Second-Generation Tamil Youth Mental Health

Second-Generation Tamil Youth & Their Experiences Accessing Community-Based Mental Healthcare Services

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Lay Abstract

Second-generation Tamil youth are an understudied population with a growing need for mental health support. This study describes the experiences of second-generation Tamil youths and their access to community-based mental healthcare services in the Greater Toronto Area. Nine participants were interviewed using a semi-structured interview guide to collect data on their experiences accessing community-based mental healthcare services. Concurrent data analysis was conducted with data collection, and themes around the dimensions of access emerged: awareness, availability, acceptability, affordability, accessibility and accommodation. Further research is necessary to explore key strategies to implement when providing mental healthcare support to the second-generation Tamil youth population to better meet their unique needs, and tackle barriers preventing early access to services. Findings from this study are important to help inform the practice of nurses and practitioners alike, policy, and education to better support the unique needs of the second-generation Tamil population and promote mental health.

Abstract

Background: Second-generation Tamil youth experience intergenerational trauma from their first generation parents, along with various other mental health stressors which can continue well into adulthood. Early intervention and access to community-based mental healthcare services can serve as a protective factor and prevent chronic mental health issues. However, cultural and access barriers prevent second-generation Tamil youth from accessing much needed mental healthcare support. The purpose of this study is to explore how second-generation Tamil youth describe their experiences accessing community-based mental healthcare services and to identify barriers and facilitators to accessing mental healthcare services.

Methods: This study used Qualitative descriptive design and was informed by the Penchansky and Thomas Access framework with Saurman's addition. Nine second-generation Tamil youth in the Greater Toronto Area were interviewed using a semi-structured interview guide to collect information about their experiences accessing community-based mental healthcare services. Concurrent data analysis was conducted to promote rich data collection which helped identify themes among participant responses. Each theme helped identify barriers and facilitators to accessing community-based mental healthcare services. The thematic analysis clarified details and descriptions of the experiences of second-generation Tamil youth.

Results: Data analysis revealed six themes that fit within the dimensions of access: awareness, availability, acceptability, affordability, accessibility and accommodation. Findings from this study helps identify barriers and facilitators to accessing community-based mental healthcare services as experienced by participants.

Conclusion: While second-generation Tamil youth were able to describe their experiences accessing community-based mental healthcare services, not all participants were successful in

accessing a service. Further research is necessary to explore key strategies to ensure accessible mental healthcare support for second-generation Tamil youth, to better meet their unique needs, and to remove barriers preventing early access to services. Findings from this study are important to help inform the practice of nurses and practitioners, policy, and public education to better support the unique needs of the second-generation Tamil population and other newcomer groups and promote mental health.

Keywords: second-generation, Tamil, youth, mental health, community-based services

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List of Abbreviations

APN - Advanced Practice Nurses

CanTYD - Canadian Tamil Youth Development Centre

CNS - Clinical Nurse Specialists

GTA - Greater Toronto Area

HiREB - Hamilton Integrated Research Ethics Board

NP- Nurse Practitioner

QD - Qualitative Descriptive

RN - Registered Nurse

RNAO – Registered Nurses Association of Ontario

RPN - Registered Practical Nurse

SA - South Asian

TCM - Theory of Cultural Marginality

WHO – World Health Organization

Declaration of Academic Achievement

I declare that I, Kirthiga Ravindran, am the author of this thesis. I recognize the contributions of Dr. Olive Wahoush, Dr. Nancy Carter and Dr. Christy Gombay in both the research process and the completion of this thesis. This copy includes all final revisions as accepted by the Supervisory Thesis Committee.

Chapter 1: Introduction

Canada is known for being a cultural mosaic, with a majority of newcomers settling in Toronto, Ontario (Statistics Canada, 2016a). In fact, foreign-born residents constitute 29.1 % of Ontario's total population (Statistics Canada, 2016a). The South Asian (SA) population in Canada equates to 25% of this growing minority population (Statistics Canada, 2016b). The SA population includes people from Sri Lanka, India, Pakistan, Bangladesh, Afghanistan and other countries and is the largest racialized group in Canada with a total population of 1.6 million people (Statistics Canada, 2016b; Veenstra, 2009). The Tamil subgroup is one of the largest within the SA minority group with majority of them migrating from Sri Lanka (Statistics Canada, 2016a). Most of the Tamil population in Canada have settled in Toronto. A majority of the Tamil population in Canada left Sri Lanka due to the Civil War from 1983-2009 which has been declared a genocide and has resulted in the recent passing of the Tamil Genocide Education Week Act, 2021 in Canada (Thanigasalam, 2021).

Most immigrants and refugees who migrate to Canada do so for a better life (Beiser et al., 2002). Most immigrants arriving in Canada choose to come, and others arrive as refugees or asylum seekers fleeing conflict or natural disasters. Many bring with them an array of mental health concerns particularly those who are forced migrants (refugees and asylum seekers) (Beiser et al., 2002). The government of Canada's immigration plans are to increase the number of newcomers to Canada per year over the next 3 years to 500,000 by the year 2025 for permanent residents based on the categories of economic contributors, family reunification, refugees, protected persons and immigrants for humanitarian and compassionate need (Fraser, 2022). This would result in the total numbers of immigrants coming to Canada annually to be 1% of the total population (Fraser, 2022).

A preliminary review of the literature suggests that at the time of immigration, newcomers are commonly healthier than their domestic-born counterparts (Chiswick et al., 2008; Elshahat et al., 2021). Despite the selective immigration process, which favours those who exhibit qualities such as likelihood of economic success, and meeting health requirements; reports have found that during the post-migration period, newcomers' health advantage declines (Chiswick et al., 2008; Kennedy et al., 2015; Sanou et al., 2014). This decline is attributed to lifestyle changes such as work and diet, acculturation, poor knowledge of the current health-care system and rights, difficulty communicating with health practitioners, cultural barriers, and discrimination that stems from racism and xenophobia (Antecol & Bedard, 2006; Biddle et al., 2007; Bourdillon & Bennegadi, 1992; McDonald & Kennedy, 2005; Powles et al., 1990). Due to the varying stressors of resettlement, integration and assimilation in a new country, newcomers face significant mental health challenges (Beiser et al., 2002). For example, a study of Mexican newcomers found that they had better mental health than those born in the United States of Mexican descent, showcasing the damaging psychological impacts of longer term migration (Elshahat et al., 2021; Escobar, 1998).

Individuals born in Canada are approximately three times more at risk for suicide attempt than newcomers to Canada (Public Health Agency of Canada, 2020). Second-generation youths born in Canada to first generation immigrants are of concern as they are at an increased risk for suicide attempt and mental health concerns. In fact, the Tamil community has experienced an increase in Tamil youth suicides over the past few years and the Varman's Smile Foundation was created after a teen died by suicide on March 2nd, 2019 (Cribb, 2021). The foundation was created by family members and is supported by members of the Tamil community who are aware

of the challenges posed by Tamil youth suicide. The foundation aims to support mental health and normalize conversations around mental health and asking for help.

A large study in Ontario found that immigrant youth and children are approximately 27% less likely to have contact with mental health-related services compared to non-immigrant youth and children (Georgiades et al., 2019). Although overall prevalence of a mental disorder is lower among immigrant youth, this is anticipated to change with increases in the long-term and affect second-generation youth (Georgiades et al., 2019). Thus, disparities with immigrant youth making contact with mental health services require further investigation (Georgiades et al., 2019).

Background

Previous research reports highlight, the 'Healthy Immigrant Effect' whereby newcomers are generally healthier than Canadians when they first settle in Canada, however after 10 years, there is a decline in general health for newcomers (Fuller-Thomson et al., 2011). Newcomers face unique stressors such as culture shock, language barriers, finding employment and pressure to assimilate among others, stressors that have negative effects on their mental health (National Research Council, 1996). Newcomers, whether they claim refugee or immigrant status depart their nation for reasons such as poverty, conflict, persecution, human rights violations, natural disasters, or to work, join family or to study (United Nations, 2021). Typically, many newcomers experience traumatic pre-migration and pre-settlement histories which profoundly influence their mental health (Canadian Task Force, 1988). Mental health is a key components of one's overall health (WHO, 2018)

The World Health Organization (WHO) defines mental health as "a state of wellbeing 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" (WHO, 2018). According to WHO (2018) without mental health there is no health.

Immigrant youth can either be first-generation, 1.5 generation or second-generation (Arthur et al., 2008). Immigrant youth who immigrated to the receiving country with their parents at age 12 or over are referred to as the *first-generation*. The *1.5 generation* are those who arrived in Canada with their parents under or around age 12. Lastly, *second-generation* are those who are Canadian-born to first-generation parents.

Healthy youth development is directly correlated to providing youth with support, resources, relationship experiences and opportunities to become competent and successful adults (Bernat & Resnick, 2006). Various factors can jeopardize the healthy development of youth, for example, environmental factors such as familial characteristics, quality of school they attend and the community they reside in (Bernat & Resnick, 2006). The consequences of these contextual factors can lead to engagement in risky behaviour such as violent acts, substance use and unsafe sexual practices; other factors such as obesity and mental illness can jeopardize health development for youth (Bernat & Resnick, 2006). While mental healthcare needs are on the rise, youth are at a vital stage of development for mental health and substance abuse intervention (McGorry et al., 2011). Thus, it is important to explore youths' experience of mental health care and receiving support.

Early intervention for youth aged 14-25 who are at increased risk for chronic mental health and substance abuse and addiction disorders, have been proven to increase chances of recovery (National Institute of Mental Health, 2001). Early intervention approaches show that although risk factors may be present, affected or at risk youth can still become competent and successful adults with supports and sufficient appropriate protective factors (Bernat & Resnick,

2006). Access to community-based mental health services is a protective factor for youth experiencing mental health needs (National Institute of Mental Health, 2001). A more recent study found that less than one third of children and youth who met the criteria for a mental disorder had contact with a mental health provider due to lack of service capacity and availability (Georgiades et al., 2019). This startling finding suggests the need for more information from newcomer youth to strengthen prevention, early intervention and service capacity to support the mental health needs of youth in Ontario.

A Canada wide study revealed that newcomers from Asian countries, particularly SA, were less likely to utilize mental health services by contrast to the general population (Tiwari & Wang, 2008). Newcomer youth face unique mental health stressors as they are not only impacted by migration related stressors, but may also face stressors related to culture such as acculturative stress and dual identity (Tyyskä, 2015). These findings showcase a need for further supports for Canadian newcomer's mental health.

Mental Health

The World Health Organization (WHO) defines mental health as "a state of wellbeing 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" (WHO, 2018). According to WHO (2018) without mental health there is no health. Worldwide, depression is a leading cause of disability and is one of the major contributors (16%) to the global burden of disease (James et al., 2018). In fact, depression among other mental disorders can lead to suicide (James et al., 2018). Generally, women are more impacted by depression than men (James et al., 2018). Youth undergo an important phase of development, with multiple emotional, social and physical changes (WHO, 2020). These changes along with exposure to

poverty, abuse or violence can precipitate mental health problems such as depression (WHO, 2020). However, through the promotion of psychological well-being and protection of youth from risk factors and adverse experiences can result in improved well-being during adolescence (WHO, 2020).

Mental Illness & Addiction

Mental illness and addiction refer to a range of disorders known for affecting mood, thinking and behaviour (Smetanin et al., 2011). These disorders can vary from mood disorders such as anxiety and depression; psychotic disorders such as schizophrenia and bipolar disorder; and substance use disorders and gambling problems (Smetanin et al., 2011). Approximately one in five Canadians will experience a mental illness or addiction problem in any given year (Smetanin et al., 2011). This then translates to roughly one in two Canadians will have had a mental illness by age forty. In fact, 70% of mental health problems have their onset during childhood or adolescence (Government of Canada, 2006). Men have a higher incidence rates of addiction than women, whereas women typically have higher rates of mood and anxiety disorders (Pearson et al., 2013). Factors such as homelessness, pre-existing chronic conditions and income also play a factor in the likelihood of developing a substance disorder or mental illness (Pearson et al., 2013). Factors that are commonly experienced by newcomers settling in Canada. Mental health and physical health are directly influenced by one another, therefore those with a long-term medical condition are more likely to experience a mood disorder and vice versa (Patten et al., 2005). Furthermore, those with a pre-existing mental illness are twice as likely to experience a substance use disorder, and 20% of people with a mental illness have a co-occurring (concurrent) substance use disorder (Buckley et al., 2009). Those with a substance use disorder are three times more likely to have a mental illness (Rush et al., 2008). The population in the

lowest income group have an increased likelihood up to three-to-four times than the highest income group to report poor-fair mental health (Mawani & Gilmour, 2010). Lastly, 23-67% of Canadians experiencing homelessness report having a mental illness, this is a concern for newcomers as they are more likely to live in poverty particularly in the first 10 years in Canada (Canadian Institute for Health Information, 2007).

Prevalence of Suicide in Canada

Among youth and young adults aged 15-34 years of age, suicide is the second leading cause of death in Canada (Government of Canada, 2020). This translates to approximately 11 people dying by suicide each day and approximately 4,000 people dying by suicide each year (Government of Canada, 2020). The occurrence of death by suicide is approximately three times greater among men in comparison to women (Government of Canada, 2020). A substantial number of Canadians have thoughts, plans and attempts at suicide, however reported rates do not represent the true extent of the problem due to the stigma and other factors around suicide (Government of Canada, 2020). Approximately 11.8% of youth report having thoughts of suicide during their lifetime and 2.5% report thoughts of suicide in the past year (Government of Canada, 2020). In addition, approximately 4% have reported making a suicide plan in their lifetime, with 7% of people from the lowest income quintile and 3% of people from the highest income quintile (Government of Canada, 2020). Lastly, 3.1% of the Canadian population reported making a suicide attempt in their lifetime (Government of Canada, 2020).

Youth Mental Health

Youth are at a vital stage of development for mental health and substance use intervention (McGorry et al., 2011). Early interventions for mental health significantly increase chances of recovery for youth (WHO, 2018). The National Institute of Mental Health has found

that 50% of lifetime mental illness and addictions cases arise before the age of 14 and 75% of cases before age 24. In fact, 34% of Ontario high-school students have displayed moderate-to-serious levels of psychological distress such as symptoms of anxiety and depression, with 14% displaying serious levels of psychological distress (Boak et al., 2016). Early intervention can lead to better health outcomes and increased chances of recovery with improvements for health in adulthood. Youths aged 18-25 undergo many life changes during these stages of development as they transition to adulthood (McGorry et al., 2011). Youth aged 18-25 vary in their lived experiences as some maybe young parents, in school, working, or facing a range of stressors that vary and maybe new to them (McGorry et al., 2011; WHO, 2018). In Ontario, the age span for community mental health services for youth vary, however they typically include youths aged 12-25. During these stressful times it is vital to find the appropriate supports to help youths build a more sustainable life where they can prosper both physically and mentally (Georgiades et al., 2019; WHO, 2018). This life stage is a crucial time to promote mental health and wellbeing, and the specific SA youth mental health needs are worth noting.

