RACIALIZED IMMIGRANTS' ACCESS TO MENTAL HEALTHCARE SERVICES

Understanding Racialized Immigrants' Access to Mental Healthcare Services in Ontario, Canada

By ZOHA SALAM, B.A.[H], MSc

A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in Global Health

McMaster University DOCTOR OF PHILOPSHY (2024) Hamilton, Ontario (Global Health)

TITLE: Understanding Racialized Immigrants' Access to Mental Healthcare Services in Ontario, Canada
AUTHOR: Zoha Salam, BA[H] (University of Windsor), MSc (McMaster University), G.Dip. (McMaster University)
SUPERVISOR: Dr. Ameil Joseph
NUMBER OF PAGES: xiv, 259

LAY ABSTRACT

Racialized immigrants in Canada experience barriers when accessing mental healthcare services. While there is research that documents these barriers, there is a lack of focus on understanding how this large population’s experiences can be shaped by their legal status. The goal of this dissertation was to understand factors that influence racialized immigrants’ access to mental healthcare services in Ontario, Canada. To explore this issue, this was done through a scoping review and interviews with 16 service users and 10 mental healthcare providers. The findings point to gaps in mental healthcare services that are driven by both system and individual level factors. Meaning changes to improve services must start at the top, specifically changes to policies that limit access to care. However, it is important to not use a blanket approach in developing solutions for this broad population because it will limit how services can be adapted to their unique needs.

ABSTRACT

There are distinctions noted in mental healthcare service uptake based on immigration status among racialized immigrants in Canada. Research focused on understanding mental healthcare disparities in accessing care within this broad population group often attends to individual-level drivers, which detracts from how systemic factors play a role in producing disparities. Through a three project study, this dissertation aims to explore how access to mental healthcare services among this broad population is influenced by different factors. First, a scoping review aimed to identify barriers and facilitators encountered by racialized immigrants when accessing mental healthcare services across Canada. Second, a qualitative descriptive study explored 16 racialized immigrants' experiences of accessing mental health services in Ontario, Canada. Third, a qualitative descriptive study centred on the perspectives of both 16 service users and 10 mental healthcare service providers to explore how the immigration and mental healthcare systems coalesce together and play a role in shaping access to services. The findings from all three studies demonstrate how individual and systemic-level factors produce certain inequities for racialized immigrants when accessing mental healthcare services in Ontario. Improving access to mental healthcare services for this broad population group requires attention to how service delivery exists and is shaped by macro-level factors. By highlighting legal status as a starting point for interrogation related to understanding disparities in access, a more nuanced understanding can be gained to pinpoint drivers contributing to the issue. There also needs to be an emphasis on situating how the existing mental healthcare infrastructure plays a role, specifically how access is mediated through

one’s legal status. Racialized immigrants are not a monolithic group and therefore, development of equitable policies, programs, and service delivery related to mental health should account this complexity rather than a one-size-fits-all approach.

DEDICATION

میری ماں کے لیے۔	For my mother,
یہ ڈگری تمام کاموں کے ساتھ جو میں نے اپنی ، زندگی میں کی ہے میری والدہ کی محبت رہنمائی اور صبر کی وجہ سے ہے۔	This degree along with everything I have done in my life is due to my mother’s love, guidance, and patience.
وہ ہے جس نے مجھے بولنا ، پڑھنا اور لکھنا سکھایا	She is the one who taught me to speak, read, and write.
میری پرورش کرتے ہوئے آپ نے بہت غم کا تجربہ کیا ہے۔ مجھے بہت افسوس ہے کہ دنیا نے آپ کو اتنی پریشانی دی ہے۔ مجھے امید ہے کہ میں اس دنیا میں آپ کے لیے ایک اچھا بچہ رہا ہوں۔	You have experienced a lot of grief while raising me given our circumstances. I am so sorry the world has caused you so much trouble. I hope I have been a useful child to you in this life.
2000	2000
آپ دوسرے بچوں کے ساتھ کھیلنے کے لیے نیچے کیوں نہیں جاتے؟	*Why don’t you go downstairs to play with the other children?*
میں انگریزی بولنا نہیں جانتا۔	*I don’t know how to speak English.*
2024	2024
کیا آپ مجھے بتا سکتے ہیں کہ انگریزی میں یہ لفظ اردو میں کیا ترجمہ کرتا ہے؟	*What does this English word translate to in Urdu?*
مجھے اردو کے مساوی لفظ کے بارے میں یقین نہیں ہے۔	*I don’t know the word in Urdu.*

ACKNOWLEDGMENTS

“رَّبِّ زِدْنِى عِلْمًا”
"Oh, my Lord! Increase me in my knowledge." (20:114)

It feels very strange to be writing this as I never knew I thought I would get this far in my life. Individuals similar to my background are not supposed to get this far – often we are murdered at birth for being born as female, kept away from higher education, or married off. In academia, we are deliberately made to be as problems if we don't align ourselves with whiteness. I am not your subservient Pakistani woman, nor your model minority.

This doctoral degree and dissertation involved the support, love, and capacity of community I have been developing through my entire life. Some parts of my community were inherited by birth and others were made by myself. My accomplishments are a product and reflection of this community carrying me in ways such as feeding me, holding me, and listening to me. I think my dissertation was an exercise in unpacking grief we held.

To my participants for allowing me to go back in time with them to some of the most vulnerable and unsure moments in their lives. Moving to another country in the pursuit of a new life is a brave and terrifying act. I wish you the strength and support you need. Thank you for our conversations.

To my ammi-jee, Nighat Nasreen, and my siblings, Maha and Aiza. At first it was just ammi-jee and me when we came to this country. Then you slowly came along. The conversations we had while we peeled garlic and ginger, re-potted jasmine plants, and cleaned meat led to some of the foundational parts of my dissertation: what it means to have a good life given everything else.

To the racialized women in my cohort. Mercy, Su, Patricia, and Caro, you are all my older sisters who I look up to and admire. Thank you for sharing pieces of your lives and lovely conversations. I am the younger sister among us, but I hope to be just like you when I reach your milestones.

To my supervisor, Dr. Joseph, when we first met you said that you'll make up the two and a half years I lost. It feels surreal to be working with you because I have read and cited your work since my undergraduate degree, and even till today, it all resonates. Your patience and kindness gave me what I needed to finish this. I appreciate our little chats. Thank you to Dr. Carranza for listening to me and sharing opportunities where you could help my growth. Dr. Joseph and Dr. Carranza, you both provided me a racially and culturally safe space that affirmed my experiences to help me complete this project. Thank you to Dr. Wahoush for being with me since my master's thesis and now into my doctoral dissertation. Thank you, Dr. Newbold, for always being responsive and providing me guidance. Thank you all for your dedicated time and feedback.

To Dr. Héctor Alcalá, you have been with me since my undergraduate degree. Thank you for giving me the supports I needed to navigate academia as a racialized first-generation student. You always responded to my frantic texts, provided me opportunities, and gave me guidance. From helping me craft my first cover letter for my first publication to helping me think through my future. You always have been here.

To Dr. Christopher Kyriakides, joining York's Centre for Refugee Studies as a graduate student affiliate changed the trajectory of my academic career. You have been an incredible mentor to me as we worked together on the Racisms and Refugee Subcommittee. Even though I was never formally your student, you still treated me as if I was your own.

To those within institutions who subjected me to different forms of cruelty. Your commitment to racism under the guise of corporate "equity" buzzwords, a language so foreign and disgusting to me, truly played an important role. It is a shame that is all you know and embody. Telling me to be more "kind" and "polite" in situations where I am invited to share my dissent is ironic given that your white comfort is more important than creating "equitable" solutions. I acknowledge your presence in this process. Thank you for constantly reminding me, and other racialized students, that we will always be the "other" through every interaction you have with us. From cutting us off and correcting us when we mispronounce a word, taking up our speaking time, and to stealing our ideas - we see you. Congratulations on building a life and career that is only possible through subordinating the same communities you so desperately want to "help."

Inquilab zindabad.

TABLE OF CONTENTS

LIST OF FIGURES AND TABLES

Chapter 3

Chapter 4

Chapter 5

LIST OF ALL ABBREVIATIONS

ABHMCU	Andersen’s Behavioural Model of Health Care Utilization
HiREB	Hamilton Integrated Research Ethics Board
KEM	Kleinman’s Explanatory Model
QD	Qualitative Descriptive
RTA	Reflexive Thematic Analysis
SDoH	Social Determinants of Health

DECLARATION OF ACADEMIC ACHIEVEMENT

This dissertation presents three original research studies (Chapters 3-5), an introductory chapter (Chapter 1), an overarching methodology chapter (Chapter 2), and a conclusion chapter (Chapter 6). Chapter 3 has been published in *Administration and Policy in Mental Health and Mental Health Services Research.* Chapters 4 and 5 will be published afterwards.

I, Zoha Salam, am the lead author of every chapter within this dissertation. I developed the research questions, formulated the research methodology, conducted the interviews, analyzed the data, and drafted the chapters presented here. As part of my doctoral dissertation's work, I received feedback from members of my dissertation committee. All chapters are co-authored with my dissertation committee.

Chapter 1: Introduction

This doctoral dissertation follows the format of a "sandwich thesis" which has six chapters. Three of the chapters (Chapters 3, 4, and 5) are considered to be original research, where they have either been published in a peer reviewed journal or are being prepared to be published. Chapter 1 provides a brief overview of the issue being explored. It will also outline the problem statement, purpose statement, objective statement and research questions, and overview of dissertation chapters.

Brief Background and Overview

Access to mental healthcare services in Canada can become a complicated process as the full range of mental health services (e.g., psychotherapy, counselling, medications etc.) are generally not fully covered through provincial healthcare plans (Cohen & Peachey, 2014; Mulvale & Hurley, 2008; Statistics Canada, 2023). It is estimated that around one in five Canadians have experienced a mental health issue within their lifetime, and general access to counselling services are considered to be an unmet health need (Smetanin et al., 2015; Statistics Canada, 2018, 2023). From a 2013 report by the Canadian Psychological Association, it is estimated that those seeking services through a private practise are 30% self-pay and the rest is often covered through private healthcare insurance through employment (Peachey et al., 2013). It can be understood that the mental healthcare system exists as a "patchwork" within Canada due to a lack of full integration into the healthcare system. As a consequence, individuals may not receive care that is timely or affordable (Cohen & Peachey, 2014; Mulvale & Hurley, 2008; Peachey et al., 2013). For racialized immigrant groups in Canada, it has been well documented in the literature that there are systemic and individual issues that produce inequitable access to mental healthcare services (Salam et al., 2022; Thomson et al., 2015). These include language barriers, knowledge of services, and the availability of appropriate services that consider the unique needs of racialized immigrants (Salam et al., 2022; Thomson et al., 2015). As a consequence, racialized immigrant groups generally are less likely to receive and access care due to structurally imposed disadvantages compared to other Canadians (Ng & Zhang, 2020, 2021).

It is proposed in the literature that recent immigrant arrivals to Canada report better health outcomes than those born locally, including mental health (Lu & Ng, 2019; Ng & Zhang, 2020). This is known as the "healthy immigrant effect," where new immigrants are healthier on average than their Canadian born counterparts (Vang et al., 2017). However, there is a gap within the literature, as there is a growing body of knowledge which states that this does not hold true for all migrant statuses. It is estimated that refugees in Canada generally tend to have poorer mental health outcomes which can be explained by their experiences and reasons for departure from their country of origin (Ng & Zhang, 2020, 2021). The validity of the "healthy immigrant effect" construct is heavily contested in terms of mental health, as the rates of mental disorders may potentially be underreported amongst immigrants (Castañeda et al., 2015; Salami et al., 2019). This is also complicated by other systemic factors, as immigrants must undergo medical screenings, and may not be allowed to move to Canada if a health condition is found (Kanani, 2011; MacIntosh, 2019). Canada historically has had a medical inadmissibility immigration policy that essentially only allows the healthiest voluntary immigrants to be chosen, thus intentionally selecting those who are less likely to develop health problems later in life (Kanani, 2011; MacIntosh, 2019; Pottie et al., 2011). Differences in mental health disparities among racialized immigrants can be further explored through various societal and structural factors, also known as the social determinants of health (SDoH) (Castañeda et al., 2015; Hynie, 2018). This includes factors including, but not limited to, housing arrangement, geographical location, level of income, educational attainment, employment status, and belonging to a racialized group (Castañeda et al., 2015; Caulford & D'Andrade, 2012; Hynie, 2018; Mulvale & Hurley, 2008). It is argued that immigration status could also be categorized as a SDoH, as there are unique associations between health outcomes due to the process of migration itself (Castañeda et al., 2015; Hynie, 2018). Refugees on average generally have lower levels of English or French literacy, are less financially secure, and work precarious jobs (Oda et al., 2019; Salami et al., 2019; Sweetman & Warman, 2013). Conversely, immigrants from economic migration paths are more likely to be educated, have better job security, and have a better grasp of the English or French language (Sweetman & Warman, 2013). Additionally, access to employment is contingent on legal status in Canada, such as being authorized to work or holding permanent residency sometimes (Campbell et al., 2014; Hacker et al., 2015). Therefore, opportunities for immigrants are not equal and this may produce differences in mental health outcomes due to standards of living being different – additionally, having access to healthcare benefits from one's employer (Chen & Hou, 2019; Sweetman & Warman, 2013).

Problem Statement

Racialized immigrants in Canada generally are reported to have better mental health outcomes compared to white non-immigrant Canadians upon arrival (Fung & Guzder, 2018; Vang et al., 2017). While this seems to be a positive sign for this group, the statistics associated with this trend ultimately may be due to a number of factors, such as underreporting and immigrant selectivity bias (Fung & Guzder, 2018; Robert & Gilkinson, 2012; Vang et al., 2017). As briefly described above, the "healthy immigrant effect" does not provide a comprehensive or nuanced view of this population based on contextual factors. Coupled with their migration status, their intersecting identity of being racialized produces an additional layer of vulnerability that stems from discriminatory actions, such as xenophobia and racism. Racialized immigrants are regarded as a clinically underserved population due to their reported low levels of mental healthcare utilization and concerns of underdiagnosis (Simich et al., 2006). The Mental Health Commission of Canada (2015, 2016) explicitly identifies immigrants as an at-risk group due to their intersecting vulnerabilities and suggests improving the accessibility of mental healthcare services. Language barriers, health literacy, and lack of awareness of such services are the predominant barriers to accessing care detailed within the literature (Hynie, 2018; Kirmayer et al., 2011; Salam et al., 2022; Thomson et al., 2015).

The World Health Organization (2022) conceptualizes "mental health" as the following: "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community," which extends beyond Western and biomedical models. While this is one definition, it is important to recognize plural ideas of "mental health" that racialized immigrants may bring based on their social, political, and structural experiences. This allows for a more holistic exploration in understanding their appraisals of services and determining needs.

The corpus of research on mental health disparities among racialized immigrants primarily points to cultural differences as the fundamental cause (Thomson et al., 2015). Reducing this issue to individual level characteristics, such as cultural background, dismisses the interplay of systemic and structural factors in producing and maintaining these inequities (Metzl

& Hansen, 2014). Immigrants' pre-, peri-, and post-migration experiences are demonstrably distinct from one another, as they are tied to their departure and conditions imposed based on their legal status (Bobadilla et al., 2017; Campbell et al., 2014; Hynie, 2018; Magalhaes et al., 2010). Research also fails to distinguish between groups by not delineating their migration class, sometimes conflating them under the umbrella terms of "migrants" or "immigrants" (Castañeda et al., 2015). Therefore, both individual and systemic aspects must be taken into account when investigating why there are disparities present in service usage. Through focusing on the two broad migration classes as distinct groups when analyzing data, a deepened understanding can be gained by attending to the differences and similarities among them.

Purpose Statement

The purpose of this dissertation is to investigate the barriers and facilitators experienced by various racialized immigrant groups in accessing mental healthcare services in Ontario, Canada. Overall, the goal of the dissertation is to *understand the interaction of individual and systemic level factors that contribute to shaping access in mental healthcare services among racialized immigrant groups in Ontario, Canada*.

Objective & Research Questions

The main objective guiding this dissertation is to explore the barriers and facilitators racialized immigrant groups (e.g., international students, dependents, refugee claimants, settled refugees) experience when seeking mental healthcare services in Ontario, Canada. The selected research questions to achieve the study's objectives are:

1. Are there differences in the barriers and facilitators identified among various immigrant groups?
2. How do cultural and social conceptualizations of mental health shape their experiences?
3. What would the ideal mental healthcare system consist of that supports this broad populations' needs?

Delimitations

Mental healthcare providers within the dissertation will not include those who do not have a license or are not registered to some sort of professional body in Ontario, Canada. While spiritual, religious, cultural, and folk-based healers are commonly used within the population of interest and such are valuable resources, they will not be included. This is ultimately due to the fact that they are not considered to be part of the "formal" mental healthcare profession in the province. Therefore, those who are registered to a professional body will be recruited, as there is an understanding that they have had a standardized education and regulations they must follow in order to practise.

