacted about participating in other studies like this one</td>
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I have read and understood the relevant information. I understand that I may ask questions in the future and that my signature gives free consent to research participation by signing the research consent form.
Would you like to receive a summary of the research findings after the study is complete?

Yes  No

If yes, print your email here ________________________________________

This study has been reviewed and approved by the Brock Research Ethics Board. (File # XXX).

If I have any questions or concerns about my participation in this study, I may contact B. Davy, Brock University, by phone at 289 257-6455, or by email at bd14rr@brocku.ca. If I have any questions about being a researcher participant, I may also contact Brock University Research Ethics Officer in the Office of Research Services at 905-688-5550 ext. 3035, email: reb@brocku.ca.
Appendix C

BROCK UNIVERSITY

Consent Form- Support Staff

This study has been reviewed and received ethics clearance though the REB (file #____).

Title of Study: Understanding the Intersection of Cultural Variables on Mental Health Service Utilization among Immigrants and Refugees

Researchers:

Principal Student Investigator: Brittany Davy, Department for Applied Disability Studies, Brock University and the Newcomer Centre of Peel organization, bd14rr@brocku.ca, 289 257-6455

Faculty Supervisor: Priscilla Burnham Riosa, pburnhamriosa@brocku.ca, 905 688 5550 ext. 6376.

Information about the Study: The purpose of this study is to add to the existing literature regarding the influence that culture and other social factors have in facilitating and hindering mental health service utilization among immigrants and refugees. Immigrants and refugees and support staff will be recruited for the study. A focus group will be conducted with support staff participants at the Newcomer Centre of Peel or a location that is convenient for them. The focus group expected to take 60-90 minutes and will be audio recorded.

Name of Participant: (Please print) ________________________________________________
I understand that the purpose of the research project in which I have agreed to participate is to help professionals further understand culture and mental health and the most effective ways to support newcomers to Canada. I understand that my data will not be anonymous, but it will remain confidential. Study data will be retained for 5 years after which the data will be destroyed.

I understand what this study entails and how I will be participating in it. I agree to participate in this study and I understand that I may stop participating at any time.

I agree

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<tr>
<td>• To participate in a research study that is exploring the effectiveness of mental health services for newcomers within Canada</td>
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<td>• to allow the researchers to talk to others and publish papers about my results, but never mention my name</td>
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<td>• to allow the information gathered from this study to be used in different ways in other studies to help improve mental health services</td>
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<td>• to be contacted about participating in other studies like this one</td>
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</table>
I have read and understood the relevant information. I understand that I may ask questions in the future and that my signature gives free consent to research participation by signing the research consent form.

Participant Name (Print) ___________________________ Date ______________________

Participant Signature _______________________________________

Witness Signature _______________________________________

Would you like to receive a summary of the research findings after the study is complete?

Yes              No

If yes, print your email here _______________________________________

This study has been reviewed and approved by the Brock Research Ethics Board. (File # XXX).
If I have any questions or concerns about my participation in this study, I may contact B. Davy, Brock University, by phone at 289 257-6455, or by email at bd14rr@brocku.ca. If I have any questions about being a researcher participant, I may also contact Brock University Research Ethics Officer in the Office of Research Services at 905-688-5550 ext. 3035, email: reb@brocku.ca.
Appendix D

Newcomer Interview Guide

Hello ________, my name is Brittany Davy. I am a graduate student in the Department of Applied Disability Studies at Brock University. To let you know a little bit about me, I am of Jamaican descent and both of my parents were born and raised in Jamaica. My parents migrated to Canada 27 years ago, along with a few extended family members.

Background Info

Where did you immigrate from?
How long ago did you immigrate to Canada?
Did you come to Canada with anyone or were you on your own?
Do you have any family here with you now?
What was it like to leave your home country and come to Canada?

Mental Health & Culture

Now I’m going to ask you some questions about mental health and your culture…

“Mental health” or “mental wellness” can mean many different things in different cultures. In your culture, what do people think about mental health or mental wellness? (OR What do family/friends back home think about mental health?)

Probes: Is it talked about or kept hidden?
Is it a good thing or a bad thing?

Do you notice any differences in how people in Canada think about or talk about mental health compared to back home? (If so, what’s different? If not, why not?)

Are there any religious beliefs in your culture about mental health?
What does mental health mean to you?
Help-Seeking

We know from research that a person’s culture may affect whether or not they get help for mental health problems. What does your culture say about getting help? Is it a good thing to get help? Bad thing? Do you have support from family/friends when looking for help (ask about family and friends here and back home)?

If you need mental health help, is it easy to find? Difficult?

Have you looked into help for your own mental wellness?

If yes – Tell me about that. OR What was that like?

- Probes: Was it hard to do? Easy?
  - If yes, How were you treated by professionals when you tried to get help?
  - (If yes) Tell me about a time that you had a good experience with getting help or trying to get help?
    Tell me about a time that you had a bad experience with getting help or trying to get help?

(If no) Have you ever wanted to get help for your own mental wellness?

(If yes). What stopped you? What made it hard to get help?

Do you think that getting help for mental health is similar here compared to back home? Different? How so?

Available Services

Do you know what mental health support is available for immigrants?

Were you told about any mental health services since coming to Canada?

- (If yes) What were you told about?

What makes it difficult to get help?

What makes it easy to get help?

What do you like about mental health help in Canada? Dislike?

Is there anything you would you change about mental health help in Canada?
Appendix E

Support Staff Interview Guide

Background Info

What cultures have you worked with at NCP?

How, if at all, does your own culture affect how you work with your clients?

Mental Health & Culture

Now I’m going to ask some questions about mental health and culture…

“Mental health” or “mental wellness” can mean many different things in different cultures. What do your clients think about mental health or mental wellness?

- Probes: Is it talked about or kept hidden?
  Is it a good thing or a bad thing?

Does anyone work with clients who are originally from Canada?

- (If YES, do you think that ideas about mental health are different among those originally from Canada to your immigrant clients?)
  - (IF YES, how so?)

Help-Seeking

We know from research that a person’s culture may affect whether or not they get help for mental health problems. How does culture impact your clients and whether or not they reach out for help?

- Have you seen culture have a positive impact on help seeking? Negative impact?

What are the similarities and differences of working with immigrant clients compared to native-born counterparts?

What type of mental health support is available for immigrants?

What are cultural barriers to accessing the right supports?

What are cultural facilitators to accessing the right supports?
Any other barriers to seeking and accessing mental health support among immigrant young adults? Any other facilitators?

Have you ever helped an immigrant client find help for his/her mental wellness?
If yes – Tell me about that. OR What was that like?

   Probes: Was it hard to do? Easy?
     - If yes, Did they mention how they were treated by professionals when they tried to get help?

Available Services

What do you personally think makes it hard for individuals from different cultures to get help?
-What makes it easy to get help?

What do you like about mental health help for immigrants in Canada?
-Dislike?

Is there anything you would change about mental health help in Canada?