South Asian Youth Mental Health

Among high income nations the prevalence of mental illness is highest in the US, Canada and Australia, with prevalence rates around 20% each (GHDx, 2019). Newcomers are at greater risk for mental illness due to socio-economic, cultural and environmental factors. Particularly, The mental health of SA youth is impacted by a wide array of stressors such as, academic pressure, relationship stress, financial stress, intergenerational and cultural conflict, and family difficulties (Boak et al., 2016; Islam et al., 2017; McGorry et al., 2011). The accumulation of stressors can contribute to the development or exacerbation of mental health challenges, such as anxiety, depression and substance abuse (Islam et al., 2017). A previous study states that SA

youth face extreme pressure from their parents to excel at school and to have a good career; pressures which may negatively impact their mental health and self-perception if they do not meet expectations (Islam et al., 2017). SA youth face acculturative pressures which place a strain on their relationship with their parents and further challenges their experience of being Canadian with immigrant parents (dual identity) (Islam et al., 2017). The SA youth population consists of smaller subgroups such as the Tamil youth population who have distinctive historical experiences that also impact their mental health.

Tamil Youth in Canada

Tamil newcomers of Sri Lankan origin have traumatic pre-migration and pre-settlement histories as a result of conflict in Sri Lanka, their country of origin (Beiser et al., 2015). These traumatic experiences place their mental health at jeopardy (Beiser et al., 2015). In Canada there is an overall population of 102,170 who identify with the Tamil ethnicity and a population of 76, 250 in Toronto (Statistics Canada, 2021). Estimates of the youth population within the Tamil community in Toronto were not available. The majority of Tamil settlers who typically came from the northern Jaffna region of Sri Lanka came to Canada under humanitarian and compassionate grounds (Tyyskä, 2015). This was due to the 1983 Tamil insurgency against the Sinhalese majority. The country was originally called Ceylon until 1978, however after gaining independence from Britain in 1948, internal warfare escalated from 1983 onward creating a long period of ethnic conflict in post-colonial Sri Lanka (Tyyskä, 2015). Around this time and well into the 1990s many Tamil refugees arrived in Canada (Kandasamy, 1995). First generation Tamil newcomers in Canada, arrived after experiencing trauma in their homeland, as they settled and the second-generation were born, they continued to experience the effects of the trauma (Tyyskä, 2015). Intergenerational trauma occurs when the effects of unhealed traumas of the

earlier generations reverberate across generations (Bombay et al., 2009; Shanmuganandapala & Khanlou, 2019). Evidence indicates that intergenerational effects of traumatic experiences impact offspring of survivors of abuse, armed conflicts and genocide leading to ripple effects which include a range of psychiatric symptoms and greater vulnerability to stress (Bezo & Maggi, 2015; Han, 2006). Many second-generation Tamil youth experience intergenerational trauma from their first generation parents, along with other mental health stressors which may continue well into adulthood (Han, 2006; Tyyskä, 2015). For those facing many mental health challenges there are services available to help support maintaining optimal mental health. Nurses play a key role in caring for the greater population and carry unique skills to care for youth populations with mental healthcare needs.

Nursing Role in Mental Health

Health practitioners play a vital role in the prevention and treatment of mental illness and promotion of mental health (Delaney et al., 2018). Health practitioners such as nurses, nurse practitioners, psychiatrists, psychologists, and social workers are primary points of care for individuals in need of mental healthcare treatment. Nurses, provide varying levels of mental healthcare in Canada, most often delivered by Registered Nurses (RNs) and Registered Practical Nurses (RPN). Advanced Practice Nurses (APN) such as Clinical Nurse Specialists (CNS) and Nurse Practitioners (NP) are nurses educated at the masters' level. The CNS has the same scope of practise as RNs. Nurses (RPN, RN and NP) are now able to perform/provide psychotherapy service with restrictions on the controlled act of psychotherapy in Ontario (CNO, 2022). Nurse practitioners have an extended scope of practice in comparison to RNs and CNS roles. Nurses in mental health can work in multiple and different settings from community to acute settings and even telemental health . Nurses are in a position to screen patients for suicidal ideations or

thoughts of self-harm and subsequently to help the patient receive appropriate treatment. Nursing roles in community-based mental healthcare services focus on care coordination, case management, counselling, rehabilitation, crisis intervention and support for family members (Harrison, 2017). Further investigation into service access by second-generation Tamil youth will help inform nursing practice, education, research and policy to better service vulnerable populations (Choi, 2018; Shanmuganandapala & Khanlou, 2019). In addition, further research may inform local practice guided by the Mental Health Strategy of Canada's goal to reduce disparities in access to mental health services and risk factors in order to strengthen the ability to meet the needs of diverse communities (Mental Health Commission of Canada, 2009). The Canadian Tamil Youth Development Centre (CanTYD) is an example of a community-based mental healthcare service that has a specific focus on the Tamil youth population.

CanTYD

The Canadian Tamil Youth Development Centre (CanTYD) is a non-profit organization devoted to youth empowerment. CanTYD takes on an informal structure to service delivery by offering walk-in services and flexible operating hours to meet client needs. CanTYD believes in building a relationship with the youth through activities prior to offering mental health counselling or support. The centre was initially formed to address the needs of at-risk youth in the community however since then has grown to service both at-risk and not at-risk youth within the Tamil community.

In summary, the population growth of SAs, the incidence and prevalence of mental health issues affecting youth in Ontario, and barriers to use of mental health services support the need to explore the interaction of SA youth with the mental healthcare system. Youth aged 14-25 are at increased risk for chronic mental health and substance abuse and addiction disorders (National

Institute of Mental Health, 2001). However, early intervention with mental healthcare treatments, can improve their chances of recovery (National Institute of Mental Health, 2001). Limited access to mental healthcare services translates directly to negative implications for the mental health of vulnerable populations (Georgiades et al., 2019). This study will focus on second-generation Tamil youths to better understand how a population born and raised in the Canadian context, with influence from a migrant culture experiences navigation of the Canadian health system.

Study Purpose

The purpose of this proposed study is to describe the perceptions and experiences of Tamil youth accessing community mental health services residing in the Greater Toronto Area. Primary Research Question: *In what ways do second-generation Tamil youth aged 18-25 and of Sri Lankan origin living in the Greater Toronto Area in Ontario describe their experiences accessing community mental health services?*

Secondary Research Questions: Who do they go to for support, or where do they go for support or help? What are the barriers or facilitators to access mental health services?

Chapter 2: Literature Review

Search Strategy

The literature review was conducted using: Cumulative Index to Nursing & Allied Health Literature CINAHL/PROQUEST, Ovid MEDLINE, PsychINFO, and EMBASE. Search terms used were, “youth”, “mental health”, “mental disorders”, “South Asian”, “Tamil”, “Sri Lankan”, “immigrant”, “Toronto”, “Canada”, “Ontario”, “Newcomer” and “mental health service”. The search strategy limit was set to include all English language studies in Canada, date limit was originally set for the past 10 years. Articles were also located by searching Google Scholar and hand searching reference list of directly relevant papers. The search of the literature found limited studies conducted on Tamil youth mental health in Canada. A total of 43 articles were found through all search methods mentioned, title and abstract reviews resulted in a total of 11 articles for this literature review. Of the 11 articles, 2 focused solely on a youth sample will be synthesized separately from the 9 articles with participant samples which included youth and adults. The Critical Appraisal Skills Programme (CASP) tool was employed for the critical appraisal of papers included in this literature review (CASP, 2020).

Studies of Tamil Youth

A recent qualitative study was conducted on the mental health of SA youth in Peel Region in the Greater Toronto area (Islam et al., 2017). This study used semi-structured interviews and focus groups to analyze social determinants of health, coping strategies and mental health service access by SA youths aged 13-24 (Islam et al., 2017). SA youth identified that conflicts with their parents was the major mental health stressor for them. The youth participants with immigrant parents found that they were in a constant dilemma as they were cross-culture children and felt as though they had dual identities. They reported that if they were to choose the ‘Canadian’ way of living and acculturate, their parents would think they had

betrayed them, resulting in intergenerational conflict. Furthermore, the SA culture values modesty when it comes to dating and interacting with the opposite gender, however youth generally want to exercise their freedom to explore and date. This creates conflict between SA youth and their parents as they were raised to believe that this is not 'good'. SA youth raised in a household with financial instability and circumstances whereby they must work to make ends meet, are more likely to face mental health challenges. Similarly, if family difficulties arise such as a divorce or separation, SA youth reported having a difficult time coping especially when they take on financial or parental responsibilities. Although participants were SA, the study report does not identify the individual ethnicities within the SA group; (Islam et al., 2017). The small number of participants included 2 males and 8 females, likely reflecting more the female perspective. The authors noted this disparity was due to the stigma associated with mental health, which hindered recruitment of male participants (Islam et al., 2017).

Tysska (2015) completed a participatory action research study with Sri Lankan Tamil youth in Toronto to explore teen-parent relationships through the intergenerational solidarity framework. Study participants were 20 teens aged 13-19 years of age. The 10 female and 10 male participants included first, 1.5 and second-generation Tamil youth. The study highlights the effects of immigration and gender role changes from country of origin to receiving nation and the additional pressures on individuals to survive, resulting in mental health concerns. Mental health concerns such as alcohol abuse among men and family violence have been identified in earlier studies and noted to be further exacerbated by post-traumatic stress from having lived in a conflict zone (Kandasamy, 1995). Tyyskä (2015) details the myriad of impacts experienced by the youth such as pressures to acculturate, dealing with hybrid cultures, gender roles/expectations, intergenerational trauma, and communication gaps between parents and

children, which have impacts on their mental health. It is evident that second-generation youth experience further intergenerational conflict from being more immersed in the Western culture, as they are Canadian born and begin to acculturate to the receiving countries' norms and values from early childhood. In addition to policy implications to assist the removal of barriers to education and employment of newcomers to help enable their financial stability, the authors stressed the importance of counseling and family services to aid healthy family functioning. Since family issues are a sensitive area, the use of culturally sensitive models of practice would be paramount.

Studies of SA Newcomers and Mental Health

Several studies provided insight into mental health issues of SA newcomer adults. Islam, Khanlou & Tamim (2014) analyzed the associations between migration and mental health of SAs in Canada. The study utilized the 2007-2011 Canadian Community Health Survey data with over 1.2 million participants to identify the prevalence of mental health outcomes. The results indicated that SA Canadian-born populations (second-generation) had a higher estimated prevalence rate of poor-fair self-perceived mental health status in comparison to their immigrant, counterparts. A qualitative cross-sectional study on the perceived causes of depression of SA women in Toronto found that depression was attributed to individual, family, relationships, social, cultural or economic factors rather than spiritual or biological causes (Ekanayake et al., 2012). As a result, the researchers developed a personal-social-cultural model to understand the etiological paradigm for depression. The authors suggest the need to study how second-generation youth are perceiving the cause of their mental illness (Ekanayake et al., 2012). Beiser and colleagues (2003) referred to the Tamil community as a 'community in distress' (p. 234) and began with a story of a young father who jumped in front of a train from a subway platform to

his death with a child in his arms. This large study included 1110 participants, the majority were male, ages ranged from 18-60+ years (Beiser et al., 2003). The study used a structured questionnaire derived from the World Health Organization's Composite International Diagnostic Interview, and the Ontario Health Survey, the 19-item scale developed to assess trauma and unique content areas was developed by the team (Beiser et al., 2003). Their study explored the mental health needs and help-seeking behaviour of the Tamil community in Toronto. The authors highlighted the need for mental health policy to meet the distinctive and diverse needs of immigrant and refugee populations as both an effort for response to illness and as health promotion (Beiser et al., 2003). Youth suicide in the Tamil community continues to persist and remains an issue that requires a proactive response (Beiser et al., 2003,2011; Cribb, 2021).

Similar studies that analyzed mental health service access by SAs noted the need for further studies to be conducted to better understand how practitioners and services can specifically prepare to better serve SAs. (Bowl, 2007; Burr, 2002; Karasz et al., 2019). Burr (2002) recruited registered mental health nurses, community psychiatric nurses and approved social workers in the UK for a qualitative study to explore the construction of cultural stereotypes in mental health in order to understand the low rates of reported depression and the high rates of suicides they were witnessing among SA communities. This study along with others (Beiser et al., 2003; Bowl, 2007; Islam et al., 2017; Karasz et al., 2019) suggest that service providers need more information about the perspective of SAs, youths, and call for a re-establishment and reinforcement of the ethnocentric practices in Western psychiatry to support this population. Although the participants in these studies were not primarily youth, the results provide relevant information for why further exploration into Tamil second-generation youths

and their experiences accessing community mental health services is necessary as early intervention is crucial (National Institute of Mental Health, 2001).

The limited literature suggests there is an opportunity to explore the mental health care needs and experiences of Tamil youth seeking mental health services. The two studies which focused solely on Tamil youth identified the myriad of impacts experienced by youth such as pressures to acculturate, dealing with hybrid cultures, gender roles/expectations, intergenerational trauma, and the communication gaps between parents and children (Islam et al., 2017; Tyyskä, 2015). The studies analyzed social determinants of health, coping strategies and service access, which have impacts on the mental health of youth (Islam et al., 2017;Tyyskä, 2015). Several articles have been published on adult SA newcomers which noted the need for further studies to be conducted to better understand how practitioners and services can specifically prepare to better serve SAs (Beiser et al., 2003, 2011; Bowl, 2007; Burr, 2002; Ekanayake et al., 2012; Islam et al., 2014; Karasz et al., 2019).

Problem Identification

From the limited evidence presented in the literature review, it appears Tamil youth with mental health concerns and/or risks are under-studied The literature addressing the unique mental health needs of second-generation Tamil youth is limited. This gap in the literature is important as early interventions with mental healthcare treatment increases chances of recovery and has implications for future health in adulthood. Tamil youth experience mental health issues as a result of their parents unresolved pre-migration and settlement issues, and the myriad of acculturative stress they experience, but it is unknown how best to provide interventions to help this population.

Chapter 3: Methodology

In this chapter, the methodologies used for this study will be discussed. It will begin by describing the framework used followed by the guiding theory. Then, the following sections will be covered: the qualitative descriptive research design, research questions, study context/setting, sampling and recruitment methods, participants, data collection and data analysis, data security and encryption and rigor.