Implications

This dissertation ultimately aims to add to the current existing literature surrounding mental health disparities of racialized immigrants within Canada. The findings from this study can potentially provide valuable information to a variety of related bodies, such as mental healthcare professionals, resettlement and newcomer organizations, and policy makers. Gaining insight into how culture and society shapes and informs conceptualizations of mental health may help to improve the services that mental healthcare professionals provide. The findings from the dissertation can help to develop educational programs/courses and professional workshops for those who plan to work with racialized immigrant groups within a mental health context. The barriers and facilitators to care that stem from systemic issues may be of interest to policy makers who specifically focus on developing social welfare or healthcare related policies for this broad target population. Those policy makers who are involved within deciding funding allocations can also be provided with additional data from this study's results. Additionally, this study can bring attention to bridging and integrating more mental healthcare services into the formal healthcare system in Canada and locally within the province. For resettlement and newcomer organizations, the focus on systemic factors may also be of interest as they can develop and fund resources to overcome them. It can also provide more knowledge for producing community-led mental health promotion programs that are tailored to immigrant or refugee specific needs. Lastly, the findings may also be of interest for Canadian funding agencies and organizations who specifically focus on health disparities among racialized immigrant groups.

Overview of Dissertation Chapters

This is a "sandwich" dissertation and there are three original research papers included within it. This section will provide a brief overview of the one methodology chapter and three original research chapters.

Chapter 2 serves as the overarching methodology chapter that guides the inquiry for Chapters 4 and 5. This chapter is a more comprehensive account of the methodological underpinning of the aforementioned chapters – as they present abbreviated versions of methodology to maintain brevity. Chapters 4 and 5 have the same methodology as a conscious attempt to integrate findings and maintain consistency from a philosophical perspective. However, both chapters separately discuss in detail their guiding theoretical frameworks, participant selection and recruitment processes, and data analyses in context of what research question is being interrogated. This chapter introduces the selected methodological approach, how reflexivity was practiced in the context of the entire dissertation, and approach to analysis. This dissertation's guiding philosophical orientation is constructivist inquiry, as it acknowledges how reality and knowledge is co-constructed by individuals and their experiences, specifically how broader influences play a role. The selected methodology for this dissertation aligned with that philosophical approach is Sandelowski's interpretation of qualitative descriptive (QD) (Sandelowski, 2000, 2010, 2010) which seeks to stay as "close" to the data as possible while being open to interpretation that accounts for incorporated theoretical frameworks. Braun and Clarke's approach to reflective thematic analysis (RTA) was applied to analyze the data from the interviews to explore the research questions (Braun & Clarke, 2006, 2021).

Chapter 3, an original research paper (Salam et al. 2022), is a scoping review that explores the following question: *what are the barriers and facilitators for accessing mental healthcare services among visible immigrants and refugees in Canada?* This paper explored the first research question of this dissertation. Using the scoping review approach outlined by Arksey and O'Malley (Arksey & O'Malley, 2005) and established criteria, there were 45 articles published from 2000 to 2020 that were included. It included articles that focus both on service users' and service providers' experiences to accessing care. From this review, systemic and individual level factors were determined to impact mental healthcare service usage. The results pointed to how access is a complex issue which is shaped by one's legal status which highlights the roles of the immigration and healthcare systems.

Chapter 4, an original research paper, is a qualitative study that draws from interviews of 16 individuals from a variety of immigrant groups. This paper is aligned with the first and second research questions for this dissertation. The purpose of this study was to understand the barriers and facilitators experienced when seeking mental healthcare services in Ontario. It also aims to explore how cultural and social conceptualizations of mental health shape attitudes towards mental healthcare services. Using Andersen's Behavioural Model of Health Care Utilization (ABMHCU) (Andersen, 1995) as a conceptual framework layered with Kleinman's Explanatory Model (Kleinman, 1980), the findings identified the following major themes: structural constraints, individual influences, and appraisal of services.

Chapter 5, an original research paper, is a qualitative study that draws on interviews with 16 racialized immigrants and 10 mental healthcare providers in Ontario who provide services to racialized immigrants. This paper seeks to explore the first and third research questions. The purpose of this paper was to take on a policy-level approach in investigating how the immigration system and the provincial healthcare system both interact to produce variabilities in mental healthcare access among racialized immigrant groups. Using the ABMHCU (Andersen, 1995) as a guiding theoretical framework, there were the following factors: governing structures, service delivery, and client characteristics. By identifying fractures in the two systems and also solutions put forth by both service users and service providers, I propose a conceptual framework in understanding mental healthcare access based on the needs and experiences of racialized immigrants in Ontario. This framework blends the findings from the results of the scoping review from Chapter 3, as it makes connections to the identified layers included in there. This specific framework attends to identifying how factors from the immigration and healthcare systems can be seen as potential causes and sites for improvement in access to mental healthcare services.

Chapter 6 serves as the conclusion chapter to this dissertation and details key findings of each chapter, a synthesis of the findings, and recommendations for future areas of research.

References

Andersen, R. M. (1995). Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? *Journal of Health and Social Behavior*, *36*(1), 1–10. https://doi.org/10.2307/2137284

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Bobadilla, A., Orchard, T., Magalhaes, L., & Fitzsimmons, D. (2017). Ontario healthcare coverage eligibility among new permanent residents: A scoping review. *Journal of Immigrant & Refugee Studies*, *15*(4), 384–405.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021). *Thematic Analysis: A Practical Guide*. SAGE Publications. https://books.google.ca/books?id=eMArEAAAQBAJ

Campbell, R. M., Klei, A. G., Hodges, B. D., Fisman, D., & Kitto, S. (2014). A Comparison of Health Access Between Permanent Residents, Undocumented Immigrants and Refugee Claimants in Toronto, Canada. *Journal of Immigrant and Minority Health*, *16*(1), 165–176. https://doi.org/10.1007/s10903-012-9740-1

Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M.-E. D., Beyeler, N., & Quesada, J. (2015). Immigration as a Social Determinant of Health. *Annual Review of Public Health*, *36*(1), 375–392. https://doi.org/10.1146/annurev-publhealth-032013-182419

Caulford, P., & D'Andrade, J. (2012). Health care for Canada's medically uninsured immigrants and refugees: Whose problem is it? *Canadian Family Physician*, *58*(7), 725–727.

Chen, W.-H., & Hou, F. (2019). Social Mobility and Labor Market Outcomes Among the Second Generation of Racial Minority Immigrants in Canada*. *Social Science Quarterly*, *100*(3), 885–896. https://doi.org/10.1111/ssqu.12582

Cohen, K. R., & Peachey, D. (2014). Access to psychological services for Canadians: Getting what works to work for Canada's mental and behavioural health. *Canadian Psychology/Psychologie Canadienne*, *55*(2), 126.

Fung, K., & Guzder, J. (2018). Canadian immigrant mental health. *Mental Health and Illness in Migration. Mental Health and Illness Worldwide. Singapore: Springer*, 1–21.

Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: A literature review. *Risk Management and Healthcare Policy*, 175–183.

Hynie, M. (2018). The social determinants of refugee mental health in the post-migration context: A critical review. *The Canadian Journal of Psychiatry*, *63*(5), 297–303.

Kanani, N. (2011). Race and madness: Locating the experiences of racialized people with psychiatric histories in Canada and the United States. *Critical Disability Discourses*.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., Pottie, K., & (CCIRH), C. C. for I. and R. H. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *183*(12), E959–E967. https://doi.org/10.1503/cmaj.090292

Kleinman, A. (1980). *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry*. University of California Press. https://books.google.ca/books?id=ZRVbw6-UyucC

Lu, C., & Ng, E. (2019). Healthy immigrant effect by immigrant category in Canada. *Health Reports*, *30*(4), 3–11. https://doi.org/10.25318/82-003-x201900400001-eng

MacIntosh, C. (2019). Medical inadmissibility, and physically and mentally disabled would-be immigrants: Canada's story continues. *Dalhousie LJ*, *42*, 125.

Magalhaes, L., Carrasco, C., & Gastaldo, D. (2010). Undocumented migrants in Canada: A scope literature review on health, access to services, and working conditions. *Journal of Immigrant and Minority Health*, *12*(1), 132–151.

Mental Health Commission of Canada. (2015). *Informing the Future: Mental Health Indicators for Canada*.

Mental Health Commission of Canada. (2016). *The Case for Diversity Building the Case to Improve Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Populations*.

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine (1982)*, *103*, 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032

Mulvale, G., & Hurley, J. (2008). Insurance coverage and the treatment of mental illness: Effect on medication and provider use. *Journal of Mental Health Policy and Economics*, *11*(4), 177.

Ng, E., & Zhang, H. (2020). The mental health of immigrants and refugees: Canadian evidence from a nationally linked database. *Health Reports*, *31*(8), 3–12. https://dx.doi.org/10.25318/82-003-x202000800001-eng

Ng, E., & Zhang, H. (2021). *Access to mental health consultations by immigrants and refugees in Canada*.

Oda, A., Hynie, M., Tuck, A., Agic, B., Roche, B., & McKenzie Kwame; ORCID: http://orcid.org/0000-0001-6419-8130, K. A. I.-O. http://orcid.org/McKenzie. (2019). Differences in self-reported health and unmet health needs between government assisted and privately sponsored Syrian refugees: A cross-sectional survey. *Journal of Immigrant and Minority Health*, *21*(3), 439–442. http://dx.doi.org/10.1007/s10903-018-0780-z

Peachey, D., Hicks, V., & Adams, O. (2013). *An imperative for change: Access to psychological services for Canada*.

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., Narasiah, L., Kirmayer, L. J., Ueffing, E., MacDonald, N. E., Hassan, G., McNally, M., Khan, K., Buhrmann, R., Dunn, S., Dominic, A., McCarthy, A. E., Gagnon, A. J., Rousseau, C., & Tugwell Laurence J.; ORCID: http://orcid.org/0000-0002-6228-1739, P. A. I.-O. http://orcid.org/Kirmayer. (2011). Evidence-based clinical guidelines for immigrants and refugees. *Canadian Medical Association Journal*, *183*(12), e824–e925. http://dx.doi.org/10.1503/cmaj.090313

Robert, A., & Gilkinson, T. (2012). Mental health and well-being of recent immigrants in Canada: Evidence from the longitudinal survey of immigrants to Canada. *Immigrant Integration: Research Implications for Future Policy*, 191–210.

Salam, Z., Odenigbo, O., Newbold, B., Wahoush, O., & Schwartz, L. (2022). Systemic and Individual Factors That Shape Mental Health Service Usage Among Visible Minority Immigrants and Refugees in Canada: A Scoping Review. *Administration and Policy in Mental Health and Mental Health Services Research*, 1–23.

Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *International Journal of Mental Health Nursing*, *28*(1), 152–161. http://dx.doi.org/10.1111/inm.12512

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*(4), 334–340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, *33*(1), 77–84. https://doi.org/10.1002/nur.20362

Simich, L., Hamilton, H., & Baya, B. K. (2006). Mental Distress, Economic Hardship and Expectations of Life in Canada among Sudanese Newcomers. *Transcultural Psychiatry*, *43*(3), 418–444. http://dx.doi.org/10.1177/1363461506066985

Smetanin, P., Briante, C., Khan, M., Stiff, D., & Ahmad, S. (2015). *The life and economic impact of major mental illnesses in Canada: Economic impact of major mental illnesses in Canada*.

Statistics Canada. (2018). *Mental health care needs*.

Statistics Canada. (2023). *Mental disorders and access to mental health care*. https://www150.statcan.gc.ca/n1/pub/75-006-x/2023001/article/00011-eng.htm

Sweetman, A., & Warman, C. (2013). Canada's Immigration Selection System and Labour Market Outcomes. *Canadian Public Policy*, *39*(Supplement 1), S141–S164. https://doi.org/10.3138/CPP.39.Supplement1.S141

Thomson, M. S., Chaze, F., George, U., & Guruge, S. (2015). Improving Immigrant Populations' Access to Mental Health Services in Canada: A Review of Barriers and

Recommendations. *Journal of Immigrant and Minority Health*, *17*(6), 1895–1905. https://doi.org/10.1007/s10903-015-0175-3

Vang, Z. M., Sigouin, J., Flenon, A., & Gagnon, A. (2017). Are immigrants healthier than native-born Canadians? A systematic review of the healthy immigrant effect in Canada. *Ethnicity & Health*, *22*(3), 209–241. https://doi.org/10.1080/13557858.2016.1246518

World Health Organization. (2022). Mental health. Retrieved from https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our response

Chapter 2: Methodology

This methods chapter will outline the selected methodological approach and method that is used for Chapters 4 and 5 within this dissertation. Each separate chapter, or manuscript, has its own theoretical framework that guides the exploration of a research question which is being investigated. Thus, for the purpose of this chapter, only the detailed methodology and method will be discussed to maintain brevity when re-articulated in the separate chapters. The separate chapters will detail the conceptual framework, a condensed version of the methodology and method, sampling, interviewing, and analysis.

Methodology

This dissertation's methodology is underpinned by Sandelowski's interpretation of qualitative description (QD) which is based on constructivist inquiry (Sandelowski, 1995, 2010, 2010). This approach is different from other traditional qualitative methodologies, such as phenomenology, grounded theory, or ethnography, as it seeks a straightforward summary of an individual's descriptions of a phenomenon (Sandelowski, 1995, 2000, 2010). QD aims to produce findings of interpretations which are as closely aligned to the data as possible by remaining true to the accounts presented by the participant (Sandelowski, 1995, 2000, 2010). This involves not theorizing or delving too far beyond what the participant had stated in order to not potentially misconstrue the content (Sandelowski, 1995, 2000, 2010). Sandelowski (2000) describes QD's purpose as, "the reading of lines, as opposed to reading into, between, over or beyond the lines." However, there is a level of interpretation to be done in order to understand the participants' experiences in relation to the research question being explored (Sandelowski, 1995, 2000, 2010). QD is not entirely atheoretical which reflects a constructivist approach, as theory through theoretical or conceptual frameworks can be used to inform the study, interview guide, and data analysis framework (Doyle et al., 2020; Sandelowski, 2010). QD has been used in health sciences research broadly to investigate health related experiences; therefore, QD becomes a relevant methodology for the purpose of this dissertation which seeks to understand both the experiences of mental healthcare providers and racialized immigrant service users (Kim et al., 2017). In the context of this dissertation, the decision to have a shared methodology was important when it came to integrate the findings from the two related studies based on some of the same interview questions.

Method

The selected method and analysis tool for this dissertation's two studies is Braun & Clarke's (2006, 2021b) reflexive thematic analysis (RTA). This approach contends that the researcher's role is a key aspect in understanding the phenomena that is being explored and understood. It is a method is rooted in constructivist inquiry as it acknowledges that there are multiple truths which participants bring forward, and therefore should be recognized (Braun & Clarke, 2006, 2021b) It also recognizes that reality is co-constructed between the researcher and the participant through interactions that emerge from their identities, ideas, and assumptions (Braun & Clarke, 2006, 2021b, 2021a, 2023). RTA itself is also not atheoretical, as it is a flexibly theoretical method and tool of analysis. Braun and Clarke (2021b) contend that as part of a RTA approach, "good RTA needs both theory and explicit locating in terms of theory." To further their argument given RTA's philosophical underpinnings, they argue that theoretical assumptions will always be made as part of the process of conducting research as nothing exists in a vacuum (Braun & Clarke, 2006, 2021a, 2021b, 2023). This highlights the constructivist nature of RTA, more specifically, how important it is for RTA to be situated in the context the research is being conducted in and also who is undertaking the research. This will be explained in the following section. For the purpose of this dissertation, I am taking a deductive approach to RTA which is more theory driven rather than being inductive and theory generating. I am looking to see how the data from the interviews will reflect conceptual ideas based on the conceptual frameworks that are being to explore the research questions. RTA aligns with QD because that is one of the methods Sandelowski suggests because it complements the work (2010). Sandelowski also suggests that QD is not a rigid methodology as it can be flexible to take on different textures which are aligned with what is being explored as a point of analysis (1995, 2000, 2010). QD, just like RTA, is not atheoretical and therefore blends together as a paired methodology and method.

Reflexivity

Braun and Clarke's RTA emphasizes reflexivity as a key tool driving their method (2006, 2021b). While "bias" often has a negative connotation within the domain of research, both qualitative and quantitative, Braun and Clarke take a different approach in understanding bias and posit that "bias" is inherently useful in their method (2006, 2021b). They describe that the idea of controlling for bias within qualitative research is a form of "positivism creep," where values of positivist research paradigm are sometimes unknowingly imported into qualitative research (Braun & Clarke, 2006, 2021b, 2021a, 2023). Braun and Clarke (2023) argue that a researcher's subjectivity is a tool for their RTA approach, and frequently refer to "owning one's perspective" by stating that research "will always be infused with their subjectivity, and they are never a neutral conduit, simply conveying a directly-accessed truth of participants' experience" (Braun & Clarke, 2023).

Reflexivity within RTA is not just "naval-gazing" or producing a "laundry-list" of one's identities, but to own and recognize how they have shaped the contextual circumstances of the research being conducted, and more specifically, where the data has arrived from and is being interpreted (Braun & Clarke, 2006, 2021b, 2023). In this methodology chapter, I will elaborate on instances of how my positionality has impacted the undertaking of my dissertation's research process (Folkes, 2023). I will also discuss how I engaged in practices of reflexivity.