Framework

The Access framework developed by Penchansky and Thomas (1981), along with the addition made by Saurman (2016) and was used to develop the interview guide, analysis of results and discussion section to reflect on results of this study. The study, analysis, results and discussion were informed by Choi's Theory of Cultural Marginality which will be explained later (Choi, 2001, 2018). Penchansky and Thomas (1981) state that access to services can be enhanced by addressing five dimensions of access which are accessibility, availability, acceptability, affordability and adequacy (accommodation) with respect to the service design, implementation and evaluation. Access is defined as the degree of fit between the client and the service (Penchansky & Thomas, 1981). *Availability* refers to the number and types of existing services in relation to the clients need for services. *Accessibility* is in relation to the location of services with respect to the location of clients and considers the client's transportations resources, distance, cost and travel time. *Accommodation* refers to how resources are organized to accept clients such as the appointment systems, hours of operation, and walk-in facilities. *Accommodation* also considers the client's beliefs on the appropriateness of the aforementioned factors. *Affordability* is concerned with the direct cost of services and providers' insurance, in relation to the clients' ability to pay through means such as existing health insurance. *Affordability* also considers indirect costs of time from work, travel (bus, taxi, parking, etc.); and

insurance coverage as not all services are covered by insurance and if they are there can be limits on coverage. *Acceptability* refers to the relationship between the client's attitudes about practice and personal characteristics of providers and what the provider considers acceptable personal characteristics of clients. *Awareness* is the final missing piece to access which was contributed by Saurman (2016); where she outlines that awareness is more than knowing of a service, rather it is going beyond to understand and use that knowledge (see Appendix J). Potential user's awareness means awareness of the service, who it is for, what it does, where and how to use it, why it should be used, when it is available and preserving that knowledge (Saurman, 2016b).

Choi's Theory of Cultural Marginality

Choi's Theory of Cultural Marginality (TCM) begins to address the lack of mutual understanding between clients of differing cultural backgrounds and healthcare providers. Differences may be barriers in advancing healthcare services for immigrants and culturally diverse groups (Choi, 2001, 2018). Major concepts of the theory include cross-culture conflict recognition, marginal living, and easing cultural tension. Choi states that an individual who can identify conflicts between cultures is engaging in marginal living, which subsequently initiates adjustment responses to help ease cultural tension. Choi also identifies dimensions of cultural marginality which are contextual or personal influences that create the groundwork for one's experience of cultural marginality. TCM has a number of areas relevant for nursing practice; TCM can be used to understand cultural differences,impacts on nurse-client relationships and effects on issues such as client adherence to treatment. The theory can also be applied in the school nurse setting to help foster awareness and support for culturally distinct adolescent needs (Choi, 2001, 2018; Labun, 2003). Additional areas for application of TCM include education and health promotion programs, which may assess and modify an individual's personal influences,

culturally relevant therapeutic nurse-client relationships and development of cultural competence training for healthcare providers. The TCM framework helped explore the unique diverse experiences of the Tamil youth population as they are caught between the Western culture and their own Tamil culture and how that impacts health disparities when accessing mental healthcare services.

For the purposes of this study, TCM was used to help inform interview guide development, conducting of interviews, data analysis and aid in developing recommendations for practice, education and policy. TCM helped the principal investigator remain grounded in theory and helped develop and maintain understanding around the experiences of second-generation Tamil youth. The understanding of TCM helped the principal investigator to identify and analyze the distinct culturally influenced experiences of the Tamil population to answer the research question.

Research Design

A qualitative descriptive (QD) design was utilized to address the research questions as this design is effective in developing a rich description of a specified event as experienced by individuals or groups of individuals (Sandelowski, 2000). The process of undertaking a QD research design commences with the identification of a clinical practice issue and a research question addressing the specified issue (Sandelowski, 2000). The research design takes on a naturalistic conceptual approach whereby the design commits to studying a phenomenon with the intent of being as free of artifice as possible (Sandelowski, 2010). This methodological approach best fits the research question as the question aims to explore, describe and understand the varying experiences of second-generation Tamil youth. The naturalistic approach encourages participants to respond to questions in their own words and was the guiding principle used by the researcher to discover and understand mental health experiences from the perspective of second-

generation Tamil youth (Sandelowski, 2010). This approach helped capture data via the practice of "reading *of* the lines as opposed to *into, between, over*, or *beyond* line" (Sandelowski, 2000, p.335-336). By taking on the "factist" views of data, QD assumes the data will be more or less accurate and provide truthful indicators of reality of the individuals through the beliefs, behaviours and events captured by their words/responses (Sandelowski, 2010). The QD method required an iterative thematic analysis of the data to provide data-near interpretations (Sandelowski, 2010).

By describing the features of the experiences of Tamil youth with mental health concerns and accessing community services, we can better understand the access barriers and facilitators they encounter. The QD design allowed us to uncover meaningful knowledge of the phenomenon of mental health access by this population. Data collected from semi-structured interviews were analyzed to form common themes. Common themes were generated from the analysis to address the *where*, *when*, *why* and *what* of the phenomenon through simplified descriptions of information participants shared in the collected data (Sandelowski, 2010). The themes presented insights about the experience of second-generation Tamil youth seeking or accessing community mental health services in the GTA.

Research Questions

The purpose of this proposed study is to describe the perceptions and experiences of Tamil youth accessing community mental health services residing in the GTA.

Answering the following research questions will help achieve the study purpose.

The Primary Research Question:

1. In what ways do second-generation Tamil youth aged 18-25 and of Sri Lankan origin living in the GTA in Ontario describe their experiences accessing community mental health services?

Secondary Research Questions:

In the GTA:

A) Who do Tamil youth go to for mental health support?

B) Where do Tamil youth go for support?

C) What are the barriers or facilitators to access mental healthcare services faced by Tamil youth?

Study Context/Setting

This research study took place in the GTA home to the largest Tamil speaking immigrant population in Canada. Tamil youth were recruited from CanTYD, a local community youth mental health service, and social media platforms such as Instagram, Facebook and Snapchat within the GTA. Community mental health services such as Aadhya, Anbu, Frontline Community Centre, and Varman's Smile were also invited to share recruitment posters with their clients (see Appendix F).

Sampling and Recruitment Methods

Qualitative descriptive design employs numerous strategies to best address and understand the phenomenon. Strategies begin with appropriate recruitment methods to help ensure that those individuals with experience relevant to the study have opportunities to hear about the study and to participate. Purposeful sampling, is a non-probability sampling method,

where the researcher will use their judgement to choose members of the population to participate in the study (Etikan, 2016).

Sandelowski (1995) states that determining an appropriate sample size in qualitative research depends on evaluating the data collected against the research method, sampling strategy employed and intended use for the data collected. In contrast, Morse (1994) recommends that 6 participants will be adequate to discern the essence of experiences in studying phenomenon. For the purposes of the research question, recruitment stopped when nine participants completed an interview, concurrent preliminary analysis confirmed that data saturation was achieved and the pandemic restrictions made further recruitment challenging. The smaller sample of nine participants was considered acceptable as participants were a homogenous sample of second-generation Tamil youth (Morse, 1994; Sandelowski, 1995). This study commenced with a purposeful sample of second-generation Tamil youth with experience accessing or seeking community mental health services.

Participants

The inclusion criteria for this study included; (1) Tamil youth, (2) aged 18-25 years, (3) are second-generation, (4) have parents of Sri Lankan origin (5) live in the GTA and (6) who have accessed or thought of accessing community mental health services in the past six months, and (7) can speak and understand English (Etikan, 2016). This strategy helps ensure that participants are information rich and able to speak about their experiences of mental health. (Etikan, 2016).

Participants were recruited from a local community mental health service, Canadian Tamil Youth Development Centre (CanTYD) located in Scarborough. Social media was utilized to share research posters (see Appendix F) through personal and local community mental health

service pages such as: Aadhya, Anbu, Frontline Community Centre, and Varman's Smile Foundation. Key contacts from these services voiced their willingness to share information about the study to their clients verbally and via electronic flyers. Due to the global pandemic and the resulting local and regional restrictions, most services are being provided virtually with limited numbers of youth accessing in person visits, therefore advertisements for recruitment were shared predominantly online and word of mouth. Social media platforms such as Facebook, Instagram and Snapchat were utilized for recruitment to target the 18-25 age group. Introductory questions (Appendix B) were also used to determine if the interested participant met the inclusion criteria, for example, questions such as 'Are you a Tamil newcomer?', and 'Have you tried or been successful at accessing services for mental health issues in the past six months?'. This process helped ensure that participants were able to provide information to answer the research question as they had considered or had personal experience accessing community mental health services.

Local community mental healthcare centers, and organizations servicing the Tamil youth population in the GTA, and gatekeepers within those establishments were contacted to help with recruitment. Lastly, snowball recruitment was also employed as key community contacts and participants shared information about the study with potential participants (Noy, 2008). Recruitment for the QD design utilized multiple approaches to promote recruitment of Tamil youth with varied service experiences and enable data collection that will support rich description of their experiences. Recruitment commenced after ethics approval was received from the Hamilton Integrated Research Ethics Board (HiREB).

Data Collection & Data Analysis

Data collection using interviews that support participant narratives was used to help gather detailed information reflective of the phenomenon of interest. Data was collected from a

brief demographic questionnaire and semi-structured interviews. The interview guide was developed to ensure the dimensions of access which are accessibility, availability, acceptability, affordability, adequacy and awareness are addressed. Once the interviews were completed and analysis started, the access framework was used to help the researcher describe the dimensions of access from participant stories of their experiences. TCM helped the PI gather quotes for sections such as acceptability, awareness and additional findings as TCM considers marginal living whereby if an individual can identify conflicts between cultures they are engaging in marginal living. TCM helped guide the PI by keeping the PI grounded in theory to understand, recognize and reflect on the impacts of across culture conflict recognition, marginal living and adjustment responses to ease cultural tension as participants are caught between the Tamil culture and the western culture. Due to the pandemic and local regional restrictions on in-person meetings, the interviews were predominantly online. Consent was obtained from participants prior to recording interviews and participants were given the option to keep their video turned on or off. Semi-structured interviews were recorded in full using the Zoom platform and transcribed (Zoom Video Communications, 2021).

Online Interview Process

Prior to commencing each interview prospective participants had the opportunity to read the information letter and consent form, and to have their questions answered. If they met the selection criteria and agreed to participate, they were then asked for their consent to participate and permission to have the interview recorded. Participants were given the choice to choose between keeping audio only on, or both video and audio. Interviews were completed using the Zoom platform (Zoom Video Communications, 2021). The interview lasted up to 1 hour and were completed one-to-one with the researcher. As pandemic restrictions eased in Ontario, three

interviews were conducted in-person and recorded via Zoom, all public health measures were followed.

The primary investigator leading interviews (see Appendix D) made notes during and after each interview, which is referred to as journaling. These notes focused on difficulties or hesitations by participants, reflections on interviewer's interview style, and points to focus on for future interviews. All recordings were checked for completion, and transcripts were checked against audio recordings to ensure they were complete and correct. The analysis focuses on developing a rich description and interpretation of the data (Sandelowski, 2000).

Data analysis for the semi-structured interviews adopted Burnard's (1991) methodology (see Appendix H). Transcripts were first read. The first four transcripts were read by the primary investigator and members of the team. Readers were asked to jot down notes about themes as they relate to the accessibility framework and Choi's theory, as well as overall themes noted. After discussion, a coding framework was developed. The primary investigator and another member coded four transcripts individually and then discussed adequacy of the coding framework and made adjustments. The remaining transcripts were then coded by the primary investigator. Themes were developed based on the research question such as description of experiences, or barriers and facilitators. Quirkos software program was utilized with double password protection to code data and combine coded data from all interviews to form themes (Quirkos, 2022). Concurrent data analysis was used, whereby each interview audio-recording and transcript were reviewed on an on-going basis rather than waiting until all interviews were completed. Analysis began during the early interviews, concurrently with data collection. For subsequent interviews, the interview guide was fine-tuned to allow for further exploration of early themes. Interview questions such as "How has the pandemic affected your mental health

and need for accessing community mental health services?" and "What do you think are good strategies to spread awareness of mental healthcare services?" were added to the interview guide as result of concurrent analysis. Data saturation is achieved when no new findings are found in interview responses and there is sufficient information to replicate the study (Fusch & Ness, 2015). Notes about steps in the research process, decisions and issues addressed in the interviews were documented in memos and journaling. A resource listing local community-based mental healthcare services (see Appendix G) were offered to participants and kept on hand in-case of emergency.

Data Security & Encryption

To maintain confidentiality data was stored using Microsoft Office 365 Storage provided by McMaster University for secure, off premises cloud-based storage. OneDrive was used to share and transport information. Microsoft Teams was utilized to enable collaboration with the research team with secure access limited to collaborators invited to the Office 365 platform. The platforms have standard encryption and files were password protected. The research team accessed files on password protected devices. The transcriptionist maintained confidentiality and protection of personal health information of participants and all documents were shared securely through SecureDocs (SecureDocs, 2022) The data will be stored for five years' post-publication and then will be deleted from all electronic record sources.

Rigor

Rigor is concerned with assuring that the study methods are thorough and accurate as it is important to ensure that the study is capturing what was intended (Sandelowski, 1993). In this study, the researcher reviewed recruitment and interview planning with the supervising faculty and debriefed with the faculty supervisor after the first interview was completed (Creswell & Miller, 2000). The researcher transcribed the first interview; the researcher and the supervisor,

who is an experienced qualitative researcher, independently analyzed the transcript and compared findings (Creswell & Miller, 2000). This process promoted rigor in data analysis and helped develop the code book, which then supported the ongoing data analysis (Creswell & Miller, 2000).

The researcher engaged in reflexivity by taking notes, journaling or recording memos throughout the data collection process and analysis. As a second-generation member of the Tamil community, self-reflection was important in considering possible personal assumptions, biases, and beliefs which may alter their data collection, analysis understanding of the data (Creswell & Miller, 2000). Reflexivity by the researcher reinforced the dependability of the research (Creswell & Miller, 2000). All interviews were recorded and transcribed to ensure all of the participants words are captured which helped ensure the confirmability of the data and analysis (Creswell & Miller, 2000). The researcher consulted with the thesis supervisor for review and feedback. Feedback confirmed that the researcher implemented effective interviewing strategies, listening, summarizing and re-iterating the experiences shared by participants back to them to ensure their narratives were correctly understood. Lastly, the members of the supervisory committee reviewed transcripts, preliminary coding, and the coding framework.

Reflexivity

The primary investigator identifies as a second-generation Tamil youth with parents of Sri Lankan origin, and currently residing in the Greater Toronto Area. This insider perspective is a strength for the study and presents a risk of bias. Risks were minimized as the investigator engaged in critical self reflection during data collection and analysis to minimize risk of bias (Creswell &Miller, 2000). For example, during interviews the investigator avoided statements such as ‘I know what you mean’ and maintained a neutral listening attitude reflecting the

participants' words back to them when further clarifications were needed. The also used TCM during the reflexive process to respect and understand the experiences of participants.