Positionality

As individuals who exist in navigating complex and interwoven environments, researchers are not passive entities but curators. Within the context of research, there is the dichotomy of "outsider-insider" that has been widely used as a way of recognizing one's social location, or distance, in the context of a research project (Andress et al., 2020; Holmes, 2020; Pechurina, 2014; Zempi, 2016). Some may argue that being an "outsider" is advantageous as it prevents a certain form of bias from permeating the "research" process and promotes a level of objectivity (Andress et al., 2020; Holmes, 2020; Pechurina, 2014; Zempi, 2016). Alternatively, a general criticism of an "outsider" is that they have the potential to misinterpret and potentially cause harm to the population and phenomena being studied due to their distance. The "insider" is sometimes appreciated due to their closeness to the population and phenomena as they would have some form of shared knowledge (Andress et al., 2020; Holmes, 2020; Pechurina, 2014; Zempi, 2016). However, there is the critique that this can pose a threat to confidentiality due to the nature of relationships and also potential judgement. There is the broader assumption that the "outsider-insider" dichotomy flattens how we think of individuals and researchers themselves (Carling et al., 2014). Ryan (2015) contends that reflexivity and identity should be understood as “dynamic rhythms of multi-positionalities” given how various power differentials shape one’s status and identities by both the researcher and researched. Individuals are not exactly homogenous due to an understanding of intersectionality (Bowleg, 2012; Crenshaw, 1991).

As someone who is a racialized individual and an immigrant to Canada, albeit arriving as a dependant when I was young, my experiences of immigration have coloured my life in many ways through the process of racialization. For example, I have experienced differential treatment due to the colour of my skin, my Arabicized name, assumptions made about my Muslim, South Asian heritage, and comments about my ability to speak English. Aspects of this racist and xenophobic othering have manifested throughout my own interactions with the “mental health” system and also academia, as this has consequently shaped my assumptions and interrogations of research being done within this domain. For example, having a predominately white dissertation committee at a point in time produced a dynamic where I experienced limitations when trying to explain my connections to the work and analyses via understandings that emerge from personal and lived experience of racism and systemic racism.

My point of curiosity to this field of work comes from being grieved and frustrated with the lack of equitable, appropriate, and affordable mental healthcare services in Ontario. In relation to personal areas of concern, a goal of this dissertation was to understand the contexts of suffering for racialized immigrants seeking mental health supports. These are matters I have contended with in my own lived and personal experience. Being racialized and at a point in time being a non-citizen is something my participants and I share, and also are the two most important areas of exploration for my dissertation. Carling and colleagues (2014) describe how researchers such as myself engaging in migration related topics occupy a unique “third position” status through the fluidity of our identities rather than relying on strict dichotomies that centre differences. There were definite examples of “sameness” identified with my participants as they sometimes said phrases such as “it is so common with people like us, you know this” or “I’m sure you know what it’s like – I don’t have to explain more than I need to” when sharing a point about how racialized immigrants to Canada find it hard to find a mental healthcare provider who could understand certain aspects to mental health or their own circumstances tied to migrating into a new country. I often replied with asking them if they could still explain it to me as I may not be able to fully appreciate their experiences and foreclose conversation around the topic. There are experiences that I cannot relate to or begin to comprehend due to my social distance with certain identities; however, I can deeply empathize with participants’ experiences and listen intently without judgment. Based on my personal experiences with the “mental health” system as briefly described above, I have some assumptions carried over when interacting with my participants who are mental healthcare providers. Aside from my own experiences, I do reflect on the experiences of those within my communities and loved ones. As I was going to pursue this field myself through being accepted into a doctorate program in Clinical Psychology and my intentions were to work with racialized immigrant clients, I was aware of specific challenges particular to racialized immigrants that existed in the profession itself. However, I did not impose my ideas during the interviews with both set of participants and instead just left it as a space for exploration by letting my participants setting the tone.

Recruitment and Data Collection

My dissertation was self-funded which limited the number of individuals I could recruit without it becoming too expensive for me personally while keeping in mind that I had a limited graduate stipend which did not cover my basic living expenses. Researchers such as myself who come from financially precarious backgrounds (e.g., lack of a permanent job position, supporting family, my finances going towards medical needs), this key aspect shapes how financial decisions are made related to the undertaking of a research project. For example, hiring a translator becomes difficult for me with my dissertation given the population of interest. Therefore, as part of my criteria for my service user participants, I had explicitly written that they must feel comfortable having a conversation in English. This approach of framing departs from typical language standardization requirements that are based on testing (e.g., IELTS or English as Second Language) as they can be dehumanizing, and quite frankly, racist. The legitimacy of language "fluency" is something that needs to be questioned as it reinforces deficit-based ideas of racialized immigrants in the context of research (Gibb & Danero Iglesias, 2017; Perry, 2011).

Another point of consideration related to funding was the selected form of compensation for both participant groups. Compensation must be meaningful and worthwhile for participants and considered to be non-coercive, meaning that participants should not feel that they are losing out on something majorly financial if not participating (Head, 2009). However, given the time when interviews took place, a global pandemic was occurring which had devastating financial impacts on individuals, it could not be understated that any amount of financial support becomes helpful to an individual. I decided that my service user participants would each receive $20 e-gift cards to any place they wished, and my service provider participants would get a $10 e-gift card to Tim Hortons. For my service user participants, $20 was selected solely because it is considered to be the suggested "livable wage" in Ontario, with a range from $18.65 in

Southwestern Ontario to $25.05 in the Greater Toronto Area (Ontario Living Wage Network, 2023). Interviews were to last up to an hour and thirty minutes for both sets of participants. These e-gift cards were sent to participants' emails once the interviews were completed. As aligned with my university's ethics boards' requirements, participants could receive the compensation even if they did not complete the interviews entirely.

Specific details related to participant eligibility and selection can be found in my dissertation's separate chapters. This dissertation received approval from Hamilton's Integrated Research Ethics Board (HiREB) for its two studies (#13736 and #13739). Recruitment of the participants was done digitally through my own personal channels and professional networks. For example, I relied on my professional network which included an affiliation with a Canadian university research centre that focused on refugees and immigrants – York University's Centre for Refugee Studies. Information about my studies were distributed through their listservs, which included an approved script and posters. Digital flyers of my two studies were shared with my personal channels across WhatsApp and other social media platforms. My social capital and relationships within the communities I occupy, either professionally or personally, is a key factor which helped facilitate recruitment.

The interview guide was structured in a linear fashion, starting off with introductions and providing a clear roadmap of what is to be expected by a breakdown of the topics that will be discussed. The participant's rights based on HiREB's guidelines were also iterated, and participants were then given an opportunity to ask any questions regarding the interview or consent form before starting. In the introductions, I stated why I was undertaking this research and also shared aspects of my positionality (e.g., when I came to Canada and what my ethnic background was) to help situate the conversation and to establish that this topic being discussed is personal to me. I felt that disclosing details about my background were important in building relationships with my participants as it helped them understand why I was pursuing this topic, and more specifically, who I am beyond my academic credentials to dispel a notion of "professionalism" that is often important within academic settings (Folkes, 2023; Reyes, 2020). In conducting the actual interviews, participants were provided opportunities for breaks after every section was completed. During each interview, I would take handwritten field notes into a notebook that I had, and these notes captured key ideas and quotes said by the participants that stuck out to me. The use of field notes for data collection has been offered as a usual practice in participant observation studies, but also during qualitative studies that involve direct interviews (Emerson et al., 1995, 2001). In acknowledging that the topics of discussion could be distressing, I paid close attention to the tone of voice and pauses of the participants. Silence illuminates a story as much as words accent an account being shared; therefore, highlighting the inherent value of silence as a process of storytelling (Kawabata & Gastaldo, 2015; Poland & Pederson, 1998). Ahead of time of the interview, a resource list of free to access social and wellness resources in Ontario were compiled and provided to participants. In some cases, when I felt if things were becoming too "heavy," I would check in after the participant had paused after speaking to ask them if they were doing okay and would like to take a break. Holding space in an online context is extremely difficult, specifically one where the individuals are not visible (Salam et al., 2021). Throughout the interview, I would paraphrase back to my participants what they had shared to me in order to make sure of two things: that I understood them correctly and to also give them space to potentially further detail their answers. After every interview was complete, a summary of the participant's experiences was written in my notebook along with some areas of introspection. I paid attention to how participants' experiences echoed my own or diverged based on differences of context (e.g., resources, issues at hand, or life circumstances) as an approach to practise reflexivity.

When it came to the actual interviews with both participant sets, they were conducted via Zoom which is a videoconferencing platform approved by HiREB. For providing more privacy to participants and also being mindful of internet connectivity issues, the interviews were audio only with the video turned off. This was appreciated by participants as they remarked they could take care of some chores around their space as we spoke or that they did not feel awkward when talking about "deep" topics. All interviews were recorded by Zoom's built-in feature. However, it is important to note that while Zoom is an approved platform through HiREB, there are complications posed to maintaining privacy especially for individuals who have more precarious legal statuses (Salam et al., 2021). Because Zoom recorded the interviews, it automatically transcribed the interviews as they were uploaded into the platform's cloud. The auto transcription feature is not entirely accurate as it had mistakes due to audio errors that may potentially arise from accents or processing delays, and therefore it was not a key component I relied on for my analysis. Transcriptions of interviews are a key resource for data for many qualitative researchers, and different approaches are taken depending on one's preferences and goals. Some researchers produce literal transcriptions of interviews while others include contextual details, such as pauses, emphasizing on certain words, or patterns of intonation. Additionally, approaches to transcription can "sanitize" participants' shared accounts through correcting grammar, "whitewashing" accents, and removing stuttering which lends into problematic reconstructing of events and expressions (Oliver et al., 2005; Witcher, 2010). While I did not go back to every interview and transcribe it individually word for word, I kept summaries as described in the previous paragraph which centred key ideas, themes, topics, and quotes. I would re-listen to interviews in entirety when going through my analysis process and rely on my notes as they held information that I believed was more important to me in understanding my participants' experiences given what they decided to emphasize in their accounts (Emerson et al., 1995, 2001). Given my participants and language considerations, I felt that I would remain closer to the data if I relied on the raw audio of the interviews and my interview notes/summaries rather than having a set of "clean" transcripts to use as traditionally qualitative researchers have done (Nascimento & Steinbruch, 2019; Point & Baruch, 2023). This also lends into aspects of upholding rigour in qualitative practise, as transcripts can impose certain assumptions by removing details as described above (Davidson, 2009; Nascimento & Steinbruch, 2019; Point & Baruch, 2023; Witcher, 2010). More on the analysis will be described below.

Analysis

RTA involves a six-phase process for analyzing the data. Braun & Clarke (2006, 2021b) describe this as a "process" rather than a set of "steps" to demonstrate that it is not a linear approach due to the nature of it. Here, I will elaborate on the six phases of the analytic process and provide examples of how I undertook this by engaging with the data for the two different studies.

1. Familiarizing yourself with the dataset

This involves going back to the data and acquainting oneself with it by reading and re-reading it. In my circumstance, this included me re-reading my interview notes and summaries and then listening to the entirety of the interviews over again and making more notes (Witcher, 2010). I would also pay attention to the tone, pauses, and general emotion of the interviews as I re-listened to help situate me into the environment again (Emerson et al., 1995, 2001). These notes would include me reflecting on what I had initially written down during the interviews or adding further things I did not pick up or attend to during the interview process. As a process of reflexivity, I asked myself questions, such as: how is their experience different from mine? Is this something they felt comfortable sharing based on our shared identities? How else could this data be interpreted if I was closer to their circumstances (e.g., being an international student, asylum claimant, or a psychotherapist)? Am I losing out on understanding things because I am so far removed? Have I heard similar stories shared by people with my communities? These questions when re-engaging with the interviews/data were important as it helped me identify potentially new insights that I did not have when initially doing the interviews (Braun & Clarke, 2021a, 2023).

2. Coding

In the "coding" process, this involves going through the data (e.g., transcripts and notes) and identifying segments that are relevant to understanding the research questions being explored. While related processes of coding such as having pre-defined codes, or a codebook, is not appropriate and discouraged by Braun & Clarke for engaging with their RTA approach because it comes from a positivist lens, coding is not atheoretical (Braun & Clarke, 2021a). This meant that ideas related to the guiding theoretical and conceptual framework along with my own biases impacted the determination of what was a segment of data that was relevant to the research question or interest. I would go through my interview notes and summaries and pick out broader "codes" that were identified by applying code labels that helped me make sense of the data presented. I coded every interview individually and noted if related code labels were being identified in other interviews through my interpretation of the conversations. Without risking analytic foreclosure of relying on making sure that the data fits with the conceptual frameworks being utilized given that a deductive RTA approach was used, I focused on emphasizing unanticipated findings (Braun & Clarke, 2021b, 2023).

3. Generating initial themes

As the popular adage by Braun & Clarke (2006, 2021b) goes, "themes do not emerge," and this is demonstrated by how themes are generated within RTA as the researcher is an active agent in producing knowledge through their analyses and interpretation of the data (Braun & Clarke, 2021a, 2021b, 2023). In this stage of the RTA process, I compiled the clusters of codes across the interviews that I identified. I paid attention to contradictions between individuals' experiences as well as similarities to help produce a spectrum of insights which would lead to a deeper understanding of the issue being interrogated. In this process, I developed a chart on a word document which had the overarching codes mapped into "candidate themes" which I generated by determining how this helped explore the research question. The goal was not to simply generate a list of "candidate themes" through the identified codes, but also to pay attention to how these "candidate themes" represented the research question by capturing broad shared meanings.

4. Developing and reviewing themes

In this stage of the process for RTA, the previous "candidate themes" are scrutinized by going back to the entire data set and determining whether they still apply. Within this process, some of the "candidate themes" were collapsed into others because of the shared meanings between them or were broken down further into other themes. The main aim of this stage is to reengage with the data set and be flexible enough in order to determine if the theme's central organizing concept is valid. Additionally, the relationships between certain "candidate themes" is drawn in order to show the scope of what is being identified through the research question. Overall, in this process I paid attention to how these "candidate themes" helped further shape the narrative or were providing meaningful insight into the data. I asked questions to myself, for example: does this overlap with what is currently known in the literature? Is this something that is under stated within the literature and is not given enough focus in academia given dominating frameworks and is shared amongst mental health or immigration activist organizations? Is this "candidate theme" dimensional enough to encompass a central organizing concept? Have I heard about these similar experiences from individuals in my own life who are in similar circumstances?

5. Refining, defining, and naming themes

As this stage is titled, this is exactly what had happened. I took a week long break and then returned to the data once with fresh eyes to refine my analyses. During this break, I had conversations with my friends and loved ones about what I found through the data so far by giving them high level summaries. Their feedback was important to me because they were racialized and also immigrants, two identities which deeply contributed to the introspection I was undertaking as I returned to the data. I found their insights very important as it helped further contextualize the information I had been given by speaking with my participants. I also attended lectures and workshops that were being delivered by other racialized researchers on topics similar to what I was examining. I also shared my findings to my committee members during committee meetings to receive feedback and their thoughts. Then after re-engaging with the data with the feedback and notes I had taken from conversations with my friends, I worked with the data until I felt it was exhaustive, the time to polish up the themes by refining, defining, and naming them arrived. In this stage, the boundaries of themes were identified, and clear demarcations were made by writing up short summaries of what the themes did and did not mean. This process helped to refine themes which had "fuzzier" boundaries based on my interpretations. In returning to the word document chart, this involved producing a concise set of sentences which provided an overview of the theme along with examples of quotes which demonstrated the theme. The final "candidate themes" were then given relevant names which summarized the central organizing concept.

Rigour

As a way of understanding, the process of "triangulation" has been contested by Braun & Clarke (2023) for RTA as it has origins in positivism and often has been used as a process to derive a singular truth. RTA acknowledges that there are multiple truths out there, and therefore crystallization is an approach for facilitating rigour as it draws from various sources of data, theoretical frameworks, and methods (Tracy, 2010). Within this dissertation, two studies are being conducted to understand from different participant populations and the questions being posed converge to examine certain topics (e.g., barriers and facilitators to care). Additionally, as a key point of crystallization, both studies rely on similar conceptual frameworks, but are united through a key theme: to understand a study population's experiences when seeking out services. Therefore, crystallization provides conceptual coherence to support the rigour of this dissertation's undertakings. The traditional ideas of generalizability as a method for determining rigor does not apply within qualitative research methodologies, especially one that is from the constructivist paradigm (Braun & Clarke, 2023).

However, transferability is another concept which applies instead and this centres on how the research findings transfer to similar contexts (Tracy, 2010). In further iterating methodological rigour, Lincoln and Guba's notion of trustworthiness through the four criteria of credibility, transferability, dependability, and confirmability were demonstrated (Guba & Lincoln, 1994; Lincoln & Guba, 1985). For credibility, there were instances of "peer debriefing" with my friends who were detached from my research area but had similar lived experiences to the ones that were being explored as part of my research questions (Guba & Lincoln, 1994; Lincoln & Guba, 1985). I also engaged with my doctoral advisor and committee members in discussing the findings, albeit they are "experts," their feedback still provided important verification of what I was encountering through interviews (Guba & Lincoln, 1994; Lincoln & Guba, 1985). For transferability, my findings were written with "thick descriptions" to allow a reader to understand their situation (Guba & Lincoln, 1994; Lincoln & Guba, 1985). This included details about their gender identity, economic background, and even their feelings. For dependability, I made sure to ask my participants all of the research questions even though they may have provided the answer to a question which would have been answered later in the sequence of the interview (Guba & Lincoln, 1994; Lincoln & Guba, 1985). This was to ensure that there was standardization of the interview protocol across all research participants. Lastly, for confirmability, I actively documented my reflexivity throughout this entire dedicated methods section and within my interview notes in order to understand how my own experiences shaped the findings (Guba & Lincoln, 1994; Lincoln & Guba, 1985). This is expected and aligned with the RTA step of refinement of themes (Braun & Clarke, 2021b, 2023).

6. Writing it up

While considered to be the last “stage” of the process, this did not mean that returning back to the data was impossible. In RTA, Braun & Clarke advise going back to the data at this stage and seeing if there was anything missing that could help the broader narrative developing through the identified themes (Braun & Clarke, 2006, 2021b). This included returning to my initial interview summary and analysis notes. When I was satisfied with the themes, I refined the chart of central themes and sub themes and included examples of data extracts (i.e., quotes from participants) to help provide examples when writing my analyses and interpretations. The goal of this process is to provide an analysis of the themes along with conclusions that centre on supporting them and further enriching the research question. At this stage, my written findings were forwarded to my broader committee to receive feedback.

References

Andress, L., Hall, T., Davis, S., Levine, J., Cripps, K., & Guinn, D. (2020). Addressing power dynamics in community-engaged research partnerships. *Journal of Patient-Reported Outcomes*, *4*(1), 24. https://doi.org/10.1186/s41687-020-00191-z

Bowleg, L. (2012). *The problem with the phrase women and minorities: Intersectionality-an important theoretical framework for public health.* https://doi.org/10.2105/AJPH.2012.300750

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021a). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352.

Braun, V., & Clarke, V. (2021b). *Thematic Analysis: A Practical Guide*. SAGE Publications. https://books.google.ca/books?id=eMArEAAAQBAJ

Braun, V., & Clarke, V. (2023). Toward good practice in thematic analysis: Avoiding common problems and be (com) ing a knowing researcher. *International Journal of Transgender Health*, *24*(1), 1–6.

Carling, J., Erdal, M. B., & Ezzati, R. (2014). Beyond the insider–outsider divide in migration research. *Migration Studies*, *2*(1), 36–54. https://doi.org/10.1093/migration/mnt022

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, *43*(6), 1241–1299. https://doi.org/10.2307/1229039

Davidson, C. (2009). Transcription: Imperatives for qualitative research. *International Journal of Qualitative Methods*, *8*(2), 35–52.

Doyle, L., McCabe, C., Keogh, B., Brady, A., & McCann, M. (2020). An overview of the qualitative descriptive design within nursing research. *Journal of Research in Nursing*, *25*(5), 443–455.

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (1995). Processing fieldnotes: Coding and memoing. *Writing Ethnographic Fieldnotes*, 142–168.

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (2001). Participant observation and fieldnotes. *Handbook of Ethnography*, 352–368.

Folkes, L. (2023). Moving beyond 'shopping list'positionality: Using kitchen table reflexivity and in/visible tools to develop reflexive qualitative research. *Qualitative Research*, *23*(5), 1301–1318.

Gibb, R., & Danero Iglesias, J. (2017). Breaking the silence (again): On language learning and levels of fluency in ethnographic research. *The Sociological Review*, *65*(1), 134–149. https://doi.org/10.1111/1467-954X.12389

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of Qualitative Research*, *2*(163–194), 105.

Head, E. (2009). The ethics and implications of paying participants in qualitative research. *International Journal of Social Research Methodology*, *12*(4), 335–344. https://doi.org/10.1080/13645570802246724

Holmes, A. (2020). Researcher Positionality—A Consideration of Its Influence and Place in Qualitative Research—A New Researcher Guide. *Shanlax International Journal of Education*, *8*, 1–10. https://doi.org/10.34293/education.v8i4.3232

Kawabata, M., & Gastaldo, D. (2015). The less said, the better: Interpreting silence in qualitative research. *International Journal of Qualitative Methods*, *14*(4), 1609406915618123.

Kim, H., Sefcik, J. S., & Bradway, C. (2017). Characteristics of qualitative descriptive studies: A systematic review. *Research in Nursing & Health*, *40*(1), 23–42.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry. Newberry Park*.

Nascimento, L. da S., & Steinbruch, F. K. (2019). "The interviews were transcribed", but how? Reflections on management research. *RAUSP Management Journal*, *54*, 413–429.

Oliver, D. G., Serovich, J. M., & Mason, T. L. (2005). Constraints and opportunities with interview transcription: Towards reflection in qualitative research. *Social Forces*, *84*(2), 1273–1289.

Ontario Living Wage Network. (2023). *Calculating Ontario's Living Wages*. https://assets.nationbuilder.com/ontariolivingwage/pages/110/attachments/original/1699276527/Calculating_Ontario's_Living_Wages_-_2023.pdf?1699276527

Pechurina, A. (2014). Positionality and Ethics in the Qualitative Research of Migrants' Homes. *Sociological Research Online*, *19*(1), 111–120. https://doi.org/10.5153/sro.3208

Perry, K. H. (2011). Ethics, Vulnerability, and Speakers of Other Languages: How University IRBs (Do Not) Speak to Research Involving Refugee Participants. *Qualitative Inquiry*, *17*(10), 899–912. https://doi.org/10.1177/1077800411425006

Point, S., & Baruch, Y. (2023). (Re) thinking transcription strategies: Current challenges and future research directions. *Scandinavian Journal of Management*, *39*(2), 101272.

Poland, B., & Pederson, A. (1998). Reading between the lines: Interpreting silences in qualitative research. *Qualitative Inquiry*, *4*(2), 293–312.

Reyes, V. (2020). Ethnographic toolkit: Strategic positionality and researchers' visible and invisible tools in field research. *Ethnography*, *21*(2), 220–240.

Ryan, L. (2015). "Inside" and "Outside" of What or Where? Researching Migration Through Multi-Positionalities. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *16*(2 SE-Researcher, Migrant, Woman: Methodological Implications of Multiple Positionalities in Migration Studies). https://doi.org/10.17169/fqs-16.2.2333

Salam, Z., Nouvet, E., & Schwartz, L. (2021). Reflections of methodological and ethical challenges in conducting research during COVID-19 involving resettled refugee youth in Canada. *Journal of Medical Ethics*, medethics-2021-107291. https://doi.org/10.1136/medethics-2021-107291

Sandelowski, M. (1995). Qualitative analysis: What it is and how to begin. *Research in Nursing & Health*, *18*(4), 371–375. https://doi.org/10.1002/nur.4770180411

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*(4), 334–340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, *33*(1), 77–84. https://doi.org/10.1002/nur.20362

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry*, *16*(10), 837–851.

Witcher, C. S. (2010). Negotiating transcription as a relative insider: Implications for rigor. *International Journal of Qualitative Methods*, *9*(2), 122–132.

Zempi, I. (2016). Negotiating Constructions of Insider and Outsider Status in Research with Veiled Muslim Women Victims of Islamophobic Hate Crime. *Sociological Research Online*, *21*(4), 70–81. https://doi.org/10.5153/sro.4080

Chapter 3: Systemic and individual factors that shape mental health service usage among visible minority immigrants and refugees in Canada: A scoping review

Author Order: Zoha Salam, Odera Odenigbo, Bruce Newbold, Olive Wahoush, Lisa Schwartz

Preface: This chapter explores what is currently known in the literature surrounding the barriers and facilitators experienced by racialized immigrants when accessing mental healthcare services in Canada.

This manuscript was completed between January 2021 and March 2021.

This article has been published in *Administration and Policy in Mental Health and Mental Health Services Research*.

Salam, Z., Odenigbo, O., Newbold, B., Wahoush, O., & Schwartz, L. (2022). Systemic and individual factors that shape mental health service usage among visible minority immigrants and refugees in Canada: a scoping review. *Administration and Policy in Mental Health and Mental Health Services Research*, *49*(4), 552-574.

Contributions

Zoha Salam conceptualized the scoping review study, developed the search syntax and review protocol, screened articles for review as according to guidelines, analyzed the data, wrote the first original draft of the manuscript, and responded to reviewer comments. Odera Odenigbo acted as the second reviewer, helped analyze the data by providing feedback, and helped edit the manuscript. Dr. Bruce Newbold, Dr. Olive Wahoush, and Dr. Lisa Schwartz provided feedback to the findings and edited the draft of the manuscript for clarity.

Declarations

Funding

The authors have no relevant financial or non-financial interests to disclose.

Conflicts of Interest/Competing Interests

The authors have no conflicts of interest to declare that are relevant to the content of this article.

Abstract

Purpose: There exists considerable research which reports that mental health disparities persist among visible minority immigrants and refugees within Canada. Accessing mental health care services becomes a concern which contributes to this, as visible minority migrants are regarded as an at-risk group that are clinically underserved. Thus, the purpose of this review is to explore the following research question: “what are the barriers and facilitators for accessing mental health care services among visible immigrant and refugees in Canada?"

Methods: A scoping review following guidelines proposed by Arksey and O'Malley (2005) was conducted. A total of 45 articles published from 2000 to 2020 were selected through the review process, and data from the retrieved articles was analyzed.

Results: Wide range of barriers and facilitators were identified at both the systemic and individual levels. Unique differences rooted within landing and legal statuses were also highlighted within the findings to provide nuance amongst immigrants and refugees. With the main layered identity of being a considered a visible minority, this yielded unique challenges patterned by other identities and statuses.

Conclusion: The interplay of structural issues rooted in Canadian health policies and immigration laws coupled with individual factors produce complex barriers and facilitators when seeking mental health services. Through employing a combined and multifaceted approach which address the identified factors, the findings also provide suggestions for mental health care providers, resettlement agencies, policy recommendations, and future directions for research are discussed as actionable points of departure.

Keywords: migration, mental health services, barriers, facilitators, visible minority

Systemic and individual factors that shape mental health service usage among visible minority immigrants and refugees in Canada: A scoping review

Introduction

Human movement is impacted by globalization, a process which entails economic, political, and social factors (Castelli, 2018). In the 2016 census report, 21.9% of Canada's population consisted of "immigrants" (Statistics Canada, 2017a). From 2011 to 2016, 1,212,075 new immigrants had settled in Canada, and among those 60.3% were voluntary migrants who came to Canada for work or better economic opportunities (i.e., economic and family class migrants) and 11.6% were refugees (Statistics Canada, 2017a). Canada's demographics are shifting over time, as more than one-fifth of Canada's population belongs to a "visible minority" group, a term used within the Canadian Employment Equity Act to describe those who are "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour" (Statistics Canada, 2017a). This trend is projected to increase, and it is expected that by 2036 one-third of the population will belong to a visible minority group (Statistics Canada, 2017b). In terms of background, the largest visible minority populations in Canada, in order, are those who identify as South Asian, Chinese, and Black (Statistics Canada, 2017a). The aforementioned statistics reflect a very diverse breakdown of Canada's demographics, but also highlights that special attention should be given to a growing population of immigrants and refugees, namely those who belong to a visible minority group (Statistics Canada, 2017b).

Migration itself is a unique process which is influenced by the circumstances of departure; therefore, the experiences of visible minority immigrants and refugees are significantly distinct when it comes to adapting to new life in Canada due to their migration paths (Chimienti, Bloch, Ossipow, & de Wenden, 2019; Lane, Farag, White, Nisbet, &

Vatanparast, 2018; Newbold & McKeary, 2018; Rothe, Tzuang, & Pumariega, 2010). This also includes produced differences in mental health statuses, such as prevalence rates of mental health disorders, and self-evaluations of mental health as well. Refugees are more likely to have post-traumatic stress symptoms and other mental health issues due to pre and peri-migration experiences of persecution, length of stay in a refugee camp, violence, and witnessing armed conflict (Lu & Ng, 2019; Ng & Zhang, 2020). Visible minority immigrants and refugees are considered to be a clinically underserved population and prevalence rates of mental health issues are difficult to properly estimate (Ganann et al., 2020; Lu & Ng, 2019; Newbold & McKeary, 2018; Ng & Zhang, 2020). From a scoping review of articles from 1978 and 2014 conducted by Khan and colleagues (2017), they identified that large gaps in data from national surveys (e.g., Canadian Community Health Survey) have led to discrepancies in such estimates, for example, not delineating between migration classes, generation status, or using visible minority status synonymously with immigration status (Mental Health Commission of Canada, 2016). However, it does remain supported that visible minority immigrants and refugees are less likely to utilize services compared to White Canadians (Chiu, Amartey, Wang, & Kurdyak, 2018; Mental Health Commission of Canada, 2015, 2016; Urbanoski, Inglis, & Veldhuizen, 2017). From a nationally represented study utilizing the Canadian Community Health Survey linked to data from the Longitudinal Immigration Database, Ng and Zhang (2021) found that first generation immigrants along with refugees were less likely to utilize services than those who were second-generation, or Canadian born. However, refugees were more likely to report lower levels of mental health status and also not any more likely to seek out services compared to immigrants. Mental health care service (MHCS) utilization is also varied across groups, as this is influenced by accessibility factors including, but not limited to: awareness of programs available, language proficiency, or financial capacity (Levesque, Harris, & Russell, 2013). This is further layered with individual level factors, such as how conceptualizations of mental health are shaped by one's cultural heritage and environment, and therefore the Canadian context and culture may be considered contrasting and novel to newcomers who potentially may be seeking out MHCS (Pottie et al., 2011; Salami, Salma, & Hegadoren, 2019). Through understanding systemic and individual level factors involved in influencing MHCS utilization, a more targeted approach can be developed to improve access for visible minority immigrants and refugees.

The purpose of this scoping review is to explore the following research question: "*what are the barriers and facilitators for accessing mental health care services among visible immigrants and refugees in Canada?"*

Methods

The scoping review guidelines defined by Arksey and O'Malley (2005) were used for the purpose of this review. Arksey and O'Malley (2005) define the following five steps: identifying the research question, identifying relevant studies, study selection, charting the data, and summarizing the data.

Identifying Relevant Studies

Relevant articles were searched within the following databases: CINAHL (via EBESCO), PsycINFO, Medline, and Embase. A combination of subject headings and keywords appropriate to the selected individual databases were constructed to focus on the four main concepts of barriers and facilitators, mental health, mental health care services, and migrants. Some example keywords included: help-seeking, psychological distress, psychological help, immigrants, and refugees. The full search strategy can be provided upon request. As the geographical context of this scoping review is situated within Canada, keywords and subject headings including the provinces and territories along with major cities were utilized within the search strategy to retrieve locally relevant studies. The search was conducted on January 27th, 2021. All items were imported for review on February 2nd, 2021.

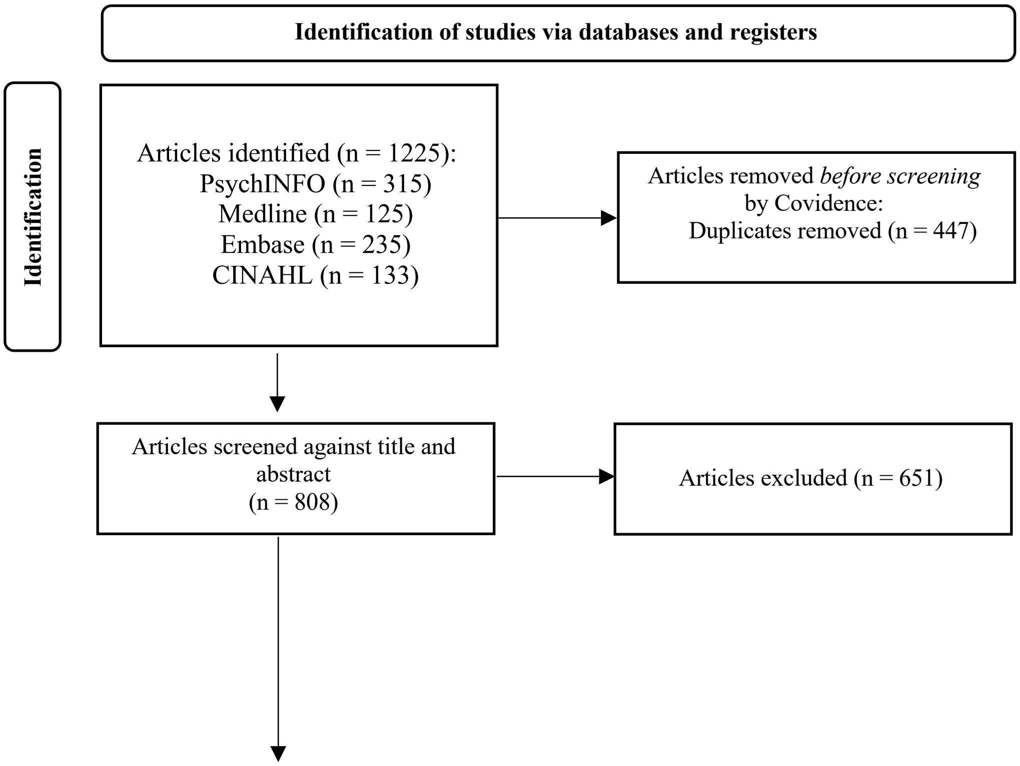
Inclusion criteria included the following: anywhere in Canada; focusing on either refugees and/or immigrants; discusses *either* mental health care providers' or users' experiences, self-reports, or ratings relating to barriers or facilitators of accessing and utilizing MHCS; peer-reviewed items; and written in English.