Chapter 4: Findings

This chapter presents findings from the nine semi-structured interviews guided by Penchansky and Thomas's (1981) Access framework that were completed using a qualitative descriptive methodology. Several strategies were utilized to identify, describe and organize the study findings. These strategies include, descriptive statistics, inductive content analysis, and the use of Quirkos as a data management tool. Memos and journal notes were used to clarify findings and helped clarify understanding of the specific participant comments. Participant demographics and types of services that participants were looking for are described.

Demographic Characteristics of Participants

Nine second-generation Tamil youths participated in the study, they included six females and three males all between 18-25 years of age, with a mean age of 21. One participant was born in Sri Lanka and came to Canada at the age of six, this participant was included in the study as most of their school experience was in Canada and preliminary analysis found that their responses were closely aligned with those of other participants. The remaining eight were second-generation Tamil youths. Six participants are pursuing post-secondary education and three have completed an undergraduate degree and are currently employed. One of the six participants pursuing post-secondary education is enrolled in a college program the other five are in university programs. All nine participants currently live at home with their parents. Two of the nine participants identified Tamil as their primary language.

After reviewing the interview transcripts and analyzing the data, final codes were grouped into themes which aligned well with the framework. Findings are presented here using the themes of Awareness, Availability, Acceptability, Affordability, Accessibility, and Accommodation; synonymous with the accessibility framework (Penchansky & Thomas, 1981; Saurman, 2016).

Types of Services Participants Sought Out

Participants described the types of services they were looking for to support their mental health: services were school based or community-based services. Participants shared their reluctance to go to a primary healthcare provider such as a physician, psychiatrist or psychologist for supports due to cultural stigma around receiving mental healthcare and affordability. Many participants stated they have thought of and had moments where they felt they needed mental healthcare, however they did not act on these needs due to stigma and affordability.

School Based Services

Participants shared how their initial point of contact for a possible mental health support service was through their educational institute whether it be elementary school, high-school or university. However, participants shared their disappointment when they realized these services were targeted towards academics versus mental health and well-being. Participants described the type of support they were looking for such as counselling or therapy on topics such as relationships, family dilemma, cultural pressures, education, stress management and financial services. Several barriers were apparent during attempts to access academic-based services such as limited available appointments and stigma.

Community-based Services

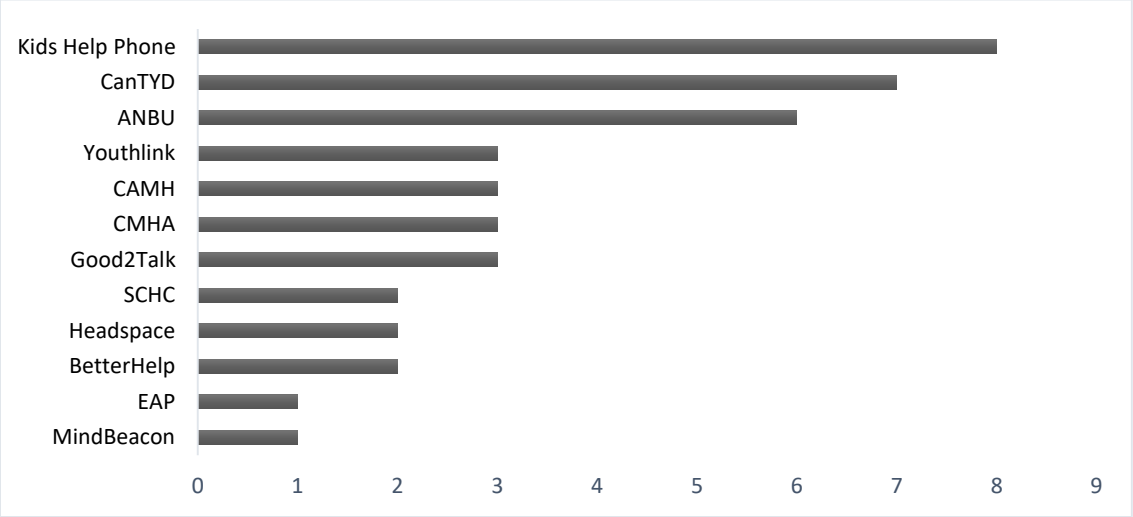
Participants shared their preference to CanTYD services and lack of use of other community-based services were noted. In the next sections, participant's data describing access to mental health services is organized using the Access framework. The access framework consists of the following dimensions: awareness, availability, acceptability, affordability, accessibility and accommodation.

Awareness

Awareness is related to the potential user's awareness of the service, who it is for, what it does, where and how to use it, why it should be used, when it is available and preserving that knowledge (Saurman, 2016). Participants identified that traditional methods of advertising services such as through posters or emails were not effective in persuading them about mental health services, however they found that social media platforms such as Twitter or Instagram were more engaging and personable. Participants shared awareness of several community-based services available to them when presented with a list of 12 community-based mental health services (see Figure 1). Despite being aware of services that are available participants did not utilize many of the services. Eight out of nine participants were aware of Kids Help Phone, however only one participant utilized the service (see Table 1). Six participants were aware of ANBU, due to its social media presence, however none of the participants have used this service. Seven participants were aware of CanTYD and 6 participants have used CanTYD.

Figure 1

Participant's Awareness of Mental Healthcare Services



Note. This figure contains the following abbreviations: Employee Assistance Program (EAP), Scarborough Centre for Healthy Communities (SCHC), Canadian Mental Health Association (CMHA), Centre for Addiction and Mental Health (CAMH), Abuse Never Becomes Us (ANBU), and Canadian Tamil Youth Development Centre (CanTYD)

Table 1

Participant's Awareness and Use of Mental Healthcare Services (n=9)

Type of Mental Healthcare Service	Name of Service	Awareness of Service	Use of Service
Phone Services	Kids Help Phone	8	1
	Good2Talk	3	1
Online & App Based-Services	MindBeacon	1	0
	BetterHelp	2	0
	Headspace	2	0
Community Services	Canadian Mental Health Association (CMHA)	3	0
	Centre for Addiction and Mental Health (CAMH)	3	0
	Canadian Tamil Youth Development Centre (CanTYD)	7	6
	Youthlink	3	1
	Abuse Never Becomes Us (ANBU)	6	0
	Scarborough Centre for Healthy Communities (SCHC)	2	1
Employment Service	Employee Assistance Program (EAP)	1	0

Participants identified being more receptive to in-person or interactive presentations, or workshops during school, or after school programs. One participant shared how they first

became aware of services in school: “From high school […] they came to school drop-ins, so they […] physically advertised themselves too” (Participant A02, female).

Participants stated that they struggled with knowing where or how to look for culturally specific resources which served as a barrier for them to access services. A female university participant shared this when describing how her lack of knowledge prevented her from accessing services:

> I feel like I would have been more comfortable speaking to a Tamil counsellor, but I guess at the time I also couldn’t find one or I didn’t know how to look for … or where to look for the resources. So I guess that’s where it was quite limited and I just … I didn’t end up going back [referring to a university student counsellor].
>
> (Participant A03, female)

When participants were asked to name the different types of mental healthcare providers they were aware of, they listed the following: psychotherapist, psychiatrist, psychologist, social worker, therapist, guidance counsellor, social worker, counsellor, teacher and doctor. Lastly, male participants commonly stated that being aware of a peer using a mental healthcare service would push them to use the service, which was a facilitator. A male participant described what might have made things easier:

> What could have pushed me into doing it? Maybe if I knew a friend that did it or something and I got like a recommendation or if I knew somebody else …. I don’t know anyone else that has … reached out to any other mental health services either so maybe that would have made things easier.
>
> (Participant A05, male)

Overall, participants lacked adequate awareness of services including who the service is designed and targeted for, and where and when to access them.

Availability

Availability refers to the numbers and types of existing services in relation to the clients' need for services (Penchansky & Thomas, 1981). Participants reported availability of services was limited with few available appointments and long wait times for services, for instance those offered in schools, such as a school counsellor and appointments to see a psychiatrist. One participant described her experience and a conversation she had with a peer trying to access service. She stated: "Because one of the things with their counselling at uni[veristy], is they are fully booked. They are always fully booked" (A06, female) This participant also described another conversation she had with a peer:

> I remember one of my friends mentioning later on in uni[versity] that when they went, the next appointment is in three months and she's just like well what the hell, I need it now, not in three months.
>
> (Participant A06, female)

Other participants identified lack of variation of services to meet their needs and noted that academic advising services were present in high school and in post-secondary institutions however mental health/ well-being services were not available at the main campus. Participant were asked what services they needed, and they identified needing services for help to support them around family issues, cultural pressures, relationships, education pressure, self-esteem and stress and anxiety. The following statement describes a participant's experience with the type of mental health services available at school: "I know they have the guidance counsellors, but I feel

like they're not really there to listen to your household issues or your like … your personal problems versus it being education" (Participant A04, female). This participant was explaining that guidance counsellors focus on education rather than personal issues. The focus on supporting education rather than mental health needs was reported by almost all participants.

Acceptability

Acceptability is the relationship between the client's attitudes about practice and personal characteristics of providers and what the provider considers acceptable personal characteristics of clients (Penchansky & Thomas, 1981). Participants described their perceptions of mental healthcare services and the personal characteristics of mental healthcare providers that they found acceptable. Acceptability is described by participants under the sub-themes of preferences for provider characteristics, practice setting, building trust, negative perceptions of mental health services and privacy.

Preferences for Provider Characteristics

Participants from this study engage in marginal living as they have influences from the Tamil culture as well as the Western culture. In the following section, results are provided that provide insight into the unique mental health needs of Tamil Youth and how this influences how they perceive a provider would be able to understand their distinctive perspective. These include descriptions of their experiences as Tamils, and family dynamics. These results help to inform the acceptability of provider characteristics, and provide more insight into youth decisions about accessing help.

A female participant shared how comparisons made by her parents impact her mental health:

> I think because in their mindset they've come from a war-torn area, like from Sri Lanka, they worked there, they worked so hard to get over to Canada, flee the war, start from zero, work so hard to build a name for themselves, have a job, take care of a family so for them that's hard work. So for us, they compare that significantly to me or my brother saying oh you guys got everything handed to you, what's so difficult, what is stress, you don't know what stress is, you don't know what tired means and they'll compare oh I used to work around the clock, twenty-four hours without sleep and without food and to them they think that's what equals hard work. And that comparison it's hard for them to let go of their time and how it's difficult for our time now, like they can't transition that mindset.
>
> (Participant A04, Female)

The parental perspective described by the participants displays the pressures second-generation Tamil youths experience and where they are originating from. Another participant shared similar feelings and described how difficult it is to live up to these expectations.

> It's hard because obviously your parents, they immigrated from like Sri Lanka to Canada to give you a good life and then you feel bad that you're not meeting up to their expectations. If you were to drop out or do anything that would put a strain in their reputation, it's just bad on you overall. It's really difficult to live up to their expectations. It can be fun at times, but it's also difficult.
>
> (Participant A02, Female)

Unrealistic and high expectations by parents is one of the issues participants identified, another concern a participant noted that they would like a provider to understand is the

following: “things that like we go through in terms of what parents, say, especially like what Tamil parents say to you, which really affects your mental health and how you view yourself” (Participant A01, Female). What is said by parents were not the only words that were affecting participants, a participant shared how the words other family members used affected her mental health:

> I put pressure on myself, it came from other family members in the sense aunties and uncles in our family they would directly say anything to me all the time, like here and there. I’ve experienced that where they’d bother me about what I’m doing in school, they were curious about that. I didn’t want them to put pressure on my parents or I didn’t want them to talk to my parents or ask them things about what I’m doing. If let’s say I wasn’t doing well, I wouldn’t want my parents to feel bad about that. So I guess that’s where I started to put pressure on myself more than my parents ever did. I didn’t want them to have a bad name from their own relatives
>
> (Participant A03, Female)

Participants shared how preference for a provider would be someone who could understand these unique experiences; the pressures from parents and other family members, use of harmful words, difficulty living up to these expectations, and protecting their family name.

Six out of the nine participants stated they would prefer having a Tamil provider as it would be beneficial to have someone who can understand the unique experience within the Tamil culture and household. A female participant answered the question of how important it was and explained the relevance of having a Tamil provider:

> Hundred percent. I find […] a lot of people don't understand […] an average Tamil household or the dynamics of like your parents like male dominance and female issues and then you being the child and them taking on their anger and frustrations on you. So when you're a child and you're trying to reach out to somebody that's also probably experienced that at some point in their life, they could probably relate to you on a better level than someone that's not Tamil.
>
> (Participant A04, female)

Participants also identified that preference would be towards second-generation Tamil providers over first-generation providers as experiences and expectations of growing up in Sri Lanka versus in Canada would vary. There was also a clear preference for providers who are a similar age to them as they expressed that the provider can relate better to the life stage that they are currently experiencing. Male and female participants preferred providers who were the same sex as them. The youths also expressed being more receptive to providers who made an active effort to be welcoming, friendly and approachable. One described the ideal mental healthcare provider would be, "Friendly, enjoyable to talk to, very approachable, very accepting" (Participant A07, male). Participants stated providers who made the effort to build trust with users prior to therapy through informal group activities, helped service users be more receptive and vulnerable during private sessions. Acceptable characteristics included congruent cultural background, generation, age, gender, personality and ability and efforts to build trust.

Practice Setting

When asked, participants shared their preferred setting for services. Formal practice settings refer to a community-based setting whereby there is a strict structure; the service user books an appointment to meet with a provider, shows up for their appointment and has a formal

one-on-one session with the provider. An informal or communal setting refers to a community-based setting whereby there is a flexible structure; service user can walk-in or book an appointment, and providers are welcoming and receptive to service users in both group and one-on-one sessions. Informal or communal settings provide generic mental health support services to allow users to learn about potential services offered and to help build trusting relationships between service providers and service users prior to getting into one-on-one personal sessions. Formal settings will provide direct one-on-one services which may be intimidating and assumes trust between provider and service user. An informal or communal setting is important for acceptability of a provider due its influence on building a trusting relationship with the client. A female participant shared her preference for mental healthcare practice settings:

> I feel if it's informal, I feel … I can be like more comfortable because there's more people around me and where … where when it's like one-on- one, I get overwhelmed and anxious.
>
> (Participant A09, female)

This participant was able to articulate how the setting contributed to her mental health issues and how an alternative method of an informal setting may have been more effective. They also reported that informal environments increased willingness to use services as users do not feel as though they are using a 'mental healthcare' service, thus reducing stigma.