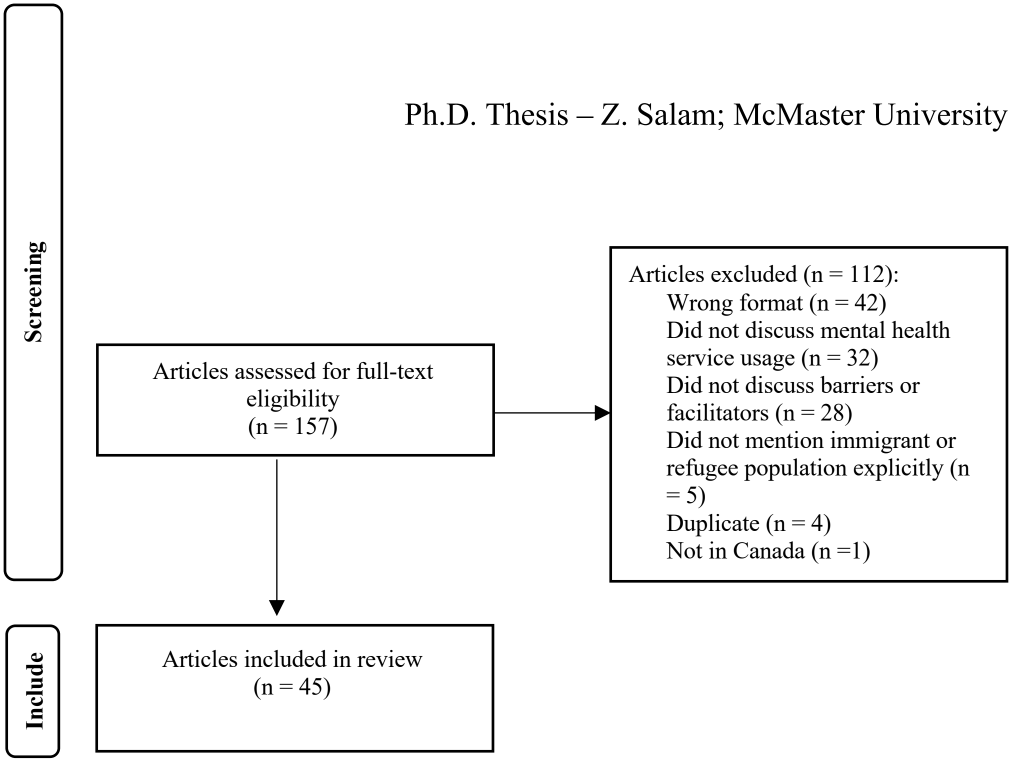
Exclusion criteria included: theses and dissertations; conference papers and supplements; reviews (systematic, meta-analyses, scoping, etc.); and book chapters.

Study Selection

Citations were imported into an online reference manager, Covidence, and were then screened for eligibility. Title and abstracts of the retrieved articles were screened and selected for full text review by both ZS and OO. Figure 1 provides the PRISMA diagram which details the literature search process and selection flow.

Figure 1. PRISMA study selection flow chart





Charting The Data

The remaining articles were extracted for relevant information by ZS into a Microsoft Excel sheet. Data from the following categories was noted: Title of study, author(s), year of publication, province, number of participants, focus group, migration class, and aim of the study. Details are presented in Table 1.

Table 1

Description of Selection Sources for Review

Title	Authors	Year of publication	Province	Number of participants	Demographics	Target group	Aim of the study	Methodology
Using the cultural formulation to resolve uncertainty in diagnoses	Adeponle et al.	2012	Quebec	N = 323	Afro-Caribbean, African, East Asian, Southeast Asian,	Refugee & Immigrant	To explore factors associated with change in psychotic disorder diagnosis	Quantitative - cross-sectional survey

of psychosis among ethnoculturally diverse patients					and South Asian, Hispanic, & Middle Eastern			
Interactive mental health assessments for Chinese Canadians: A pilot randomized controlled trial in nurse practitioner-led primary care clinic	Ahmad et al.	2020	Ontario	N = 50	Chinese	Immigrant	Exploring the outcomes of an interactive computer-based survey that focuses on mental health issues	Mixed methods - randomized control trial & interviews
Maternal depression in Syrian refugee women recently moved to Canada: A preliminary study	Ahmed et al.	2017	Saskatchewan	N = 12	Syrian	Refugees	To explore experiences of maternal depression and accessing mental health services	Mixed methods - focus group and survey
Experiences of immigrant new mothers with symptoms of depression	Ahmed et al.	2008	Ontario	N = 10	Chinese, Indian, Pakistani, Egyptian, Haitian, and South	Refugee & Immigrant	To explore experiences of managing post-partum depression	Qualitative - semi-structured interviews

					American			
Examining the impact of migrant status on ethnic differences in mental health service use preceding a first diagnosis of schizophrenia	Anderson et al.	2017	Ontario	N = 2607	African, Caribbean, South Asian, East Asian, Latin American, North African & Middle Eastern	Immigrants	To explore the effects of ethnic group and migrant status on pattern of health service use preceding a first diagnosis of schizophrenia	Quantitative - cross-sectional survey
Pathways to first-episode care for psychosis in African-, Caribbean-, and European-origin groups in Ontario	Anderson et al.	2015	Ontario	N = 81	Black-African & Black-Caribbean	Immigrant	To explore and compare the pathways to care and duration of untreated diagnosis for Black Canadian groups within first-episode psychosis	Quantitative - cross-sectional survey
Incidence of psychotic disorders among first-generation immigrant	Anderson et al.	2015	Ontario	N = 418 433	Every group	Refugee & Immigrant	Explore the incidence of schizophrenia and related disorders	Quantitative - retrospective cohort

s and refugees in Ontario							within first-generation immigrants and refugees	
Black African newcomer women's perception of postpartum mental health services in Canada	Baiden & Evans	2020	Ontario	N = 10	Sub-Saharan African	Immigrant	To explore sociocultural factors that impact newcomer Black women's perception of mental health and mental health service utilization	Qualitative - semi-structured interviews
The Crying Clinic: Increasing accessibility to Infant Mental Health services for immigrant parents at risk for peripartum depression	Bohr et al.	2021	Ontario	N = 44	Southeast Asian, South Asian, East Asian, West Asian, & Caribbean	Immigrants	To explore barriers and facilitators for infant mental health programs	Quantitative - cross-sectional survey
Willingness to use mental health services for depression	Boukpessi et al.	2021	Quebec	N = 262	African	Immigrant	To explore the willingness of African immigrants in	Quantitative - cross-sectional survey

among African immigrants and White Canadian-born people in the province of Quebec, Canada							Canada to seek help for depression	
Cultural brokers' role in facilitating informal and formal mental health supports for refugee youth in school and community context: a Canadian case study	Brar-Josan & Yohani	2019	Alberta	N = 4	Educational cultural brokers	N/A	How cultural brokers facilitate access to mental health care for refugee youth	Qualitative - semi-structured interviews
Language barriers in mental health care: A survey of primary care practitioners	Brisset et al.	2014	Quebec	N = 113	Primary mental health practitioners	N/A	To explore mental health practitioners' experiences with linguistic diversity among migrant clients	Quantitative - cross-sectional survey

Wellness centre: an evidence-guided approach to delivering culturally relevant community psychogeriatric services for Chinese elders	Chan & Sadavoy	2012	Ontario	N = 333	Chinese	Immigrant	To explore how a culturally sensitive service delivery model improves access to care	Quantitative - program evaluation
Why do Chinese Canadians not consult mental health services: Health status, language or culture?	Chen et al.	2009	British Columbia	N = 1084	Chinese	Immigrant	To explore how demographic and health factors that significantly affect likelihood to consult mental health services	Quantitative - cross-sectional survey
Determinants of mental health consultations among recent Chinese immigrants in British Columbia, Canada: implicatio	Chen et al.	2008	British Columbia	N = 152,184	Chinese	Immigrant	To explore how various social determinants of health influence mental health care utilization	Quantitative - cross-sectional survey

ns for mental health risk and access to services								
Exploring community capacity: Karen refugee women's mental health	Clark	2018	British Columbia	N = 12 & N= 26	Karen & Community health and social service providers	Refugee	The experiences of Karen refugee women and how social structural factors influence their mental health and well-being during resettlement.	Qualitative - ethnographic field observation, semi-structured interviews, and focus groups.
If I was going to kill myself, I wouldn't be calling you. I am asking for help: Challenges influencing immigrant and refugee women's mental health	Donnelly et al.	2011	Alberta	N = 10	Chinese & Sudanese	Refugee & Immigrant	To understand the mental health care experiences of factors that shape coping among immigrant and refugee women	Qualitative - Interviews

Perceptions and understandings of mental health from three Sudanese communities in Canada	Este et al.	2017	Canada wide	N = 32	Sudanese	Refugee	To explore the perceptions and understandings of mental health and illness	Qualitative - semi-structured interviews
Mental health service utilization by Ethiopian immigrants and refugees in Toronto	Fenta et al.	2007	Ontario	N = 342	Ethiopian	Refugee & Immigrant	To examine Ethiopian migrants' mental healthcare service use patterns	Quantitative - cross-sectional survey
Factors influencing attitudes towards seeking professional help among East and Southeast Asian immigrant and refugee women	Fung & Wong	2007	Ontario	N = 1000	Chinese, Korean, & Vietnamese	Refugee & Immigrant	To examine the relationship of causal beliefs, perceived service accessibility and attitudes towards seeking mental health care	Quantitative - cross-sectional survey

Influence of maternal birthplace on postpartum health and health services use	Ganann et al.	2012	Ontario	N = 1045	N/A	Immigrants	To explore the differences in health status, rates of post-partum depression, perceptions of health services, unmet service needs, and barriers to service use among migrant women in Canada	Quantitative - cross-sectional survey
Influences on mental health and health services accessibility in immigrant women with post-partum depression: An interpretive descriptive study	Ganann et al.	2020	Ontario	N = 11	Bangladeshi, Chinese, Colombia, Indian, Jamaican, Pakistani, Filipino, and Sudanese	Immigrant	To explore factors that contribute to post-partum depression and the role of health services in supporting immigrant women with post-partum depression	Qualitative - interviews

Help seeking of immigrant and native born parents: a qualitative study from a Montreal child day hospital	Guzder et al.	2013	Quebec	N = 20	N/A	Immigrant	To explore immigrant and non-immigrant parents in their help-seeking experiences for their children with severe childhood mental health disorders	Qualitative - semi-structured interviews
Korean-Canadian immigrants' help-seeking and self-management of suicidal behaviours	Han & Oliffe	2014	British Columbia	N = 15	Korean	Immigrant	To explore help-seeking and self-management for suicidal behaviours	Qualitative - semi-structured interviews
Mental health consultation among Ontario's immigrant populations	Islam et al.	2018	Ontario	N = 3995	N/A	Immigrant	To explore the prevalence rates and characteristics associated with mental health consultation between immigrants and Canadian-born individuals	Quantitative - cross-sectional survey

The role of Afro-Canadian status in police or ambulance referral to emergency psychiatric services	Jarvis et al.	2005	Quebec	N = 351	Afro-Canadian & Asian Canadian	Immigrant	To explore the differences between ethnicity in pathways to emergency psychiatric services	Quantitative - cross-sectional survey
Facilitating mental health support for LGBT forced migrants: A qualitative inquiry	Kahn et al.	2018	Canada wide	N = 22 & N = 7	Service providers & Bahamian, Bangladeshi, Iranian, Lebanese, Middle Eastern, and Ghanaian	Refugee	To explore facilitators and barriers to mental health care in Canada	Qualitative - semi-structured interviews
Promoting the wellbeing of lesbian, gay, bisexual and transgender forced migrants in Canada: Providers' perspectives	Kahn et al.	2017	Canada wide	N = 22	Service providers (lawyers, advocates, and mental health practitioners)	N/A	To explore the challenges that service providers face when working with this group	Qualitative - interviews

Effects of service barriers on health status of older Chinese immigrants in Canada	Lai & Chau	2007	Canada wide	N = 2,214	Chinese	Immigrant	To explore the barriers associated with mental health service usage	Quantitative - cross-sectional survey
Defining mental illness and accessing mental health services: Perspectives of Asian Canadians	Li & Browne	2000	British Columbia	N = 60	Chinese, Indian, & Filipino	Immigrant	To explore how the definition and meaning of mental illness relates to barriers Asian Canadians find in accessing mental health services	Qualitative - semi-structured interviews
Cultural background and socioeconomic influence of immigrant and refugee women coping with postpartum depression	O'Mahony et al.	2013	Alberta	N = 30	Latin America, East Asian, Middle Eastern, and South Asian	Refugee & Immigrant	To explore how sociodemographic variables influence how immigrant and refugee women seek help to manage post-partum depression	Qualitative - semi-structured interviews

How does gender influence immigrant and refugee women's postpartum depression help-seeking experiences?	O'Mahony & Donnelly	2013	Alberta	N = 30	Latin American, South Asian, Middle Eastern, African, and East Asian	Refugee & Immigrant	To explore how sociocontextual factors shape how migrant women seek help for post-partum depression	Qualitative - semi-structured interviews
Barriers and facilitators of social supports for immigrant and refugee women coping with postpartum depression	O'Mahony et al.	2012	Alberta	N = 30	Central and South American, Chinese, Middle Eastern, and South Asian	Refugee & Immigrant	To explore how contextual factors shape how immigrant and refugee women seek help	Qualitative - semi-structured interviews
The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers	O'Mahony & Donnelly	2007	Alberta	N = 7	Health care providers	N/A	To explore health care providers' concerns about immigrant women's mental health and how they access mental health care.	Qualitative - semi-structured interviews

Health care providers' perspective of the gender influences on immigrant women's mental health care experiences	O'Mahony & Donnelly	2007	Alberta	N = 7	Health care providers	N/A	To explore health care providers' concerns with immigrant women's mental health care experiences	Qualitative - semi-structured interviews
Mental health needs of visible minority immigrants in a small urban center: Recommendations for policy makers and service providers	Reitmanova & Gustafson	2009	Newfoundland & Labrador	N = 8	N/A	Immigrants	To understand barriers and facilitators associated with mental health care access	Qualitative - semi-structured interviews
Primary mental health care information and services for St. John's visible minority immigrants: gaps and opportunities	Reitmanova & Gustafson	2009	Newfoundland & Labrador	N = 8	N/A	Immigrant	To explore opportunities for improving access to primary mental health care services	Qualitative - semi-structured interviews

Interdisciplinary case discussions as a training modality to teach cultural formulation in child mental health	Rousseau et al.	2020	Quebec	N = 154	Mental health clinicians	N/A	To explore the impacts of a new training program to enhance cultural competency when working with children	Qualitative – focus groups
Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers	Salami et al.	2019	Alberta	N = 53	Immigrant service providers	N/A	To explore immigrant service providers' perceptions of access to and use of mental health services for immigrants and refugees	Qualitative - interviews and focus groups
Newcomers’ health in Brantford and the counties of Brant, Haldimand and Norfolk: perspectives of newcomers and service providers	Sethi	2013	Ontario	N = 212 / N = 237	Service providers / Immigrants & Refugees	Refugee & Immigrant	To explore how service providers and migrant's perceptions of barriers to care compare	Mixed methods - survey design & interviews

Taking culture seriously: Ethnolinguistic community perspectives on mental health	Simich et al.	2009	Ontario	N = 185	Latin American, Chinese, Polish, Punjabi Sikh, and Somali	Immigrant	To explore community perspectives on concepts of mental health, mental illness and mental health experiences	Qualitative - focus groups
The impact of policy changes on the health of recent immigrants and refugees in the inner city. A qualitative study of service providers' perspectives	Steele et al.	2002	Ontario	N = 10	Service providers	N/A	To explore service providers' opinions about the impact of policy changes	Qualitative - semi-structured interviews
Healthcare worker's perceptions of barriers to care by immigrant women with postpartum depression: An exploratory	Teng et al.	2007	Ontario	N = 16	Healthcare workers	N/A	To explore healthcare workers' experiences of providing care to immigrant women suffering from post-partum depression	Qualitative - semi-structured interviews

qualitative study								
Mental health help-seeking attitudes, utilization, and intentions among older Chinese immigrants in Canada	Tieu & Konnert	2014	Alberta	N = 149	Chinese	Immigrant	Assessing how demographic factors and Chinese cultural beliefs impact mental health help-seeking	Quantitative - cross-sectional survey
Understanding immigrants' reluctance to use mental health services: A qualitative study from Montreal	Whitley et al.	2006	Quebec	N = 15	West Indian	Immigrant	To explore factors that contribute to the underuse of mental health services	Qualitative - interviews

Summarizing The Data

The data was analyzed through narrative synthesis, similar to Arksey and O'Malley's (2005) approach, to identify key areas and themes while examining the data from the selected articles. Themes were first examined and determined by ZS, and then discussed with OO to validate. See Table 2 for an overview of the themes and their corresponding subthemes.

Table 2

Overview of Findings and Themes

Area	Theme	Subtheme
Structural and Systemic Level Factors	Accessibility	Costs

		Geography Availability of Services Language barriers
	Service providers	Training Discrimination Shared identity Professionalism Holistic care
	Migration class	Precarious legal status Access to healthcare insurance
	Interlocking systems	Pathway to care Trust of medical and legal system
Social and Individual Level Factors	Stigma	Cultural and societal
	Layered identities	Gender identity and sexual orientation Age
	Social networks	Family and community
	Understanding of mental health	Mental health literacy and awareness of services Cultural conceptualizations of mental health Severity and diagnosis

Results

From the search, a total of 45 articles were selected based on the exclusion and inclusion criteria. Two broad categories of barriers and facilitators emerged: systemic and social. Within those, different themes and related subthemes were identified which will be elaborated on. Unless stated otherwise, the term “migrants” within the following results section will refer to both immigrants and refugees due to the overlapping information from the selected papers.

Where appropriate, a distinction will be made between the two broad migration classes to provide further contextualization or demarcate certain differences.

Characteristics of Sources

The years of publication for the articles included ranged from being old as from 2000 to recently as 2020. In terms of location of the studies: four items included samples across Canada and others were from Alberta (9), British Columbia (5), Newfoundland & Labrador (2), Ontario (17), Quebec (7), and Saskatchewan (1). The methodologies of the studies were varied, as this included mixed methods (3), qualitative (25), and quantitative (17). The sources selected focused on a wide variety of sample groups, as there were immigrants (20), migrants (8), refugees (2), both migrants and service providers (3), and service providers (12).

Structural and Systemic Level Factors

Accessibility

Costs. Financial feasibility of paying for MHCS was reported to be one of the barriers associated with MHCS (Reitmanova & Gustafson, 2009a, 2009b; Salami et al., 2019). This is not surprising, as MHCS such as psychotherapy and counselling are not covered within provincial health insurance plans across Canada. For many newly arrived migrants, financial precarity and job insecurity are very common problems (Reitmanova & Gustafson, 2009a). Thus, it is understandable that affordability of MHCS becomes a systemic issue specific to this group. Low-cost or free MHCS provided through community health centers or resettlement agencies were welcomed alternatives, even though some indicated that the quality was somewhat inadequate based on their needs (Salami et al., 2019).

Geography. Location was an important characteristic in accessing appropriate MHCS. Living in metropolitan cities was correlated with having a more ethnically diverse selection of both health and MHCS providers. This increased the likelihood of finding a mental health care provider who was experienced with working with their respective population (Fung & Wong, 2007). Similarly, cities with larger immigrant populations had a variety of settlement agencies and cultural centres, which by extension included community-based resources (Chan & Sadavoy, 2012; Ganann, Sword, Black, & Carpio, 2012). Consequently, location became a barrier in accessing MHCS as those who lived in areas with a smaller population of migrants in general, such as the Maritime provinces, were less likely to find appropriate MHCS or even health care providers who could provide culturally informed or relevant and migrant specific care (Reitmanova & Gustafson, 2009a, 2009b). Another limiting factor was whether the location was easily accessible through public transit and was closer to home. Ganann et al. (2020) detailed that for mothers in particular, making a long trip with young children and handling strollers became a hindrance in seeking services for post-partum depression. Difficulties with transportation were coupled also due to harsh winter weather conditions and physical ailments, such as recovering from a cesarian section (Ganann et al., 2020).

Availability of services. This encompassed a variety of related issues, such as wait times, scheduling, and modalities of MHCS, which became deterrents for both migrant populations. Studies included within this review indicated that a lack of specialized services, such as trauma or culturally informed or relevant, were not widely available (Kahn, Alessi, Kim, Woolner, & Olivieri, 2018; Kahn, Alessi, Woolner, Kim, & Olivieri, 2017; Salami et al., 2019). For women, a lack of baby-sitting or childcare services at locations were concerns as they could not leave their child at home (Salami et al., 2019). The use of telephone service/consultation was a solution for women who did not have access to adequate transportation or access to baby-sitting services, but this was met with mixed results (Ganann et al., 2020; O’Mahony, Donnelly, Bouchal, & Este, 2012). This was a more discrete method which allowed them privacy as they were in the comfort of their home. For others, this was very inconvenient as they could not physically see the provider at the other end and questioned their genuine concern. Additionally, for women who were living in multigenerational homes or joint living arrangements with their in-laws, there was no opportunity for privacy. Salami et al. (2019) found that many migrants work irregular hours, and therefore unable to take time off for appointments. For those who are within precarious low-paying jobs and are also the main source of income for their household, this poses a significant challenge (Salami et al., 2019)

Language barriers. The majority of the studies included within this review indicated that language barriers were a major an obstacle in accessing MHCS. This was predominately in the context of newly arrived migrants, as their English or French language skills were quite limited (Clark, 2018; O’Mahony & Donnelly, 2007b). The availability of a translator becomes an important resource, but Brisset et al. (2014) argues that is dependent on who exactly the individual is (Brisset et al., 2014). For many women within the studies, generally their partner or child translate for them, but this has mixed results as sometimes they could not convey to the health care or MHCS provider an accurate description (Brisset et al., 2014; Clark, 2018; Donnelly et al., 2011). However, through a study conducted by Brisset et al. (2014), translators who were trained professionals specifically within the medical context were an asset for both provider and patient. Many providers did indicate that an unavailability of professional translators was primarily due to financial costs and a lack of training on how to successfully work with them (Brisset et al., 2014).

Service Providers

Training. Several studies within this review indicated that the training, skill sets, and experiences of MHCS providers were important in regard to providing appropriate, culturally informed or relevant, and trauma-informed care for both migrant groups (Chan & Sadavoy, 2012; Reitmanova & Gustafson, 2009b; Sethi, 2013; Simich, Maiter, Moorlag, & Ochocka, 2009). Mainly, cultural competency training was highlighted to be a major concern or an asset (Salami et al., 2019; Sethi, 2013; Teng, Blackmore, & Stewart, 2007). Even though some providers had related training, they still had never worked specifically with refugee clients and their complex needs stemming from trauma (Kahn et al., 2017; Reitmanova & Gustafson, 2009b). Programs which focused on training mental health care providers involved various methods, such as going through vignettes of various scenarios or building further competency with the cultural formulation interview located within the fifth edition of the Diagnostic and Statistics Manual of Mental Disorders (Adeponle, Thombs, Groleau, Jarvis, & Kirmayer, 2012; Ahmad, Wang, Wong, & Fung, 2020; Rousseau, Johnson-Lafleur, & Papazian-Zohrabian, 2020). While culturally informed or relevant care was a core component of training, some lacked an understanding of the contextual experiences of newly arrived migrants, such as resettlement struggles.

Discrimination. Studies indicated that both refugee and immigrant experienced prejudiced attitudes and discrimination towards them from their mental health care provider or their staff (Baiden & Evans, 2020; Li & Browne, 2000; O’Mahony & Donnelly, 2013; Sethi, 2013). This occurred while either seeking out MHCS or during their appointments. Participants noted that they were discriminated based on their intersecting identities of gender, migrant class, and ethnicity. For many women in several studies, they had stated that they felt that they were treated unfairly in various contexts, such as hearing comments like being asked why they decided to have more children when they were seeking services for post-partum depression symptoms (O'Mahony & Donnelly, 2007a, 2010; O'Mahony et al., 2018). Another common example was when the MHCS provider would ignore them and only speak to their designated interpreter, even while they were fluent enough in English to hold a conversation on their own (Li & Browne, 2000). Negative sentiments towards newcomers and certain racially charged comments were also described (Baiden & Evans, 2020; Li & Browne, 2000). Misdiagnosis was another concerning issue, as those who were Afro-Caribbean were misdiagnosed with psychosis or were labeled as uncooperative and aggressive by clinicians (Adeponle et al., 2012). The experiences described above often produced negative consequences for both immigrant and refugees seeking mental health services, as some stated that this prevented them from trying again to access MHCS or it made their mental health worse.

Shared identity. The identity of the mental health care provider was a conflicting variable for migrants when seeking help. For many, a shared/similar soicioethnic identity was a preference when looking for a MHCS provider (Ganann et al., 2012; Han & Oliffe, 2015; Reitmanova & Gustafson, 2009a). They did not have to worry about a language barrier or a cultural difference; making it easier for them to discuss their needs without having to rely on an interpreter or educate the practitioner on culturally specific issues (Fung & Wong, 2007; Han & Oliffe, 2015; Reitmanova & Gustafson, 2009a; Teng et al., 2007). However, the identity of the mental health care provider for some a negative factor based on contextually specific issues. For example, those who were Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) refugees, sometimes actively avoided providers based on their shared socioethnic identity out of fear due to the oppression they fled from in their home country (Kahn et al., 2018, 2017). Migrants, both newly arrived or long settled, and living in a smaller city or well-knit community avoided such providers out of concerns of privacy as within these communities, many health care providers held multiple roles (religious leader, well respected individual, family friend, etc.).

Professionalism. Across multiple studies, migrants indicated that the professionalism of mental health care providers and their staff influenced their help-seeking process either positively or negatively. This commonly entailed behaviours such as, but not limited to; the amount of time providers spent with them, understanding their migration experiences, building trust with them, genuinely wanting to learn more about their experiences, and generally having a pleasant demeanour (Ahmed, Stewart, Teng, Wahoush, & Gagnon, 2008; Brisset et al., 2014; Donnelly et al., 2011; Kahn et al., 2017; O'Mahony & Donnelly, 2007b; Reitmanova & Gustafson, 2009b; Whitley, Kirmayer, & Groleau, 2006). As indicated in some studies, when any of the aforementioned factors were severely lacking, many felt that this negatively impacted them and their view of MHCS in general.

Holistic care. Those mental health care providers who worked as part of a holistic team often had better therapeutic relationships and outcomes with their refugee and immigrant clients. These teams included allied health professionals (e.g., social workers), translators, and trained cultural brokers (Brisset et al., 2014; Salami et al., 2019; Sethi, 2013). The latter often helped in providing information, such as culturally or contextually relevant background information, which helped the provider to further understand their client's understanding of their presenting mental health issue.

Similarly, both refugee and immigrant clients indicated it was extremely beneficial when their MHCS provider gave them information to additional resources, such as resettlement agencies, domestic abuse shelters, and vocational services (e.g., language, job training, etc.) (Salami et al., 2019; Sethi, 2013). While not exactly within their job description, these MHCS providers played an important role specifically for newly arrived migrants in helping them address their material needs (O'Mahony et al., 2012; Reitmanova & Gustafson, 2009a).

Migration Class

Precarious legal status. Migration class became an area for extreme concern as some were in precarious positions due to the temporality of their landing status (Baiden & Evans, 2020; Donnelly et al., 2011; O'Mahony & Donnelly, 2013; Salami et al., 2019). Studies on the migration status impact and experiences of MHCS identified that those who arrived on a work/education visa or were processing their asylum claim were worried and afraid of deportation or the expiration of their permission to be in Canada (Baiden & Evans, 2020; Donnelly et al., 2011; O'Mahony & Donnelly, 2013; Salami et al., 2019). Their precarious legal status made it difficult for them to seek out MHCS or even go to the hospital or the emergency room in situations of extreme mental duress (Baiden & Evans, 2020; Donnelly et al., 2011; O'Mahony & Donnelly, 2013; Salami et al., 2019).

Access to healthcare insurance. Across Canada, all provinces and territories have different guidelines for when migrants can enrol in their respective health insurance plans. For example, in Ontario, there has typically been a three-month waiting period until an immigrant is eligible to apply to the Ontario Health Insurance Plan (OHIP). During this period, many immigrants often have to either delay seeking care and thus let their symptoms worsen or pay exorbitant out of pocket fees (Baiden & Evans, 2020; Donnelly et al., 2011). Coupled with a lack of information provided to them on alternatives to seeking more affordable care, this makes their experiences of navigating access to necessary MHCS more complicated (Baiden & Evans, 2020;

Donnelly et al., 2011; Ganann et al., 2020). For refugees, this was not a problem as they are entitled to health care insurance through the Federal Interim Healthcare Program for the first year after arrival.

Interlocking Systems

Pathway to care. There were multiple pathways to accessing MHCS identified within the selected articles for this scoping review. These were influenced by various factors, such as age, proximity to community resettlement agencies, and ethnicity. Migrant youth, both newly arrived and long settled, were most likely to be identified with mental health related issues through their school system, and therefore their parents were provided information on how to go about seeking appropriate MHCS for them (Brar-Josan & Yohani, 2019; Guzder, Yohannes, Zelkowitz, J., & S., 2013). Schools often provided services on-site if there were services available (Brar-Josan & Yohani, 2019). For those who had regular access to a family doctor, this was associated with the increased likelihood of having a mental health consultation and also accessing MHCS through referrals (Chen, Kazanjian, & Wong, 2008; Fenta, Hyman, & Noh, 2007; Islam, Khanlou, Macpherson, & Tamim, 2018). This was also the case for those newly arrived migrants who were involved with a community clinic associated with a resettlement agency, as this included a variety of resources and a holistic care service (O'Mahony et al., 2012). Lastly, regarding ethnicity, Jarvis (Jarvis, Kirmayer, Jarvis, & Whitley, 2005) found that those who were Afro-Caribbean were more likely than other ethnic groups in Canada to access MHCS and be involuntarily committed to psychiatric facilities through being arrested or having encounters with law enforcement (Jarvis et al., 2005).

Trust of medical and legal system. Alongside experiences of discrimination in part from providers, there was also the overarching belief by migrants that the health care system is inextricably linked to the legal system. This was understandably so, as migrants sometimes come from countries where there is distrust towards the government based on historical factors. For refugees, this is heightened due to a fear of persecution or a corrupt system, which they fled from. Many hesitated to access MHCS due to the repercussions associated with being formally diagnosed with a mental illness (O'Mahony & Donnelly, 2013). Afro-Caribbean populations indicated that they had a general mistrust of both the health care system and the legal system due to experiences of medical racism (Baiden & Evans, 2020; Boukpessi, Kpanake, & Gagnier, 2020; Jarvis et al., 2005). For migrant women who were single mothers, they expressed concern of their children potentially being taken away from them by child protective services (CPS) if they were to seek out MHCS themselves and thus be deemed an incompetent parent due to a medical issue (Guzder et al., 2013; O'Mahony et al., 2012; Simich et al., 2009). Migrant parents were reluctant to have their children diagnosed or access MHCS for the same reason; they worried that CPS would take their children if social workers were involved in their child's care. These concerns were subdued when the associated individuals took the time to educate, address questions, and provide further information to parents. Sometimes, a cultural broker or well-known community member was involved within this process in order to foster trust (Brar-Josan & Yohani, 2019).

Social and Individual Level Factors

Stigma

Cultural and societal. While stigma related to mental health is also a sentiment common within Canadian society, there was heightened stigma towards mental health within visible migrant communities (Este, Simich, Hamilton, & Sato, 2017). This was associated with the word 'crazy' being used and described by participants within studies (Este et al., 2017; Salami et al., 2019; Simich et al., 2009). The usage of MHCS was also stigmatized and viewed negatively, mainly due to the shared idea of not revealing one's problems to those outside of the family. Mental health and mental illness are considered to be a "family problem," something not to be discussed openly within the community (Han & Oliffe, 2015; Simich et al., 2009). These views highlight the salience of cultural norms of honour and maintaining group harmony within collectivistic societies and cultures, which many visible migrants come from. Stigma was also informed and shaped by similar cultural norms regarding femininity and masculinity. For women, they were worried about having their roles as a mother or wife questioned by their family or community (O'Mahony et al., 2018). Men, on the other hand, were less likely to seek out MHCS in general due to cultural norms of masculinity which emphasized men to appear stoic (Simich et al., 2009). Overall, stigma seemed to be more of a concern for recently arrived migrants as a barrier to seeking MHCS, but those who were settled here for longer did not express that stigma was a pressing issue. This may be due to acculturation, as norms and discussion of mental health are becoming more acceptable within the general Canadian society due to informational health campaigns such as #BellLetsTalk, a national Canadian corporation led strategy which aims to remove the stigma surrounding mental health through health promotion and providing resources. We discuss factors related to this, for example, age, in the following subsection.

Layered Identities

Gender identity and sexual orientation. A very distinct gendered experience of seeking MHCS was identified within the sources selected. Reproductive health for women particularly during and after pregnancy is associated with increased detection or reporting of mental health concerns (Ganann et al., 2020; O'Mahony & Donnelly, 2007b). There were also women only support groups and group therapy sessions for this specific issue which women could access if they were available. For migrant women, both recently arrived and long-term, their husband's influence was reported to be an important factor in seeking out MHCS. Many women are often sponsored by their husbands for resettlement in Canada, thus being legally dependant on them. While some husbands were supportive in their wife's help-seeking journeys, others were not so much (Ganann et al., 2020; O'Mahony & Donnelly, 2013; O'Mahony et al., 2012). O'Mahony and Donnelly (2013) interviewed immigrant and refugee women regarding their post-partum depression help-seeking experiences and found that entrenched gender hierarchies became a detriment. A concerning issue related to domestic abuse was noted, as husbands often did not let their wives go seek out MHCS as an attempt to prevent them from reporting instances of intimate partner violence or becoming more independent (O'Mahony & Donnelly, 2007a). This was also a concern for recently arrived migrant women as they were reliant on their husbands for transportation, finances, and translation support (O'Mahony & Donnelly, 2013). Some women reported fears of being deported from threats made by their husbands (O'Mahony & Donnelly, 2013). Migrant women in general are extremely vulnerable to domestic abuse and related forms of abuse due to their precarious positions. Their educational credentials generally not being recognized in Canada also places them at risk of not becoming financially independent (O'Mahony, Donnelly, Raffin Bouchal, & Este, 2013).