Building Trust

Participants identified that building familiarity with the provider and the provider sharing relevant personal experiences subsequently encouraged them to be open with the provider as trust had been built. One participant described the setting and the ability to get to know providers when sharing their experience from when they first joined CanTYD:

> Before that we would hang out on a casual or social basis, not just one-on-one, but in a group setting. We would go out to like rock climbing or skating or … go outdoors and kind of we built that … trust and then I knew that that was somebody that I could open up to and she was someone who also helped me in my educational life, figuring out my next steps so I knew that she was someone that cared for me. And so even though it wasn't a personal connection in terms of family, family friends or something, knowing that there was someone I could reach out to that looked out for me and my wellbeing, I felt comfortable reaching out to her the other way when I needed … when I had an issue or a problem.
>
> (Participant A04, female)

The participant was able to share how the informal structure to mental health services helped build trust between her and the provider as she became more familiar and comfortable with her. The participant was able to rely on the provider to provide her with supports for her stress and anxiety around education. Participants felt that providers who were vulnerable with them by sharing their experiences created more trusting relationships with them.

Negative Perceptions of Mental Health Services

Participants stated their negative perception of mental healthcare services came from their parents due to the stigma around mental healthcare within the Tamil community. Stigma was a barrier to accessing services. Participants described how their parents would make negative statements about them using services. One participant stated the following when describing if they would have support from family while seeking community services: "well truthfully I probably wouldn't even tell anyone in the family if I were to seek therapy because

yes, they would think like what's wrong with you, why do you need [it]" (Participant A04, female)?

This quote describes the participant's perception of both the need for mental health support and utilization of services. A significant barrier described within the Tamil community is the negative perceptions of mental healthcare service use.

Privacy

Primary healthcare providers can be a physician or Nurse Practitioner. Participants mentioned the importance of privacy during service use and assurance that their primary healthcare provider and family would not find out that they are using the service. Participants shared their hesitancy if the primary healthcare provider or mental healthcare provider is from the Tamil community due to concerns around gossip culture present in the Tamil community. Participants found that having counsellors of similar age allowed them to feel more trust and less afraid of privacy breaches due to gossip than with older counsellors who may be first generation. Finally, the providers' methods of service delivery can impact acceptability depending on the user's preference for service to be delivered in-person, via text, phone call or video chat, depending on which method would help maintain their privacy.

Affordability

Affordability considers cost of services, and providers' insurance, in relation to the clients' ability to pay through means such as existing health insurance (Penchansky & Thomas, 1981). Affordability also considers indirect costs of time from work, travel (e.g., bus, taxi, parking, etc.) and direct costs covered by insurance or out of pocket costs as not all services are covered by insurance (Penchansky & Thomas, 1981). Participants stated that affordability is a factor in accessing services over the long-term as they would not be able to afford continued

services because they are costly. One participant described having to prioritize paying for tuition rather than mental healthcare services. The participant stated:

> If … you know obviously if it's free that's … you're more willing to go and try it out I guess. if there's money involved … you think okay, where can this money go to, that's where I guess it gets tricky because sometimes I could be thinking oh, instead of paying for this I could put this money towards school.
>
> (Participant A03, female)

The participant was able to describe the conflicting priorities she had between choosing to pay for her own mental healthcare versus her education. Another participant noted that although services are covered by their health insurance there is lack of privacy from insurance billing systems at their university and that was a barrier to them accessing service. A participant attending a university stated, "… also school doesn't bill under. … the school's insurance anymore, they bill under your primary insurance and then school's insurance" (Participant A01, female). She explained that the billing system would compromise her privacy as the school switched to 'primary insurance,' which means billing a student's *parent's* insurance if available, then would bill through the school's insurance provider if a primary insurance was not available. This billing practice meant that parents would then have access to claims made on their insurance coverage, therefore compromising the student's privacy. The student stated this then caused her to opt out of the school's health insurance plan. Participants indicated that being employed and having insurance coverage from their employer made accessing services affordable, however long-term affordability may not be possible due to limits on visits covered by insurance. A participant commented that even "if you want to see someone private it's

ridiculously expensive even online" (Participant A01, female). The participant described her unsuccessful search for a private mental healthcare service due to high costs.

Accessibility

Accessibility is about the location of services with respect to the location of clients and considers the client's transportation resources, distance, cost and travel time (Penchansky & Thomas, 1981). All participants stated they chose services close to where they live, where they attend school or on campus. One described her reasoning for choosing a service on campus: "[The] fact that it was on campus. I think it was very close and I knew it was free and I could see someone very, very quickly" (Participant A01, female). Overall, a convenient and easily accessible location made it easier for service users to access.

Accommodation

Accommodation refers to how resources are organized to accept clients such as the appointment systems, hours of operation, and walk-in facilities (Penchansky & Thomas, 1981). Accommodation also considers the client's beliefs on the appropriateness of the aforementioned factors (Penchansky & Thomas, 1981). Participants stated they found the lack of availability of appointments; appointments being booked months in advance and lack of walk-in options limited their access to services. Participants stated there would often be one provider serving the entire university or college, not enough to service the population attending the institution. Participants also stated that hours of operation need to extend beyond 9-5pm which is more appropriate in the education setting as students are on campus until 9 or 10 pm for classes. They preferred CanTYD as hours there are extended and better able to meet their needs as they are available during the day, evenings, and weekends, and they have the presence of multiple staff which made them very accommodating to students with their walk-in options. A participant stated "Well it's open all the time, so it's really […] available and accessible for me" (Participant A08, male). Participants

stated CanTYD's informal, or flexible structure made the service more accessible and acceptable. One participant who is a service user at CanTYD described her ideal mental healthcare service for youths: "Probably like this, a spot where kids can come, relax, at least get their mind off school, just people like youth workers that are here. Just easy to access whenever," (Participant A07, male). These statements highlight the importance of accommodating youth with flexible hours, access to multiple staff and creating a welcoming atmosphere or setting.

Additional Findings During the Study

The use of the Penchansky & Thomas's Access framework helped answer the research question, however other significant findings were identified and are shared in this section. Additional findings include the impacts of the pandemic, with restrictions on personal freedom, expectations from parents, hope and future improvement for mental healthcare. Below are what participants had to share and may inform service providers awareness to better support the second-generation Tamil youth population.

Impacts of Pandemic

It became very evident that the pandemic played a significant role in each participant's mental health. Participants shared how public health restrictions during the pandemic exacerbated feelings of anxiety and how they felt their mental health decline, because they were unable to use typical coping mechanisms. Participants shared how lack of access to their support systems due to public health restrictions and fears of becoming ill negatively impacted their mental health. Participants stated during the pandemic they would have most likely not reached out to a service provider because it would have been harder to seek assistance as more providers were no longer taking in-person visits and had switched to virtual visits or consultations. Participants shared how cultural factors such as living at home with parents resulted in limited

privacy during the pandemic, because if they were to leave the house to go for a counselling session, their parents would inquire where they are going and why they were going there. Participants also shared how texting is a good alternative in situations were there is less discretion such as where there is more risk of exposure to family members. A female participant shared how she felt added pressure from living at home with family and their expectations of her and she wanted to move out, but could not due to cultural normative practices. During the pandemic social isolation caused people to rely on social media for communication and entertainment, participants shared the added stress from social media and burden on taking on all the worlds problems that were being shared during this time.

Lack of Freedom

Participants voiced the lack of freedom they felt from their parents that contributed to their poor mental health. Participants shared how they were not allowed to go out and de-stress with hobbies or friends, making it difficult to balance life stressors such as work, household chores, and school stress. Collectively these were cultural-based stressors they felt from their parents. Participants also shared how expectations at home did not allow them to be who they are such as gender expectations where a female should not be going out regularly, however males could go out and face fewer repercussions. Participants also shared the freedom that comes with age as they gain more independence and can freely sign up for services if needed without worrying about their parent's reaction if they were to find out. These culturally influenced stressors experienced by second-generation Tamil youth are worth noting to inform service providers in helping support this population.

Expectations from Parents

Participants shared how expectation from their parents placed a lot of pressure on them, negatively impacting their mental health. They shared the unrealistic expectations their parents have for their children as the parents have immigrated from Sri Lanka and endured years of resettlement hardship. Participants report that parents project these struggles onto their children, pressuring their children to not taint their parent's reputation. These pressures and expectations extend beyond the immediate family to their aunts and uncles, adding to their pressure to please everyone. Parents were also noted to place a huge emphasis on their children to attain a good education allowing little or no room for failure. Participants shared their fear of failure, the need to be in control, and belief that they must finish University level education to know that their life will be okay. Unrealistic expectations to manage school and work. and the feelings of guilt while struggling to gain independence were stressors to their mental health. Understanding the pressures experienced by parental expectations can help better understand the mental health needs of this population.

Hope

Participants shared how they feel more hope as they are starting to recognize second-generation Tamils in their 20s, or older who are educated and beginning to work in roles/careers that will help support the Tamil population roles in health care such as social workers, psychologists, psychotherapists, and other professionals. They believe if the Tamil community as a whole become more educated on mental health and resources it would be beneficial for the general population and the Tamil community in particular. Participants shared how parents are more understanding now than ever before due to mainstream cultural influences and may benefit from an education session. However, they also felt that parents would still prefer that their child talk to them rather than a stranger. Participants shared how their parents may be more receptive

to learning about mental health and its challenges if they learn about it from an elder, as elders are respected sources of advice. Participant also spoke about how they are seeing radical changes on ideologies and perceptions of mental health and that it is becoming more accepted and less taboo. Despite the barriers to accessing services previously identified by participants, their resilience is demonstrated by how hopeful they are for their future, and their ability to navigate to get access to needed services.

Future Improvements for Mental Health Support

Participants also offered their suggestions for future improvements for mental health support. They shared how in an ideal world, free mental healthcare services would be available to youths to help transition them towards a more independent and fulfilling life. They identified a need for mental health programs in school to normalize prioritizing mental health and wellbeing. They hope for more mental health training for teachers to adequately support students in the school environment and free mental health training for students to help them gain more knowledge on mental health and how to support others who may be struggling. Participants shared having accessed services and seeing how the benefits motivated them to prioritize their mental health more than before. Participants suggested having more after-school programs or clubs such as a Big Brother, Big Sister program where schools partner to bring professionals in to talk about Mental Health. Participants also stated that having wellness days to help students de-stress would be helpful.

Participants shared how their early contacts with professionals for support were often through the education system, such as their teachers or guidance counsellors. They identified a need for better supports around mental health with trained regulated professional counsellors who are able to ensure screening for mental illness and can provide supports for maintaining

good mental health. Participants were able to describe community-based mental health supports as opposed to support by physicians or accessed through physician, which seems to be a gap in addressing their mental health concerns. Due to stigma in the Tamil culture participants avoided receiving support by a physician, reinforcing the need for early contacts with community-based mental healthcare services.

Chapter 5: Discussion

This qualitative study explored and described the experiences of second-generation Tamil youths accessing community-based mental health services. Study themes from the analysis, identified barriers and facilitators, recommendations for practice, policy, education, and future research will be discussed in this section. This section will close off with strengths and limitations to this qualitative descriptive study and suggested revisions to the framework.

Barriers to Accessing Mental Health Services

Overall, participants shared their perceived barriers to accessing community mental healthcare services' and school-based support services for mental health. Awareness of services was hindered by methods of advertising said services as traditional posters or emails were not effective for this group. In this study, traditional methods of advertising services such as through posters or emails were not effective in persuading them about mental health services, however as reported in another study, social media platforms such as Twitter or Instagram were more engaging and personable (Stawarz et al., 2019). Similar to other reports, there is a lack of available mental health professionals to support youth in general and Tamil youth in particular when accessing services while attending an educational institution whether it be elementary, secondary or post-secondary education. It became evident on several occasions that participants did not prioritize their mental health especially when conflicting priorities such as school and work were present. A study by Islam et al. (2017) from the initial literature review had similar findings were south Asian youths felt a lot of pressure from their parents to focus on education and career and their parents viewed help-seeking with disdain. This left the impression on the South Asian youths to view mental health negatively and created stigma for help-seeking. Participants reported barriers to acceptability of service use included characteristics of service providers who vary in age, gender or generation with respect to the youths seeking help and

providers who do not make an active effort to build trust with users. Participants also voiced their concerns for potential privacy breaches when using services and noted older generations of Tamil service providers and the cultures reputation to gossip as a potential threat to their privacy. Participants also shared their own learned negative perceptions of using mental healthcare services, learned from their parents and other family members who would question their need for using service and would highly oppose their use of service. Most participants were pursing post-secondary education and stated their concern for lack of affordable mental healthcare services and the lack of privacy when insurance coverage is billed through their parent's insurance rather than student benefit plans. Long-term affordability of services did not appear to be an option. Limited accommodations from services such as strict schedules with operating hours limited to Monday-Friday and 9-5pm, and very formal environments were barriers to accessing services. Typically, informal care for mental health care are through religious leaders, non-health professionals and self-help, which are often sought out by low socio-economic populations (Paula et al., 2022). Informal care for mental health are often created by groups who are marginalized from the main stream system, however once members of the group become integrated into the formal system such as Tamil nurses or providers, then formal care may change and be accessible and effective for this population. The TCM helped the PI reflect on the desire for informal service structures by participants and its implications for service delivery. In addition to describing barriers to accessing mental healthcare services participants were also able to share several facilitators.

Facilitators to Accessing Mental Health Services

Information gathered from interviews suggest participants were able to identify existing facilitators and provide suggestions for future methods to improving access to community mental health care services. Participants found engaging and personable methods of advertising such as

social media and in-person drop-in sessions to be more effective in spreading awareness of a mental healthcare services. Male participants particularly shared that knowing of another peer who was using a mental healthcare service encouraged them to seek services. Participants explained the necessity to build trust in order to open up and become vulnerable to be able to share their personal experiences with providers and also stated that the use of non-formal environmental and practice structures enhanced acceptability of practice. The availability of Tamil and second-generation service providers who can understand their lived experiences served as a facilitator for acceptability of providers when using services. The TCM helped the PI identify the need for representation of second-generation Tamil service providers for Tamil youths, as those engaged in marginal living will likely benefit from providers who can understand and relate to this reality. Access to insurance coverage from an employer facilitates affordability and access to services. Services on campus or close to where participants live enhances accessibility and facilitates access for youths in education. Specifically, services that accommodate the schedule and needs of youth facilitates access. Flexible hours, days of operation, drop-ins, availability of counsellors and non-formal service structure help support youth access to mental health services at CanTYD (Paula et al., 2022). Several participants stated that if more mental healthcare services were run like CanTYD they would be more inclined to use the service.

A recent pilot study offers ideas for future service for this and similar groups (Nagy et al., 2022). The study included graduate trainees who underwent 14, one-hour training sessions focused on increasing skills related to providing culturally conscious mental healthcare (attentive, sensitive and responsive to contextual and cultural experiences of patients), and used pre-, mid-, and post-assessments to assess efficacy, acceptability and feasibility (Nagy et al.).