LGBTQ+ migrants faced an added barriers when seeking out MHCS due to their identity alone (Kahn et al., 2018, 2017). While Canada affords LGBTQ+ individuals basic rights, they are still subjected to discrimination. A LGBTQ+ identity coupled with being a visible minority produced an additional layer of difficulties. For many LGBTQ+ refugees, accessing adequate quality MHCS was difficult as it was rare to find a provider who worked with LGBTQ+ clients or understood the refugee context particular to LGBTQ+ experiences (Kahn et al., 2018, 2017).

Age. There are reported trends of MHCS usage based on age. Younger migrants, under the age of 25, were more likely to access MHCS, primarily due to the combined factors of acculturation and being aware of the existence of such services provided through college and university campuses (Chen et al., 2008). This was also the case for those who had arrived in Canada at an earlier age, as they had grown up with attitudes like other Canadians towards mental health where this was a more acceptable topic. However, youth who are obviously reliant on their parents for transportation and finances had more difficulty accessing MHCS (Chen, Kazanjian, & Wong, 2009). On the other end of the age spectrum, senior migrants are less likely to use MHCS due to issues rooted primarily in deeply held cultural beliefs and less positive attitudes (Lai & Chau, 2007; Tieu & Konnert, 2014). For those who came to Canada in adulthood, certain beliefs, and attitudes towards mental health and MCHS became more entrenched over the years or were more established and resistant towards change.

Social Networks

Family and community. While many migrants primarily reside within a nuclear family due to Canada's migration policies favouring this social arrangement, extended family members overseas still played an important role. Family attitudes towards MHCS ultimately became a hindrance for who were seeking such services, and in some extreme cases individuals were faced with physical abuse if they sought help (Donnelly et al., 2011; Han & Oliffe, 2015; O'Mahony & Donnelly, 2007a; O'Mahony et al., 2012). As described briefly above within the subtheme of stigma, the influence of the family unit cannot be understated enough within understanding help-seeking behaviours among visible minority migrants. However, families who were more accepting of MHCS often supported their loved one in seeking out services, but also being involved in their care, such as reminding them to take their medications, participating in a family-based intervention, or also actively educating themselves (Donnelly et al., 2011).

Community based social networks were identified as having a strong influence, and this included the neighbourhood, religious affiliation, or a sociocultural group. The proximity and level of closeness to the community often shaped a migrant's experiences when accessing MHCS. For many newly arrived migrants, their community's influence was salient. This most likely could have been due to that they were relying on them for financial and social support while settling into Canada. In a study by Clark (2018) exploring the role of the community in Karen refugee women's resettlement experiences and mental health, the community became a great resource. Long settled Karen women who were more fluent in English often became translators for recently arrived refugee women when they were seeking MHCS or other medical services (Clark, 2018). Studies also indicated that migrant women were also told of local community health centres which could provide them with the necessary MHCS, and certain providers were recommended due to their own experiences (Ahmed et al., 2008; Ahmend, Bowen, & Feng, 2017; O'Mahony et al., 2018). However, for many newly arrived migrants, a tightly knit community was a significant barrier due to stigma, norms, and issues of privacy. Ahmed and colleagues (2017) identified an area of concern, such as that translators sometimes came from the same community and potentially may know the individual. For many, seeking out MHCS was a private venture in hopes of not letting their community know (Bohr et al., 2020). Fears of being ostracized from community events or having their relationships with others become strained were shared as part of the sigma in a few studies. For newly arrived migrants, establishing oneself both economically and socially is a complex process; therefore, it is understandable that there is a concern in the potential loss of an important social network (Clark, 2018).

Understanding Of Mental Health

Mental health literacy and awareness of services. Across many articles within this review, a predominant factor which shaped migrants' experiences with access to MCHS was the levels of mental health literacy and also the awareness of services in general (Baiden & Evans, 2020; Este et al., 2017; Li & Browne, 2000). For many migrants, they were not aware of mental illness as an area of concern. For example, many women who were diagnosed with post-partum depression initially were not aware that their lower mood was an issue that required attention (Baiden & Evans, 2020; O'Mahony & Donnelly, 2007a). The awareness of services was also an important factor, as a majority of participants across the articles indicated that they were not even aware that such services existed (Ganann et al., 2020; O'Mahony & Donnelly, 2007a; O'Mahony et al., 2012, 2013). These migrants engaged in other forms of treatment, such as spiritual, religious, and traditional methods (Baiden & Evans, 2020). Attitudes towards medication was also another barrier associated with accessing MHCS, as some migrants assumed that this was the only modality of treatment offered which made them hesitant (Boukpessi et al., 2020; Guzder et al., 2013; O'Mahony & Donnelly, 2007b; Whitley et al., 2006). When their service provider took time to educate them and address their concerns, medication was more likely accepted as a potential form of treatment (Guzder et al., 2013; O'Mahony & Donnelly, 2007b).

Cultural conceptualizations of mental health. As described in the previous sections, the availability of culturally informed or relevant MHCS was a very important consideration for many migrants (Baiden & Evans, 2020; Li & Browne, 2000). Cultural conceptualizations and understanding of mental illness and health often differed from the biomedical model which is the prominent model in the health care system and practices in Canada. Studies indicated that incorporating cultural, spiritual, and religious practices within MHCS programs was important for visible minority migrants (Ahmend et al., 2017; Baiden & Evans, 2020; Chan & Sadavoy, 2012; Este et al., 2017). For those who ascribed to the biomedical model, they were more likely to seek out services as found by Fung and Wong (2007). Many migrants often initially came to their healthcare provider or MHCS provider with concerns of bodily aches or pain which is a reflection of culturally rooted experiences of mental illness: somatization (Whitley et al., 2006). Similarly, phrases related to fatigue, nausea, or localized bodily sensations were commonly used to describe distress among migrants (Ahmend et al., 2017; Chan & Sadavoy, 2012; Whitley et al., 2006).

Severity and diagnosis. Unfortunately, a common facilitator in accessing MHCS for migrants, regardless of background, was the severity of their mental health problem (Anderson, Cheng, Susser, & McKenzie, 2015; Anderson, McKenzie, & Kurdyak, 2017). This was described both by MHCS and healthcare providers as instances when a “crisis point” had been reached, such as a suicide attempt or a mental health episode (Donnelly et al., 2011; Han & Oliffe, 2015). Understandably, this was also in instances when the form of mental illness was interfering severely with their daily activities and no longer could be tolerated by themselves or their family (Donnelly et al., 2011; Han & Oliffe, 2015).

Discussion

This paper has provided a comprehensive overview of the barriers and facilitators visible minority migrants in Canada experience when accessing MHCS. The findings from this review point to the significant interaction between systemic factors and social factors influencing MHCS utilization. Implications for MHCS providers and community organizations, policy recommendations, and future directions for research are discussed below.

Implications For Providers and Settlement Organizations

The importance of competency cannot be understated for MHCS who currently, or plan to, work with visible minority migrant clients. Competencies in two domains emerged as facilitators to seeking MHCS: cultural and structural. Cultural competency is the ability to be cognizant of cultural factors, such as beliefs and values, that shape understanding of mental health (Metzl & Hansen, 2014). From the items described in this review, culturally informed or relevant care included MHCS providers asking their clients to define their mental health issues within their own terms. Structural competency is a departure of the former, and emphasizes the understanding of how social, political, and economic factors are influencing the production, experience, and maintenance of the presenting health issue (Metzl & Hansen, 2014). Structural competency was exemplified when providers were understanding of the distinct experiences that refugee and immigrants face rooted within their legal status (Metzl & Hansen, 2014; Reitmanova & Gustafson, 2009b).

Professionalism emerged as a facilitator, as migrants indicated that experiences of discrimination and feelings of being rushed were determinants of their willingness to seek care again (Ahmed et al., 2008; O’Mahony et al., 2012, 2018). A warmer and more approachable attitude when working with visible minority migrant clients was noted to be important, as it facilitated the therapeutic relationship which led to client satisfaction. Designating an adequate amount of time and allowing the client to ask questions are also important features (Higginbottom et al., 2013; Mabaya & Ray, 2014). Within this review, education programs, cultural sensitivity trainings, and professional development workshops emerged as key opportunities for MHCS providers to develop and enhance their capacity to work with visible minority migrant populations (Adeponle et al., 2012; Rousseau et al., 2020). Alongside professional development, there is the need for having practitioners and providers from a variety of backgrounds, specifically those who have lived experiences as immigrants or refugees and identify as a visible minority as they can provide rich insights into supporting such clients either by working with them or helping develop new materials and resources (Cabral & Smith, 2011).

MHCS providers should also seek to build relationships with resettlement agencies, community health centres, or local welfare services to address material conditions, as newly arrived migrants are at risk of poverty, domestic abuse, and food insecurity (Aube, Pisanu, & Merry, 2019; Chadwick & Collins, 2015; Chan & Sadavoy, 2012; Chase & Rousseau, 2018; Ganesan & Janze, 2005; Kostiuk, 2019; Nadeau & Measham, 2005; O'Mahony et al., 2012). Working in collaboration with other health professionals alongside with the aforementioned groups would be beneficial in order to develop effective mental health promotion programs or workshops. Settlement agencies and community health centres should educate newly arrived migrants on how to access MHCS and what is covered based on their provincial insurance plan (O'Mahony et al., 2018; Salami et al., 2018, 2019).

Policy Recommendations

As structural and systemic factors emerged within this review as important areas of attention, there are several approaches in the policy domain that should be pursued to improve MHCS access for this underserved population within Canada. To make effective change, supportive policies must be made to support migrants and MHCS providers. Policy makers should prioritize the voices of impacted visible minority migrant communities within the development of policies and programs (Kostiuk, 2019). This would include utilizing methods such as community-based participatory research approaches that centre the needs and assets of the communities in developing and curating solutions that lend into transformative changes. An example of this would be the work of Access Alliance Multicultural Health and Community Services from Toronto, which is an organization that emphasizes visible minority migrant communities as important stakeholders within their research and work with the local government. Other organizations include the Mental Health Commission of Canada and the Centre for Addictions and Mental Health that collaborate closely with government agencies and do community-engaged work as part of their initiatives.

The research strongly points to the consequences of eroding health and social policies as they produce diminished quality of life for migrant populations who are already economically vulnerable (McKenzie, Tuck, & Agic, 2014; Reitmanova & Gustafson, 2009a; Rink et al., 2017; Steele, Lemieux-Charles, Clark, & Glazier, 2002). Making it difficult to apply for benefits or assistance programs, reductions in welfare payments, deteriorating tenant rights, stagnating minimum wage are all examples of key health and social policies that impact visible minority migrants disproportionately. The reduction of such policies and related funding also influences MHCS providers by straining resources, and in turn influencing the quality of care they can provide (Steele et al., 2002). Therefore, there should be an increased attention to supporting the aforementioned domains of policies and funding areas. Local community services were found within this review to play an important role, and such more funding should be allocated to these programs and services(Aube et al., 2019).

MHCS, aside from institutionalization within a hospital or seeking a psychiatrist, are not included as part of the services available in Canadian’s universal and publicly funded healthcare system (Durbin, Lin, Moineddin, Steele, & Glazier, 2014). There is a concerning documented trend where the first point of contact for receiving mental health services among migrant populations in Canada is the emergency room. This has been attributed to a lack of access to a primary care provider or due to the inability to pay for MHCS (Gill et al., 2017; Rivera, Puyat, Wiedmeyer, & Lavergne, 2020; Saunders et al., 2018). Prescription drugs are also an area of concern, as some are not covered by provincial health insurance. Integrating MHCS in the general health system along with expanding further coverage of prescription drugs would be beneficial to improve financial accessibility (Durbin et al., 2014; Ganesan & Janze, 2005).

Future Directions for Research

While the selected studies within the scoping review provided insightful information within different domains, there were some methodological gaps that are opportunities for further inquiry.

Disaggregating demographic data related to race/ethnicity would yield more nuanced understanding of differences and similarities among groups (Kauh, Read, & Scheitler, 2021). Most quantitative studies included within this scoping review were cross-sectional studies which employed data sets from Health Canada (i.e., Canadian Community Health Survey). An example of this would be how those who come from African and Caribbean countries are given the option of only selecting “Black” when designating their cultural/ethnic group. However, this is not an informative category, as there are significant differences between those two geographical locations, which makes the conflation of these included groups further problematic (Flanagin, Frey, Christiansen, & Bauchner, 2021; Rodney & Copeland, 2009). This also erases the history of those who are the descendants of enslaved Black individuals within North America. The introduction of more refined categories within these surveys may enable new opportunities for researchers and public health measures (Kauh et al., 2021; Moscou, 2008).

In terms of other demographics of interest, there were a lack of articles focusing specifically on men. Men underutilize MHCS for numerous factors identified within this review, such as stigma and accessibility. They are also in general at higher risk of successfully committing suicide compared to women, regardless of migrant class or visible minority identification (McCreary et al., 2020). Therefore, priority should be given to understanding how to engage with visible minority men to facilitate a dialogue surrounding mental health and improve accessibility of MHCS due to specific gender-based needs. There were also no articles included within this review which explicitly identified education, religion, and disability as areas of exploration. We highly suggest for future researchers to explore these demographic categories as there are unique experiences associated with them.

A common theme within the studies was the preponderance of attributing low levels of MHCS access to individual level factors, primarily in cultural issues, when there is an amalgamation of systemic issues which contribute to this outcome. Future research within this domain should incorporate a structural determinants of health approach, which interrogates and examines systemic level factors, such as policy, which contribute to produced health outcomes (Ford & Airhihenbuwa, 2018; Hyman, 2009; Paradies et al., 2015; Policy et al., 2020). This is a refinement of the traditional social determinants of health framework that focuses mainly on sociodemographic attributes. The adoption of a framework emphasizing intersectionality as a point of analysis, such as Critical Race Theory, would be beneficial as there is an emphasis on race and ethnicity within a systemic legal context (Ford & Airhihenbuwa, 2010, 2018). Further contextualizing these social factors within a socio-political analysis would deepen the understanding of how mental health disparities are borne out of inequitable social conditions situated within polices (Bacong & Menjívar, 2021; Ford & Airhihenbuwa, 2010, 2018). Social identities are legally determined and defined, thus lived experiences of specific groups are somewhat distinct (Bacong & Menjívar, 2021; Ford & Airhihenbuwa, 2018; Hyman, 2009; Roberts, 1999).

Limitations

Due to exclusion criteria, no grey literature was examined and only articles in English were retrieved. A large amount of grey literature produced by health organization groups or municipal governments exist on this topic. A significant number of articles within this scoping review were conducted in Quebec, where the main language is French, and therefore relevant articles may have been overlooked. Additionally, the quantitative studies included for review within this paper are cross-sectional and therefore it must be explicitly stated that correlation does not imply causation.

Conclusion

This scoping review elaborates on existing research regarding visible minority migrants' experiences of accessing MHCS. It reveals the influence of systemic and social level factors becoming barriers or facilitators in multiple dimensions. Systemic issues highlighted the compounded effects of migrant status, socioeconomic variables, and inaccessible services. Social factors involved the salient role of the family and community, health literacy, and cultural understandings of mental health. Refugees and immigrants' MHCS experiences may be distinct due to their landing status and circumstances of departure, but they are similar in many ways due to them being visible minorities. As such, discrimination based on race within this review emerged as an unfortunate, but obvious factor (Hyman, 2009; Paradies et al., 2015). Access to healthcare is a right in Canada; however, for some it seems that it is conditional based on their identity. Effective change cannot be made without addressing both systemic and social factors otherwise disparities will continue to persist. The suggestions from the findings of this review point towards multiple avenues of possible action.

References

Adeponle, A. B., Thombs, B. D., Groleau, D., Jarvis, E., & Kirmayer, L. J. (2012). Using the cultural formulation to resolve uncertainty in diagnoses of psychosis among ethnoculturally diverse patients. *Psychiatric Services*, *63*(2), 147–153. https://doi.org/http://dx.doi.org/10.1176/appi.ps.201100280

Ahmad, F., Wang, J., Wong, B., & Fung, W. L. A. (2020). Interactive mental health assessments for Chinese Canadians: A pilot randomized controlled trial in nurse practitioner-led primary care clinic. *Asia-Pacific Psychiatry*, *n/a*(n/a), e12400. https://doi.org/https://doi.org/10.1111/appy.12400

Ahmed, A., Stewart, D. E., Teng, L., Wahoush, O., & Gagnon, A. J. (2008). Experiences of immigrant new mothers with symptoms of depression. *Archives of Women's Mental Health*, *11*(4), 295. https://doi.org/10.1007/s00737-008-0025-6

Ahmend, A., Bowen, A., & Feng, C. X. (2017). Maternal depression in Syrian refugee women recently moved to Canada: A preliminary study. *BMC Pregnancy and Childbirth*, *17*(1), 240. https://doi.org/http://dx.doi.org/10.1186/s12884-017-1433-2

Anderson, Cheng, J., Susser, E., & McKenzie, K. (2015). Incidence of psychotic disorders among first-generation immigrants and refugees in Ontario. *CMAJ*, *187*(9), E279–E286. https://doi.org/http://dx.doi.org/10.1503/cmaj.141420

Anderson, K., McKenzie, K., & Kurdyak, P. (2017). Examining the impact of migrant status on ethnic differences in mental health service use preceding a first diagnosis of schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, *52*(8), 949–961. https://doi.org/http://dx.doi.org/10.1007/s00127-017-1403-z

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework.