Although findings showed high efficacy, acceptability and feasibility the training included constructs that were more broad and applicable to different cultural populations rather than specific populations. The study has not yet reached the stage where the trainees get to apply what they have learned to patients and assess the efficacy, acceptability and feasibility in the real world. However, findings regarding education to improve culturally conscious mental healthcare to enhance patient care are promising.

Recommendations for Nursing Practice

The findings from this study reveal the unique barriers and facilitators this population experiences and generates implications for nurses to enhance their practice and practice setting. Implications for nursing practice include the use of Tamil nurses in schools, effective advertising, promotion of mental health prioritization, informal service structure, and appropriate hours of operation. Participants shared how they did not know the difference between the services the providers could provide and how they could help them. This served as a barrier in their decision making for choosing an appropriate service provider for their needs. Lack of awareness of role clarification of providers such as who it is for and what the professionals do served as a barrier that limited their access to services. Despite, this not being an expectation for youths it is evident that knowledge translation regarding available providers and the role they can play in treatment will help youth with accessing services. Specifically, participants of this study did not identify nurses as a service provider for community mental health support. Nurses carry a wealth of knowledge, skill and experience to support mental health services in the community, however this role is not widely known. There is a need to optimize the scope of practice and role nurses can play to help support the community with mental healthcare services. The use of Tamil nurses working on the primary prevention level can focus more efforts on spreading awareness,

educating and promoting the prioritization of mental health for the second-generation Tamil youth population.

Participants suggested effective strategies for spreading awareness of services included in-person drop in sessions to learn about and connect with services and service providers, interactive presentations or workshops during or after school programs were also noted to be effective. The use of more Tamil nurses or guidance counsellors in school with a proactive approach to mental health will be helpful in promoting and screening for mental health concerns (Islam et al., 2017). Tamil and non-Tamil nurses can also utilize findings from this study to build therapeutic nurse-client relationships by practicing cultural competence.

This study has brought to light the positive impacts of an informal structure to delivering mental healthcare services in the community. The evident lack of awareness of directly using mental health supports by several male participants displayed the informal structures ability to reduce stigma and welcome participants to engage in service use. The informal structure to mental healthcare service challenges current beliefs and structures to service delivery that take on a more traditional formal structure. Challenging current practice and incorporating more informal structures focused on building rapport with clients through activity based interactions, flexible service hours, offering both group and individual counselling sessions, and affordable service options prove to be effective methods for service delivery and retention of participants. Program planners, decision makers and nurses can use findings from this study to effectively advertise service, to promote the prioritization of mental health, and advocate for informal practice settings.

Lastly, hours of operation need to be adjusted to service the appropriate population. It is evident that mental healthcare services, especially those with a formal structure operate on

typical business hours. However, individuals who may need to utilize the service are not able to attend those appointment times due to obligations such as school or work. Participants who are students identified that many have classes late in the evening, however the mental healthcare services available on campus will be closed at five. Mental healthcare needs can arise at any time of day; appropriate policy needs to be in place to respond to needs of service users. Around the clock services with flexible hours will help the population feel supported and ensure mental health concerns are addressed rather than reinforcing the idea that prioritization of one's mental health can be put off. Therefore, the implementation of policy to advocate for more services with flexible hours of operation will help improve service access.

Recommendations for Policy

Overall, there are six main recommendations that have been noted from the findings of this study for policy change. The six recommendations for policy change are (1) professionals in schools to promote prevention and early detection of mental illness, (2) adequate number of providers to population ratio, (3) privacy when planning services, (4) privacy when planning billing system for service use, and (5) adequate insurance coverage to promote affordability.

Policy changes need to be made to address the needs of this population. Participants shared the need for mental healthcare supports from a trained registered professional within their education system starting from elementary school. There needs to designated individuals who are familiar to all students, actively engaging with them and promoting mental healthcare service use. The addition of school nurses to every school setting can help foster awareness and support for the culturally distinct second-generation Tamil population and other newcomer second-generation populations who may be experiencing trauma. School nurses play a key role in student mental health, in fact a study found that registered nurses and nurse practitioners in schools reported the need for additional mental health education (Bohnenkamp et al., 2022;

Markkanen et al., 2021). School nurses in Finland noted that despite school nurses having basic mental health knowledge and skills, they still required more education on mental health intervention, assessment methods, and ways to support culturally diverse students (Markkanen et al., 2021). An online education program called MH-TIPS proved to be feasible, relevant and accessible for school nurses which ultimately allowed them to feel more prepared to conduct mental health interventions and motivate students to seek help (Bohnenkamp et al., 2022). Promotion of positive mental health strategies, coping mechanisms and help-seeking behaviour starting at a young age can create fundamental behaviour patterns to prevent and mitigate risks of developing a mental illness and poor coping strategies.

In addition, it became evident that there are insufficient numbers of registered professionals to service population needs especially in post-secondary institutions. Participants have shared that despite being on a campus with tens of thousands of students there may only be one or two counsellors available for mental healthcare support and services often have limited hours of access. Provider client ratios such as these are not adequate to promote optimal mental health functioning and well-being for post-secondary students, especially in high-stress environments. Institutions must be accountable for meeting the needs of the population they are serving. The Registered Nurses Association of Ontario (RNAO) enables nurses to advocate for policy change during their annual general meeting through resolutions (*RNAO*, 2022). Nurses can advocate for appropriate provider to population ratios, through resolutions which then go into the hands of policy makers who can work with members of the provincial parliament to create the appropriate policy changes. During the 2020 pandemic RNAO helped advocate and shape the parameter for the addition of 625 RNs in schools across Ontario (Grinspun, 2020).

RNAO can continue to advocate the maintenance of RNs in schools to continue to provide mental health supports for students.

Discretion while utilizing a mental health care service is paramount in ensuring clients feel safe, protected and can be free from judgement. Specifically, with the population under study it was evident that stigma plays a key role in wanting service use to be surreptitious. A qualitative study found that telehealth options for delivery of mental health services proved to be flexible and responsive, however some users still feared for privacy as others may overhear their conversation (Venville et al., 2021). Majority of participants from this study which included both users and service providers identified that they preferred in-person delivery of mental health service for its safety and privacy, and for the ability of providers to read non-verbal cues. There should be policy to inform infrastructure design for where mental healthcare services will be provided and strategies to help maintain anonymity of service use from the public. A participant shared the lack of privacy due to her post secondary institution changing the policy for insurance coverage. The policy changed from students being able to utilize the school's health insurance plan to cover costs, to a student having to use parental insurance coverage primarily if available and then the student health insurance plan. When wanting to maintain privacy of mental healthcare service use, their privacy became compromised when her parents now had access to insurance coverage usage. This served as a barrier to the student wishing to access community mental healthcare service. Policy must ensure the organization is meeting the best interests of the users and students should be able to choose which insurance plan they wish to use. Stigma will continue to be a barrier to access until it is addressed at all possible levels. Policies that promote the privacy of service users will help increase mental healthcare service access by the second-

generation Tamil youth population and other second-generation populations with similar experiences.

Furthermore, lack of affordability is another barrier for service access and continuity of service use. There needs to be better policy to address these financial concerns and to ensure the population can meet their mental healthcare needs. For example, mental healthcare supports are ideally meant to be short term strategies; when considering cognitively behavioural therapy which has been proven to be an effective method for mental health support, a program is intended to last for a duration for 12 weeks/sessions (Carpenter et al., 2018; He et al., 2019). Insurance plans often do not provide adequate funding to support short-term treatment plans and often may only cover the costs of a few sessions which is not an adequate amount of time to receive the necessary benefits of treatment. The implementation of policy to ensure insurance coverages provide enough funding for a 12-week duration of service use would be beneficial.

Recommendations for Education

The recommendations for education are to use findings from this study to develop cultural competence training for service providers, use findings to educate providers on barriers and facilitators to service access, and to develop education programs/workshops to reduce stigma. The findings from this study can be used to inform the development of cultural competence training for nurses and healthcare providers alike. Cultural competence training will help address the gap in developing the nurse-client relationship when working with second-generation Tamil youths by enabling culturally relevant therapeutic nurse-client relationships. The findings from this study can be used to help educate nurses who may have a role where they connect clients with an appropriate service provider by understanding the barriers this population may be facing when trying to connect to a service.

Furthermore, stigma around mental healthcare service use plays a big role in deterring service access by second-generation Tamil youths. The development of education programs/ workshops geared towards removing cultural stigma and building awareness will help improve service access. Efforts to build mental health literacy in schools and with the general public have been proven to help reduce stigma and promote help seeking behaviour (Jorm et al., 1997; Ma et al., 2022). Suggestions provided by participants such as using elders from the Tamil community to speak to first generation Tamils who are the parents of second-generation Tamils can help spread awareness. It is apparent that there may be similarities between other second generation groups and that Tamil specific recommendations may not always be possible due to resource constraints.

Recommendations for Future Research

There is limited literature conducted on youths between the ages of 12-25 years of age and access to mental healthcare services. There are also limited studies conducted on the Tamil population and accessing mental healthcare services. Attending a post-secondary institution means that most participants are likely more informed and with better access to mental health supports through campus based services than Tamil youth in general. In other words, access to mental health services in this study likely represents a 'best case'. If participants were not enrolled in a post-secondary institution or were not employed access would have been more difficult.

A limitation of this study was most participants were recruited from CanTYD and may have had similar information and options for access to services. There were three participants who thought about accessing services, but did not successfully access services. Further research with a larger sample size is needed to explore the experiences of second-generation Tamils accessing a variety of different services, accessing services over extended periods of time and at

different stages in their lives (school, work, married, etc.). Second-generation populations are born in Canada, therefore can speak the language, grew up locally and can navigate the system comfortably, however findings from this study demonstrate that significant barriers are still present. Barriers related to legacy values, beliefs and customs from the 1st generation Tamil population. Further research is needed to explore and assess the effectiveness of strategies suggested as a result of findings from this study.

There is a need to further explore the effectiveness of building and curating culturally sensitive mental healthcare programs for the Tamil population and how those programs or practice guidelines may be implemented to promote service access and retention. This study focused primarily on service access, however other factors such as rationale for perceived need of service use still needs to be further explored and identified. When considering perceived need for services programs may be created to meet specific anticipated needs for a population such as family counselling, relationship building/fostering, or even intergenerational trauma informed care practices (Islam et al., 2017). Second-generation populations are understudied and very little is known about sub groups such as the Tamil youth group. Further research is needed to better understand the second-generation Tamil population and their mental healthcare needs. As well further research on second-generation populations with other minorities is needed.

Strengths to the Study

A key strength of this qualitative study was that the principal investigator (PI) is an individual with lived experience as a second-generation Tamil youth from the GTA. Being an individual from the Tamil diaspora enabled building trusting relationships by guiding conversations respectfully to promote recruitment, engage in interviews and helped develop the interview conversation as an “insider”. The PI is also an RN by profession and has experience working with individuals with mental illness. The research process was also guided by a

committee of experienced researchers in newcomer health, global health and community-based research.

Limitations to the Study

Several limitations were identified in the study. It was difficult to recruit participants within this age range during the pandemic due to local public health guidelines limiting in person services. Recruitment posters shared at various community mental health services had a poor response. The study was conducted with a smaller than planned sample size and all participants were in or had attended a post-secondary institution which limited the findings of this study. There were three participants who thought about accessing services, but did not successfully access services. The majority of participants came from CanTYD as recruitment was eased by in-person access that enabled snowball sampling. However, this approach also created bias in results and potentially showed a favour for community mental health service practices similar to those at CanTYD. It also meant that participants may have had similar information and options for access to services. Another limitation to the study is the disproportionate ratio between male and female participants, the study totalled 3 male participants and 6 female participants. Male participants were difficult to recruit due to stigma and reluctance to speak about using community mental health services. While recruiting participants from CanTYD it became apparent that despite male participants utilizing the services available at the location, when approached to participate in the research study they denied using community mental health services. This response may also be a result of the informal structure of CanTYD's mental health service delivery, that helped reduce the stigma of using mental health services as participants did not feel that they were directly using a mental health service.

The Penchansky and Thomas Access framework in this study although helpful, limitations were also highlighted.

Recommendations for Revision of Conceptual Framework

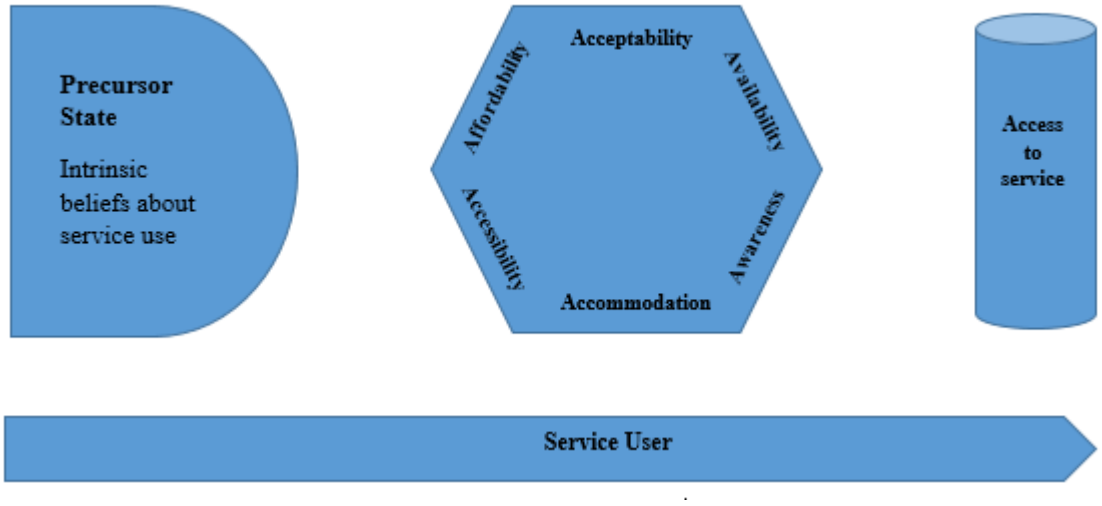
The study utilized the Penchansky and Thomas's (1981) Access framework to inform interview guide development, data collection and data analysis. The access framework effectively defines specific dimensions (availability, accessibility, accommodation, affordability and acceptability) that help to assess the "degree of fit" between the patient and the health care system. The pragmatic nature of the access framework informed the interview guide, data collection and data analysis. However, during data analysis some limitations to the framework became apparent. For instance, the access framework has limited ability to show the interaction among the dimensions of access (acceptability, affordability, accessibility, availability, accommodation, and awareness) and the intricate relationship they have with each other (see Appendix J). A visual representation with a model would have been helpful for this framework. This became evident when participants shared their experience and their experience often described components of the access dimensions, however there is no illustrated model representing how these dimensions work together and effect one another to impact the "degree of fit" between the patient and health care system. The framework also lacks description and acknowledgment of cultural barriers to access. Cultural barriers rooted in strong beliefs like that of stigma, which have affected multiple generations as described by the participants of this study, indicate that stigma around mental health service access can hinder an individual from taking a single step towards obtaining needed services. The closest dimension to describing potential cultural barriers would be acceptability, whereby the service user is assessing the service provider for acceptable characteristics such as cultural similarities. However, in the model the acceptability dimension seems too simplistic and assumes that the individual has already surpassed deep rooted cultural barriers hindering any attempt to connect to a service, and now has connected with a service and is looking for an appropriate service provider. Throughout this

research it became evident that this cultural barrier is a precursor state that needs to be acknowledged and addressed before we can explore the dimensions of access. It begs the question; how can an individual seeking help consider acceptability of a provider when they struggle to find acceptance within themselves to proceed to search out mental health support?

Penchansky and Thomas's Access framework fails to consider this very important question. The following model (see Figure 2) is a recommendation for enhancing Penchansky and Thomas's Access Framework. This proposed model displays the idea that we could have the most accessible service according to Penchansky and Thomas with Saurman's addition of awareness, however it would be underutilized if the cultural barrier (precursor state) is not acknowledged and addressed, then promotion of access would be possible.

Figure 2

Access Model Adapted from Penchansky and Thomas 1981, Saurman 2016



Penchansky and Thomas's Access framework was created in 1981 a time where colonialism may have had more influence, for example, concerns about cultural values and

norms are not prominent in this model. The current cultural landscape has changed in many countries, especially in Canada, a culturally diverse nation; thus it is imperative to consider the cultural component of access.

Saurman's (2016) addition of the awareness dimension improves the access framework by addressing a key component to access. Participants of this study have shared how they were not aware of available community-based mental healthcare services that would address their needs as previously mentioned, which implies that they also lacked knowledge of who the service could be for, what it does, where and how it should be used and when it is available. This highlighted that addressing the awareness dimension of access will help improve access for this population. On another note, Penchansky and Thomas's (1981) access framework has acceptability as a dimension of access whereby it considers the attitudes of the provider and client about service and considers cultural concerns. However, the cultural concern that is addressed with this dimension is not adequate consideration for the lived experiences of the Tamil youth population or other newcomer populations as it does not address the 'precursor state' they are in. The precursor state which considers the intrinsic beliefs the client has regarding service use needs to be addressed prior to addressing the dimensions of access in order to have successful service access.

To address this precursor state, we can utilize outreach methods that target cultural barriers promoting the social stigma associated with mental health, which is the fear of judgement by community members that participants shared (Goel et al., 2022). This study found that some participants preferred texting or online methods of receiving services to help eliminate the stigma and enable privacy while using a mental healthcare service when in-person options although ideal are not realistic to the individual. A mental health outreach service with

supportive text messages were sent out during the COVID-19 pandemic in Alberta over a six week period which resulted in improved mental health and reduced suicidal ideation for subscribers of Text4Hope (Agyapong et al., 2021). The Text4Hope texting-based intervention was aimed at alleviating pandemic-associated stress, major depressive disorder, generalized anxiety disorder and suicidal propensity during the COVID-19 pandemic. Texting services that are created with a similar model to Text4Hope, however catered towards the second-generation Tamil youth population can have the same benefits which also include economic feasibility for healthcare providers and users, privacy for users, convenience, flexibility and scalability of service. There are no one-size fits all to service access, however working with pockets of the population such as the second-generation Tamil youth and identifying key barriers and facilitators to service access can be an effective method to inform outreach services to increase service utilization and improved mental health outcomes over the lifespan (National Institute of Mental Health, 2001).

Revisiting the Researcher's Perspective

Being an immigrant and growing up in Toronto, despite being in a culturally diverse city, I often felt like a second-class citizen due to the colour of my skin and having parents who did not speak the language well. After becoming a nurse and servicing diverse communities predominantly with first and second-generation immigrants, I quickly realized I was not the only one who shared these experiences. I often found myself going out of my way to make sure those on the hospital unit who could not speak the language or facing systemic barriers were getting the help they deserved. Being a nurse has helped me realize the true power nurses have to alter the course of population health. During my nursing education and practice I noted the lack of representation of the lived experiences of the Tamil population and lack of racial health equity in literature. I realized it all came down to someone choosing to care, and fighting for it. Being

Tamil and watching the Tamil community suffer with a wide array of mental health concerns and illnesses, I knew something had to be done. I began to ask myself what needs to be changed, how can we change it, and where did it all begin? I know that the Tamil culture can have a great big influence on one's life and the dual identity of being born and raised in a Tamil community in a western nation, creates a dual identity which may cause intergenerational conflict. The second-generation population was of interest, because I wanted to see how we can ensure all immigrant based generations going forward will have the same opportunities as native born populations. I hope the findings from this study will help inform current nursing practice and allow practitioners to better service the second-generation Tamil youth population by better understanding their needs and experiences. Knowledge of the facilitators and barriers to accessing community-based mental healthcare services will hopefully help inform policy, administration, education and future research to improve access to mental health services for this population. I truly hope that this research inspires more research with the Tamil population and mental healthcare. I also hope this research inspires the Tamil population and other immigrant populations to prioritize their mental health.

Chapter 6: Conclusion

This study set out to explore how second-generation Tamil youth in the GTA describe their experiences accessing community-based mental healthcare services. It is clear there are barriers and facilitators for community mental healthcare access by this population. Cultural expectations and pressures have negatively impacted the mental health of Tamil youths. The stigma from the Tamil culture to access mental healthcare service acts as a major barrier. The findings from this study have identified the facilitators and barriers to accessing community mental healthcare services as experienced by second-generation Tamil youth under the domains of acceptability, affordability, availability, accessibility, accommodation, and awareness. Facilitators for accessing services was the use of effective advertisement strategies, peers sharing their experience using services, informal practice structure, close location of service, flexible service schedule, and insurance coverage to cover cost of service. Barriers to service access included long wait times, lack of available appointments, high cost per service, threat to privacy, rigid operating schedules, formal service structure and having unacceptable characteristics of service providers such as a non-Tamil service provider. Further research is need to explore a larger sample of second-generation Tamil youths and to study how findings from this study can be effectively implemented to promote mental health of this population.

In summary, this qualitative descriptive study begins to explore the unique experiences of second-generation Tamil youths and offers findings on how the mental healthcare system can improve its approach to servicing this population. The results from this study will help inform nurses, policy makers, researchers, employers, practitioners, and nursing educators about the barriers and facilitators for accessing mental healthcare services as experienced by the second-generation Tamil youth population.

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Appendix A

Definitions of Key Terms

First Generation: Immigrant youth who immigrated to the receiving country with their parents at age 12

1.5 Generation: Immigrant youth who arrived in Canada with their parents under or around age 12.

Second-generation: Immigrant youth who are Canadian-born to first generation parents.

Appendix B

Scripts

Email response for interested participants:

Thank you for expressing your interest in participating in this research study. Looking forward to chatting with you more, please advise your availability for a brief phone call to discuss more about your eligibility for the study.

Initial phone-call:

Thank you for your interest in checking your eligibility for this research study. If you have been admitted to a hospital for a serious mental illness, you are not eligible for this study as the study is about mental health in the community. Eligible participants for the study are (1) Tamil youth, (2) aged 18-25 years, (3) who are second-generation, (4) who have parents of Sri Lankan origin (5) who live in the GTA and (6) who have accessed or thought of accessing community mental health services in the past six months (7) can speak and understand English. Have you experienced anxiety, stress or depression in the past six months? This is not a study of mental illness effecting Tamil youth. If you still wish to participate in this study I will email a letter of information/consent form for you to review and we can follow-up with a phone call to discuss any questions you may have.

Ineligible participant response:

Thank you for your time and expressing your interest in this research study. Unfortunately, you do not meet the eligibility criteria.

Follow-up email:

Please review the attached letter of information/consent form. Please advise availability for a follow-up phone call or zoom call to go over any questions and carry out the interview.

Telephone script/ e-mail for agencies (recruitment)

Hi, I'm Kirthiga a master's student at McMaster university. Thank you for taking the time to speak with me. I am currently working on my thesis and looking to recruit participants for the study. The study is focused on understanding the experiences of second-generation Tamil youth accessing community mental health services. Would this be something you will be interested in supporting? If so, I have a flyer you can share with your clients.

Appendix C

LETTER OF INFORMATION / CONSENT

Second-generation Tamil Youth Mental Health

Investigators:

Local Principal Investigator:
Dr. Wahoush
Department of Health Sciences
McMaster University
Hamilton, ON, Canada
(905) 525-9140 ext. 22802
E-mail: wahousho@mcmaster.ca

Student Investigator:
Kirthiga Ravindran
Department of Health Sciences
McMaster University
Hamilton, ON, Canada
647-926-0347
E-mail: ravindk@mcmaster.ca

Purpose of the Study

I am doing this research for my thesis project focused on understanding the experiences of second-generation Tamil youth accessing community mental health services. This is not a study of mental illness affecting Tamil youth. If you have been admitted to a hospital for a serious mental illness, this study is focused on individuals who are using community-based services only.

You are invited to take part in this study on second-generation Tamil youth mental health. We want to hear about your experiences of being a second-generation Tamil youth in Canada. We hope to learn how those experiences have influenced your mental health and about your experiences accessing community mental health services. We hope to be able to provide suggestions to inform mental health services planning to meet the needs of the second-generation Tamil population.

Procedures involved in the Research

You are invited to attend an online interview through Zoom or in-person. You will be asked to answer a series of questions. You will be asked questions about your experiences with mental health and accessing community mental health services. I will also ask you for some background information like your age and education. The interview should take approximately 45-60 minutes to complete. The interview will be audio-taped or video-taped and written notes maybe taken as well with your permission. Recording and note taking are important to help ensure the information you share is not lost. Examples of questions are; “What does ‘Mental Health’ mean to you?”, “What was your experience accessing community mental health services like?”.

Potential Harms, Risks or Discomforts:

The risks involved in participating in this study are minimal. You may feel uncomfortable with speaking about past personal experiences. You may find it stressful to explain a negative experience you may have had. You may worry about how others will react to what you say or having to do the interview online and having someone else hear what you say. You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. And you can stop to take a break at anytime. You can withdraw from the study at any time. You only need to let the interviewer know that you want to move onto the next question, take a break or stop the interview and withdraw from the study. I describe below the steps I am taking to protect your privacy.

Potential Benefits

The research will not benefit you directly. We hope to learn more about your unique experiences. I hope that what is learned as a result of this study will help us to better understand barriers and facilitators to current community Mental Health services. This could help to provide suggestion for improvements of these services to better support the Tamil youth living in Ontario.

Payment or Reimbursement

You will be reimbursed with an electronic $15-dollar gift card to Tim Hortons.

Confidentiality

You are participating in this study confidentially. I will not use your name or any information that would allow you to be identified. No one but me or other members of the research team will know whether you participated unless you choose to tell them. Records of your interview will have your name removed and be assigned a study participation number or code to protect your identity.

This study will use the Zoom platform to collect data, which is an externally hosted cloud-based service. A link to their privacy policy is available here (https://zoom.us/privacy. While the Hamilton Integrated Research Ethics Board has approved using the platform to collect data for this study, there is a small risk of a privacy breach for data collected on external servers.

If you are concerned about this, we would be happy to make alternative arrangements for you to participate, perhaps via telephone. Please talk to the researcher if you have any concerns.

The information/data you provide will be kept in a locked desk/cabinet where only I will have access to it. Information kept on a computer will be protected by a password. Once the study recordings have been transcribed into written records, all audio recording will be destroyed and removed from all electronic files. Once the study is complete, an archive of the data, without identifying information, will be kept for five years.

b) Legally Required Disclosure

Although I will protect your privacy as outlined above, if the law requires it, I will have to reveal certain personal information (e.g., child abuse, harm to self or others)

Participation and Withdrawal

Your participation in this study is voluntary. It is your choice to be part of the study or not. If you decide to be part of the study, you can decide to stop (withdraw), at any time, even after signing the consent form or part-way through the study. If you decide to withdraw, there will be no consequences to you. You can request to have data already collected removed from the study. For example, you have the option of removing your data from the study OR information provided up to the point where you withdraw will be kept unless you request that it be removed. If you do not want to answer some of the questions you do not have to, but you can still be in the study. Your decision whether or not to be part of the study will not affect your continuing access to services at any community Mental Health service.

Information about the Study Results

If you would like to receive the summary personally, please let me know how you would like me to send it to you.

Questions about the Study

If you have questions or need more information about the study itself, please contact me at: ravindk@mcmaster.ca

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HiREB). The HiREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, HiREB, at 905.521.2100 x 42013.

CONSENT

I have read the information presented in the information letter about a study being conducted by Kirthiga Ravindran, of McMaster University. I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested. I understand that if I agree to participate in this study, I may withdraw from the study at any time. I will be given a signed copy of this form. I agree to participate in the study.

_____	_____	_____
Name of Participant (Printed)	Signature	Date

Consent form explained in person by:

_____	_____	_____
Name and Role (Printed)	Signature	Date

Appendix D

Semi-Structured Interview Guide

Second-generation Tamil Youth Mental Health: Semi-Structured Interview

Did one or both parents come from Sri Lanka?
Part of Sri Lanka parents lived in?
Were you born in Canada?
Primary Language:
Gender:
Age:
Region: Markham | Scarborough| Toronto

1. Qualitative Interview Introduction

Length: 45-60 minutes
Primary goal: To see things from your perspective. This will be more like a conversation with a focus on your experience accessing community mental health services

2. Verbal Consent

Review written consent form.
Would you like to participate in this interview?
Verbal Consent was obtained from the study participant
Verbal Consent was NOT obtained from the study participant
Ask if they have any questions before starting the interview. Make participant aware that they can leave at any time throughout the interview or decline any question. This interview will be recorded and notes will be taken.

3. Background Information

Question 1: I would like to get to know you a little, can you tell me about yourself?
Probes: What do you do? Do you live alone? What does being Tamil mean to you? How would you describe your health in general?

4. Experience Accessing Community Mental Health Service

Question 2: Can you describe your experience accessing community mental health services?
Probes: Did you try to access service? Were you successful?

Question 3: What do you think are barriers to accessing community mental health services?
Question 4: What do you think made it easy for you to accessing community mental health services?
Probes:
When you think about mental healthcare, what types of professionals come to mind?
If you had a million dollars what would mental health care look like?
Question 5: Are you familiar with these services, what made you aware of these services? What do you know about these services?

1) Kids Help Phone
2) Good2Talk
3) CMHA

4) CAMH
5) MindBeacon
6) BetterHelp
7) EAP
8) Headspace
9) CanTYD
10) Youthlink
11) ANBU
12) Scarborough Centre for Healthy Communities

Are there any other services you are aware of that are not on this list?

5. Thank you

Thank you for your time, is there anything else you feel I need to know that I haven't asked today.

*Interview guide adapted from (Islam et al., 2017)

Appendix E

Fine Tuned Semi-Structured Interview Guide

Second-generation Tamil Youth Mental Health: Semi-Structured Interview
Did one or both parents come from Sri Lanka? **Part of Sri Lanka parents lived in?** **Were you born in Canada?** **Primary Language:** **Gender:** **Age:** **Region: Markham | Scarborough| Toronto**
6. Qualitative Interview Introduction
Length: 45-60 minutes **Primary goal**: To see things from your perspective. This will be more like a conversation with a focus on your experience accessing community mental health services
7. Verbal Consent
Review written consent form. Would you like to participate in this interview? Verbal Consent was obtained from the study participant Verbal Consent was NOT obtained from the study participant Ask if they have any questions before starting the interview. Make participant aware that they can leave at any time throughout the interview or decline any question. This interview will be recorded and notes will be taken.
8. Background Information
Question 1: I would like to get to know you a little, can you tell me about yourself? Probes: What do you do? Do you live alone? What does being Tamil mean to you? How would you describe your health in general? Addition: How has the pandemic affected your mental health and need for accessing community mental health services?
9. Experience Accessing Community Mental Health Service
Question 2: Can you describe your experience accessing community mental health services? Probes: Did you try to access service? Were you successful? Question 3: What do you think are barriers to accessing community mental health services? Question 4: What do you think made it easy for you to accessing community mental health services? Probes: When you think about mental healthcare, what types of professionals come to mind? If you had a million dollars what would mental health care look like? Question 5: Are you familiar with these services, what made you aware of these services? What do you know about these services?

13) Kids Help Phone
14) Good2Talk
15) CMHA
16) CAMH
17) MindBeacon
18) BetterHelp
19) EAP
20) Headspace
21) CanTYD
22) Youthlink
23) ANBU
24) Scarborough Centre for Healthy Communities

Are there any other services you are aware of that are not on this list?

What do you think are good strategies to spread awareness of mental healthcare services?

10. Thank you

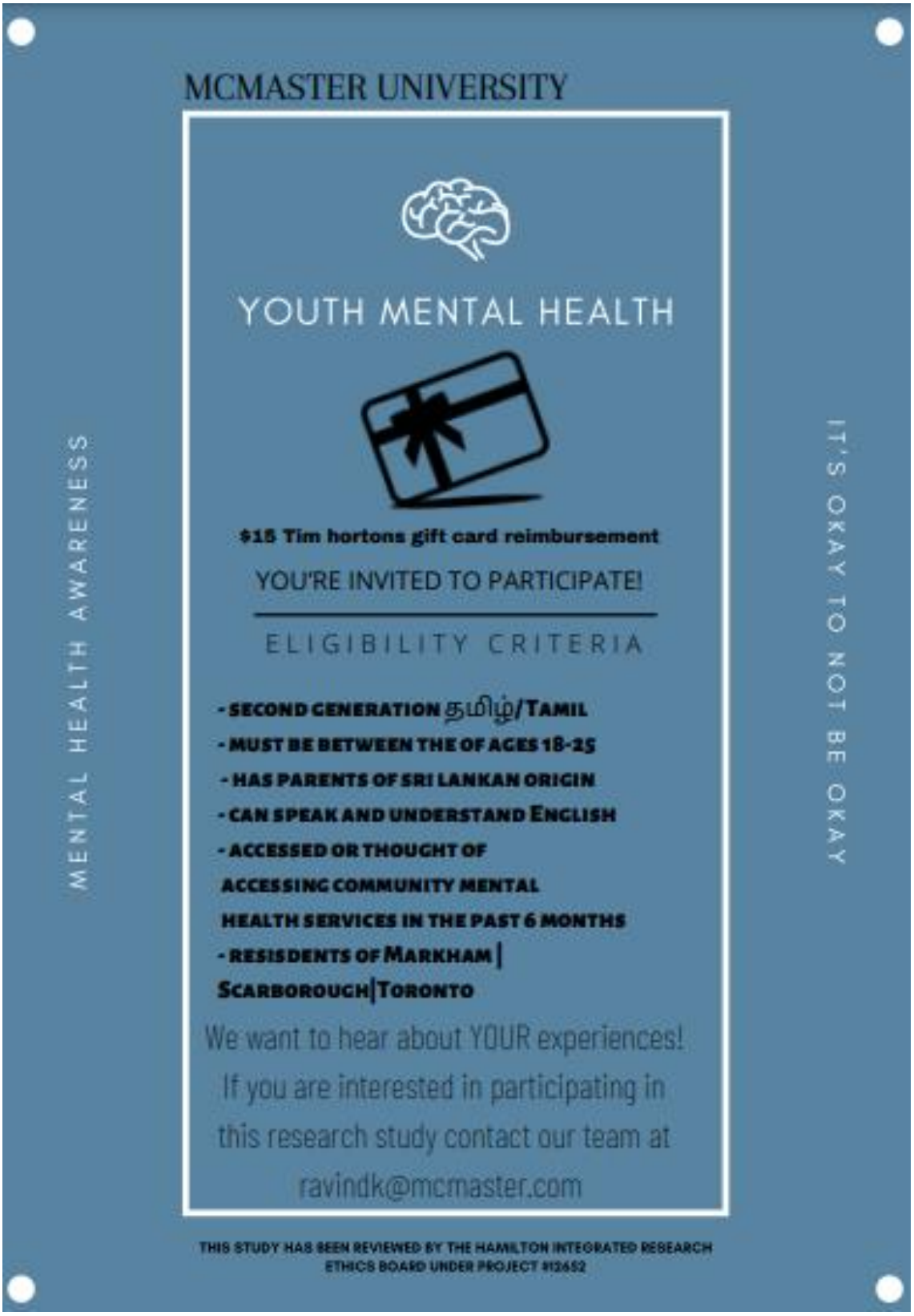
Thank you for your time, is there anything else you feel I need to know that I haven't asked today.

*Interview guide adapted from (Islam et al., 2017)

Appendix F

Recruitment Posters


MCMASTER UNIVERSITY.
YOUTH MENTAL HEALTH
$15 Tim Hortons Gift Card Reimbursement
You're invited to participate in this research study!
WHO CAN JOIN?
SECOND GENERATION TAMIL/தமிழ்
AGE 18-25
PARENTS OF SRI LANKAN ORIGIN
CAN SPEAK AND UNDERSTAND ENGLISH
ACCESSED OR THOUGHT OF ACCESSING COMMUNITY MENTAL HEALTH SERVICES IN THE PAST 6 MONTHS
LOCATIONS OF MARKHAM, SCARBOROUGH TORONTO
We want to hear about YOUR experiences!
Interested in participating? Contact our team at
ravindk@mcmaster.ca
THIS STUDY HAS BEEN REVIEWED BY THE HAMILTON INTEGRATED RESEARCH ETHICS BOARD UNDER PROJECT #12682


MCMASTER UNIVERSITY
YOUTH MENTAL HEALTH
$15 Tim hortons gift card reimbursement
YOU'RE INVITED TO PARTICIPATE!
ELIGIBILITY CRITERIA
- SECOND GENERATION தமிழ்/TAMIL
- MUST BE BETWEEN THE OF AGES 18-25
- HAS PARENTS OF SRI LANKAN ORIGIN
- CAN SPEAK AND UNDERSTAND ENGLISH
- ACCESSED OR THOUGHT OF ACCESSING COMMUNITY MENTAL HEALTH SERVICES IN THE PAST 6 MONTHS
- RESISDENTS OF MARKHAM | SCARBOROUGH|TORONTO
We want to hear about YOUR experiences!
If you are interested in participating in this research study contact our team at
ravindk@mcmaster.com
THIS STUDY HAS BEEN REVIEWED BY THE HAMILTON INTEGRATED RESEARCH ETHICS BOARD UNDER PROJECT #12652
MENTAL HEALTH AWARENESS
IT'S OKAY TO NOT BE OKAY

Appendix G

Resources

Toronto Distress Centres: 416 408-4357 or 408-HELP

Gerstein Centre: 416 929-5200

Assaulted Women's Helpline: 416 863-0511; Toll-free: 1 866 863-0511

Kids Help Phone: 1 800 668-6868; Languages: English and French

Community Crisis Line Scarborough and Rouge Hospital: 416 495-2891 for 24/7 telephone crisis support.

Service borders: south to the lake, north to Steeles Avenue, east to Port Union Road, and west to Victoria Park

Community Crisis Response Service, Distress Centre: Toll Free: 1 855 310-COPE (2673)

The Canada Suicide Prevention Service; 1-833-456-4566 (toll free) 24/7

Appendix H

Data Analysis Process Informed by Burnard (1991)

	Data Analysis Process
Step 1	Memos will be utilized as memory joggers, record ideas, themes and theories about the data.
Step 2	Transcripts are read through, notes made, general themes identified. Researcher is immersed in the data, fully aware of the "life world" of the respondent
Step 3	Transcripts read again, as many headings necessary are written down to describe all aspects of the content, excluding 'dross' (Field & Morse, 1985)- denotes unusable 'fillers' "Headings" and "Category system"- account for all of the interview "Open coding" (Berg, 1989)
Step 4	Survey list of categories and group them together under higher-order headings "Collapse" some into broader categories
Step 5	Work through new list of categories and sub-headings –repeated or similar heading are removed to produce final list
Step 6	Two colleagues are invited to generate category systems, independently, don't see researcher's list. The three list of categories are discussed and adjustments are made. Goal is to enhance validity of categorizing method, prevent researcher bias (guard)
Step 7	Transcripts are re-read alongside final list of categories and sub-headings to establish degree of coverage of interview, adjustments made.

Step 8	Work through each transcript with list of categories and sub-headings and "coded" according to the list of categories heading. Coloured highlighting pens used to distinguish between each piece of the transcript allocated to a category and sub-heading. Can also be identified on a computer using a word processor and a coding scheme devised by the individual researcher.
Step 9	Each code section of the interview is cut out of the transcript and all items of each code are collected together. Multiple photocopies are used to ensure context of coded sections are maintained. Sections that are omitted can lose context, the second copy is used for reference.
Step 10	Cut out sections are posted on sheets and labelled with appropriate heading and sub-headings.
Step 11	Selected respondents are invited to check appropriateness or otherwise of category system. Asked: "Does this quotation form your interview fit this category? Does this?..."Adjustments made. Check validity of categorizing process to be maintained.
Step 12	All sections filed together for direct reference for when writing up findings. Copies of complete interviews and original tape recordings kept, if anything is unclear can be referred back to original recording.
Step 13	Once all sections are together, write- up process beings. Start with first section, select various examples of data under that section, offer commentary to link examples. Onto next section and so on, until project is written up. During process, open to need to refer back to tape recordings and "complete" transcripts, to stay close to original meanings and context.
Step 14	Researcher must decide whether or not to link data examples and commentary to the literature. Two options: (1) Researcher

	writes findings verbatim, such as interviews to illustrate various sections. Then separate sections to link findings to literature on the topic and make comparison/contrast. (2) Researcher writes up findings alongside references to it. “Findings” section of research becomes both presentation of finding and comparison. Former is more “pure”, latter is more practical and readable.

(Burnard, 1991)

Appendix I

Theory of Cultural Marginality Model

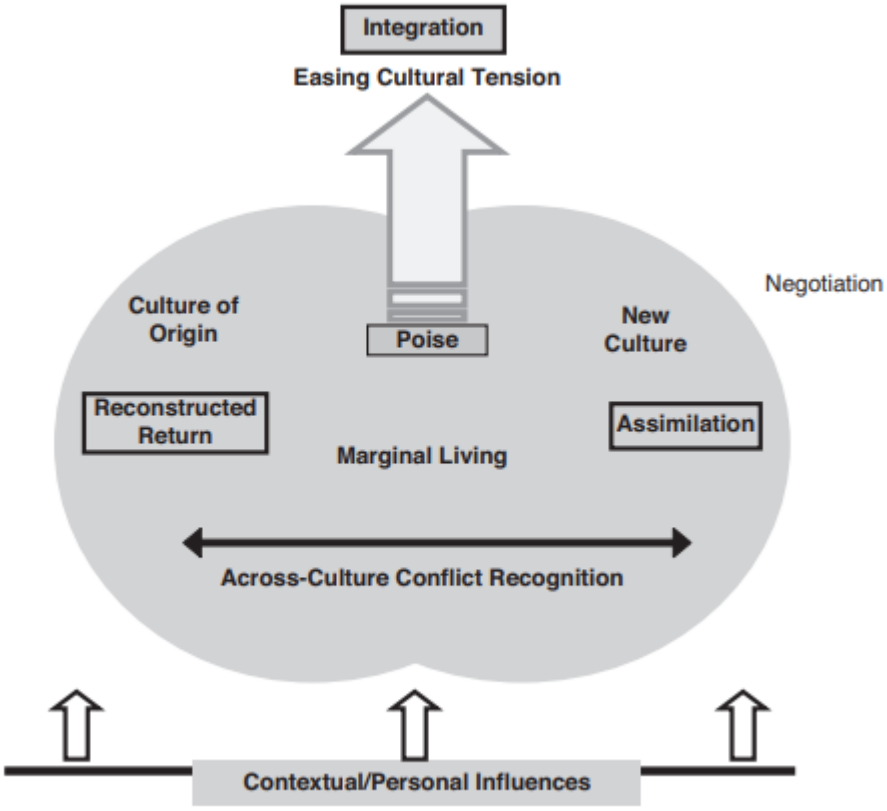


FIGURE 14.1 Cultural Marginality.

(Choi, 2018)

Appendix J

Dimensions of Access

Table 1. The dimensions of access.

Dimension of access	Definition	Dimension components and examples
Accessibility[a]	Location	An accessible service is within reasonable proximity to the consumer in terms of time and distance.
Availability[a]	Supply and demand	An available service has sufficient services and resources to meet the volume and needs of the consumers and communities served.
Acceptability[a]	Consumer perception	An acceptable service responds to the attitude of the provider and the consumer regarding characteristics of the service and social or cultural concerns. For instance, a patient's willingness to see a female doctor may determine whether a service is acceptable or not.
Affordability[a]	Financial and incidental costs	Affordable services examine the direct costs for both the service provider and the consumer.
Adequacy[a] (Accommodation)	Organization	An adequate service is well organized to accept clients, and clients are able to use the services. Considerations of adequacy include hours of operation (after-hour services), referral or appointment systems, and facility structures (wheelchair access).
Awareness[b]	Communication and information	A service maintains awareness through effective communication and information strategies with relevant users (clinicians, patients, the broader community), including consideration of context and health literacy.

[a]The five dimensions of access identified by Penchansky and Thomas.[6]
[b]A sixth dimension that may influence access.

(Saurman, 2016)