International Journal of Social Research Methodology, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Aube, T., Pisanu, S., & Merry, L. (2019). La Maison Bleue: Strengthening resilience among migrant mothers living in Montreal, Canada. *PLoS ONE*, *14*(7), e0220107. https://doi.org/http://dx.doi.org/10.1371/journal.pone.0220107

Bacong, A. M., & Menjívar, C. (2021). Recasting the Immigrant Health Paradox Through Intersections of Legal Status and Race. *Journal of Immigrant and Minority Health*. https://doi.org/10.1007/s10903-021-01162-2

Baiden, D., & Evans, M. (2020). Black African Newcomer Women's Perception of Postpartum Mental Health Services in Canada. *The Canadian Journal of Nursing Research = Revue Canadienne de Recherche En Sciences Infirmieres*, 844562120934273. https://doi.org/https://dx.doi.org/10.1177/0844562120934273

Bohr, Y., Bimm, M., Bint Misbah, K., Perrier, R., Lee, Y., Armour, L., & Sockett-DiMarco, N. (2020). The Crying Clinic: Increasing accessibility to Infant Mental Health services for immigrant parents at risk for peripartum depression. *Infant Mental Health Journal*. https://doi.org/http://dx.doi.org/10.1002/imhj.21879

Boukpessi, T. B., Kpanake, L., & Gagnier, J.-P. (2020). Willingness to Use Mental Health Services for Depression Among African Immigrants and White Canadian-Born People in the Province of Quebec, Canada. *Journal of Immigrant and Minority Health*. https://doi.org/http://dx.doi.org/10.1007/s10903-020-01061-y

Brar-Josan, N., & Yohani, S. C. (2019). Cultural brokers' role in facilitating informal and formal mental health supports for refugee youth in school and community context: a Canadian case study. *British Journal of Guidance & Counselling*, *47*(4), 512–523.

https://doi.org/10.1080/03069885.2017.1403010

Brisset, C., Leanza, Y., Rosenberg, E., Vissandjee, B., Kirmayer, L. J., Muckle, G., & Xenocostas, S. (2014). Language barriers in mental health care: a survey of primary care practitioners. *Journal of Immigrant and Minority Health*, *16*(6), 1238–1246. https://doi.org/http://dx.doi.org/10.1007/s10903-013-9971-9

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, Vol. 58, pp. 537–554. Smith, Timothy B.: Department of Counseling Psychology, Brigham Young University, Provo, UT, US, 84602, tbs@byu.edu: American Psychological Association. https://doi.org/10.1037/a0025266

Castelli, F. (2018). Drivers of migration: why do people move? *Journal of Travel Medicine*, *25*(1). https://doi.org/10.1093/jtm/tay040

Chadwick, K., & Collins, P. (2015). Examining the relationship between social support availability, urban center size, and self-perceived mental health of recent immigrants to Canada: A mixed-methods analysis. *Social Science and Medicine*, *128*, 220–230. https://doi.org/http://dx.doi.org/10.1016/j.socscimed.2015.01.036

Chan, K. C., & Sadavoy, J. (2012). Wellness centre: an evidence-guided approach to delivering culturally relevant community psychogeriatric services for chinese elders. *ISRN Psychiatry*, *2012*, 815707. https://doi.org/https://dx.doi.org/10.5402/2012/815707

Chase, L. E., & Rousseau, C. (2018). Ethnographic case study of a community day center for asylum seekers as early stage mental health intervention. *American Journal of Orthopsychiatry*, *88*(1), 48–58. https://doi.org/http://dx.doi.org/10.1037/ort0000266

Chen, A. W., Kazanjian, A., & Wong, H. (2008). Determinants of mental health consultants among recent Chinese immigrants in British Columbia, Canada: Implications for mental health risk and access to services. *Journal of Immigrant and Minority Health*, *10*(6), 529–540. https://doi.org/http://dx.doi.org/10.1007/s10903-008-9143-5

Chen, A. W., Kazanjian, A., & Wong, H. (2009). Why do Chinese Canadians not consult mental health services: Health status, language or culture? *Transcultural Psychiatry*, *46*(4), 623–641. https://doi.org/http://dx.doi.org/10.1177/1363461509351374

Chimienti, M., Bloch, A., Ossipow, L., & de Wenden, C. W. (2019). Second generation from refugee backgrounds in Europe. *Comparative Migration Studies*, *7*(1), 40. https://doi.org/10.1186/s40878-019-0138-2

Chiu, M., Amartey, A., Wang, X., & Kurdyak, P. (2018). Ethnic Differences in Mental Health Status and Service Utilization: A Population-Based Study in Ontario, Canada. *The Canadian Journal of Psychiatry*, *63*(7), 481–491. https://doi.org/10.1177/0706743717741061

Clark, N. (2018). Exploring community capacity: Karen refugee women's mental health. *International Journal of Human Rights in Healthcare*, *11*(4), 244–256. https://doi.org/10.1108/IJHRH-02-2018-0025

Donnelly, T. T., Hwang, J. J., Este, D., Ewashen, C., Adair, C., Clinton, M., … C., A. (2011). If I was going to kill myself, I Wouldn't be calling you. I am asking for help: Challenges influencing immigrant and refugee women's mental health. *Issues in Mental Health Nursing*, *32*(5), 279–290. https://doi.org/http://dx.doi.org/10.3109/01612840.2010.550383

Durbin, A., Lin, E., Moineddin, R., Steele, L. S., & Glazier, R. H. (2014). Use of mental health care for nonpsychotic conditions by immigrants in different admission classes and by refugees in Ontario, Canada. *Open Medicine : A Peer-Reviewed, Independent, Open-Access*

Journal, *8*(4), e136–e146. Retrieved from https://pubmed.ncbi.nlm.nih.gov/25426182

Este, D., Simich, L., Hamilton, H., & Sato, C. (2017). Perceptions and understandings of mental health from three Sudanese communities in Canada. *International Journal of Culture and Mental Health*, *10*(3), 238–249. https://doi.org/http://dx.doi.org/10.1080/17542863.2017.1296876

Fenta, H., Hyman, I., & Noh, S. (2007). Health service utilization by Ethiopian immigrants and refugees in Toronto. *Journal of Immigrant and Minority Health*, *9*(4), 349–357. https://doi.org/http://dx.doi.org/10.1007/s10903-007-9043-0

Flanagin, A., Frey, T., Christiansen, S. L., & Bauchner, H. (2021). The Reporting of Race and Ethnicity in Medical and Science Journals: Comments Invited. *JAMA*, *325*(11), 1049–1052. https://doi.org/10.1001/jama.2021.2104

Ford, C. L., & Airhihenbuwa, C. O. (2010). The public health critical race methodology: Praxis for antiracism research. *Social Science & Medicine*, *71*(8), 1390–1398. https://doi.org/https://doi.org/10.1016/j.socscimed.2010.07.030

Ford, C. L., & Airhihenbuwa, C. O. (2018). Commentary: Just What is Critical Race Theory and What's it Doing in a Progressive Field like Public Health? *Ethnicity & Disease*, *28*(Suppl 1), 223–230. https://doi.org/10.18865/ed.28.S1.223

Fung, K., & Wong, Y.-L. R. (2007). Factors influencing attitudes towards seeking professional help among East and Southeast Asian immigrant and refugee women. *International Journal of Social Psychiatry*, *53*(3), 216–231. https://doi.org/http://dx.doi.org/10.1177/0020764006074541

Ganann, R., Sword, W., Black, M., & Carpio, B. (2012). Influence of maternal birthplace on postpartum health and health services use. *Journal of Immigrant and Minority Health*, *14*(2), 223–229. https://doi.org/https://dx.doi.org/10.1007/s10903-011-9477-2

Ganann, R., Sword, W., Newbold, K. B., Thabane, L., Armour, L., & Kint, B. (2020). Influences on mental health and health services accessibility in immigrant women with post-partum depression: An interpretive descriptive study. *Journal of Psychiatric and Mental Health Nursing*, *27*(1), 87–96. https://doi.org/https://dx.doi.org/10.1111/jpm.12557

Ganesan, S., & Janze, T. (2005). Overview of culturally-based mental health care in Vancouver. *Transcultural Psychiatry*, *42*(3), 478–490. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=med6&NEWS=N&AN=16268239

Gill, P. J., Saunders, N., Gandhi, S., Gonzalez, A., Kurdyak, P., Vigod, S., & Guttmann Simone; ORCID: http://orcid.org/0000-0002-2736-9639, A. A. I.-O. http://orcid. org/Vigo. (2017). Emergency department as a first contact for mental health problems in children and youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(6), 475–482. https://doi.org/http://dx.doi.org/10.1016/j.jaac.2017.03.012

Guzder, J., Yohannes, S., Zelkowitz, P., J., G., & S., Y. (2013). Helpseeking of immigrant and native born parents: a qualitative study from a montreal child day hospital. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *22*(4), 275–281. Retrieved from http://www.cacap-acpea.org/uploads/documents//Helpseeking_Guzder.pdf

Han, C. S., & Oliffe, J. L. (2015). Korean-Canadian immigrants' help-seeking and self-management of suicidal behaviours. *Canadian Journal of Community Mental Health*, *34*(1), 17–30. https://doi.org/http://dx.doi.org/10.7870/cjcmh-2014-036

Higginbottom, G. M. A., Morgan, M., O'Mahony, J., Chiu, Y., Kocay, D., Alexandre, M., … Young, M. (2013). Immigrant women's experiences of postpartum depression in Canada: a protocol for systematic review using a narrative synthesis. *Systematic Reviews*, *2*, 65. https://doi.org/https://dx.doi.org/10.1186/2046-4053-2-65

Hyman, I. (2009). *Racism as a determinant of immigrant health*.

Islam, F., Khanlou, N., Macpherson, A., & Tamim, H. (2018). Mental Health Consultation Among Ontario's Immigrant Populations. *Community Mental Health Journal*, *54*(5), 579–589. https://doi.org/http://dx.doi.org/10.1007/s10597-017-0210-z

Jarvis, E., Kirmayer, L. J., Jarvis, G. K., & Whitley, L. (2005). The Role of Afro-Canadian Status in Police or Ambulance Referral to Emergency Psychiatric Services. *Psychiatric Services*, *56*(6), 705–710. https://doi.org/http://dx.doi.org/10.1176/appi.ps.56.6.705

Kahn, S., Alessi, E. J., Kim, H., Woolner, L., & Olivieri, C. J. (2018). Facilitating mental health support for LGBT forced migrants: A qualitative inquiry. *Journal of Counseling & Development*, *96*(3), 316–326. https://doi.org/http://dx.doi.org/10.1002/jcad.12205

Kahn, S., Alessi, E., Woolner, L., Kim, H., & Olivieri, C. (2017). Promoting the wellbeing of lesbian, gay, bisexual and transgender forced migrants in Canada: Providers' perspectives. *Culture, Health & Sexuality*, *19*(10), 1165–1179. https://doi.org/http://dx.doi.org/10.1080/13691058.2017.1298843

Kauh, T. J., Read, J. G., & Scheitler, A. J. (2021). The Critical Role of Racial/Ethnic Data Disaggregation for Health Equity. *Population Research and Policy Review*, 1–7. https://doi.org/10.1007/s11113-020-09631-6

Khan, M. M., Kobayashi, K., Vang, Z. M., & Lee, S. M. (2017). Are visible minorities "invisible" in Canadian health data and research? A scoping review. *International Journal of Migration, Health and Social Care*, *13*(1), 126–143. https://doi.org/10.1108/IJMHSC-10-2015-0036

Kostiuk, S. (2019). The Potentials of Actively Engaging Refugees in Creating Canadian Healthcare Policies Aimed at Improving Their Mental Health. *Issues in Mental Health Nursing*, *40*(7), 636–638. https://doi.org/http://dx.doi.org/10.1080/01612840.2019.1585498

Lai, D. W. L., & Chau, S. B. (2007). Effects of service barriers on health status of older Chinese immigrants in Canada. *Social Work*, *52*(3), 261–269. https://doi.org/http://dx.doi.org/10.1093/sw/52.3.261

Lane, G., Farag, M., White, J., Nisbet, C., & Vatanparast, H. (2018). Chronic health disparities among refugee and immigrant children in Canada. *Applied Physiology, Nutrition, and Metabolism*, *43*(10), 1043–1058. https://doi.org/10.1139/apnm-2017-0407

Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*(1), 18. https://doi.org/10.1186/1475-9276-12-18

Li, H. Z., & Browne, A. J. (2000). Defining mental illness and accessing mental health services: Perspectives of Asian Canadians. *Canadian Journal of Community Mental Health*, *19*(1), 143–159. https://doi.org/http://dx.doi.org/10.7870/cjcmh-2000-0008

Lu, C., & Ng, E. (2019). Healthy immigrant effect by immigrant category in Canada. *Health Reports*, *30*(4), 3–11. https://doi.org/10.25318/82-003-x201900400001-eng

Mabaya, G., & Ray, S. L. (2014). The meaning of health and help-seeking behaviours among refugees who have experienced collective violence prior to emigration: A Canadian perspective. *Canadian Journal of Community Mental Health*, *33*(3), 71–85. https://doi.org/http://dx.doi.org/10.7870/cjcmh-2014-024

McCreary, D. R., Oliffe, J. L., Black, N., Flannigan, R., Rachert, J., & Goldenberg, S. L. (2020). Canadian men's health stigma, masculine role norms and lifestyle behaviors. *Health*

Promotion International, *35*(3), 535–543. https://doi.org/10.1093/heapro/daz049

McKenzie, K. J., Tuck, A., & Agic, B. (2014). Mental healthcare policy for refugees in Canada. *Refuge and Resilience: Promoting Resilience and Mental Health among Resettled Refugees and Forced Migrants.*, 181–194. https://doi.org/http://dx.doi.org/10.1007/978-94-007-7923-5_12

Mental Health Commission of Canada. (2015). *Informing the Future: Mental Health Indicators for Canada*.

Mental Health Commission of Canada. (2016). *The Case for Diversity Building the Case to Improve Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Populations*.

Metzl, J. M., & Hansen, H. (2014). Structural competency: theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine (1982)*, *103*, 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032

Moscou, S. (2008). The conceptualization and operationalization of race and ethnicity by health services researchers. *Nursing Inquiry*, *15*(2), 94–105. https://doi.org/https://doi.org/10.1111/j.1440-1800.2008.00413.x

Nadeau, L., & Measham, T. (2005). Immigrants and Mental Health Services: Increasing Collaboration with Other Service Providers. *Canadian Child and Adolescent Psychiatry Review*, *14*(3), 73–76. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc4&NEWS=N&AN=2005-11539-002

Newbold, K. B., & McKeary, M. (2018). Journey to Health: (Re) Contextualizing the Health of Canada's Refugee Population. *Journal of Refugee Studies*, *31*(4), 687–704.

https://doi.org/10.1093/jrs/fey009

Ng, E., & Zhang, H. (2020). The mental health of immigrants and refugees: Canadian evidence from a nationally linked database. *Health Reports*, *31*(8), 3–12. https://doi.org/https://dx.doi.org/10.25318/82-003-x202000800001-eng

Ng, E., & Zhang, H. (2021). *Access to mental health consultations by immigrants and refugees in Canada*.

O'Mahony, & Donnelly, T. T. (2007a). Health care providers' perspective of the gender influences on immigrant women's mental health care experiences. *Issues in Mental Health Nursing*, *28*(10), 1171–1188. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc5&NEWS=N&AN=2007-17052-007

O'Mahony, & Donnelly, T. T. (2007b). The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers. *Issues in Mental Health Nursing*, *28*(5), 453–471. https://doi.org/http://dx.doi.org/10.1080/01612840701344464

O'Mahony, & Donnelly, T. T. (2013). How does gender influence immigrant and refugee women's postpartum depression help-seeking experiences? *Journal of Psychiatric and Mental Health Nursing*, *20*(8), 714–725. https://doi.org/http://dx.doi.org/10.1111/jpm.12005

O'Mahony, Donnelly, T. T., Bouchal, S. R., & Este, D. (2012). Barriers and facilitators of social supports for immigrant and refugee women coping with postpartum depression. *Advances in Nursing Science*, *35*(3), E42–E56. https://doi.org/https://dx.doi.org/10.1097/ANS.0b013e3182626137

O'Mahony, J. M., & Donnelly, T. T. (2010). A postcolonial feminist perspective inquiry into immigrant women’s mental health care experiences. *Issues in Mental Health Nursing*, *31*(7), 440–449. https://doi.org/http://dx.doi.org/10.3109/01612840903521971

O’Mahony, J. M., Donnelly, T. T., Raffin Bouchal, S., & Este, D. (2013). Cultural background and socioeconomic influence of immigrant and refugee women coping with postpartum depression. *Journal of Immigrant and Minority Health*, *15*(2), 300–314. https://doi.org/http://dx.doi.org/10.1007/s10903-012-9663-x

O’Mahony, J. M., Donnelly, T. T., Tong, H., Lung, Y., Lin, S. L., Kobayashi, K. M., … (CCIRH), C. C. for I. and R. H. (2018). Postpartum health, service needs, and access to care experiences of immigrant and Canadian-born women. *Journal of Immigrant and Minority Health*, *15*(3), 197. https://doi.org/http://dx.doi.org/10.3389/fpsyg.2018.01200

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., … Gee, G. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PloS One*, *10*(9), e0138511–e0138511. https://doi.org/10.1371/journal.pone.0138511

Policy, T. R. C. for R. and, Neely, A. N., Ivey, A. S., Duarte, C., Poe, J., & Irsheid, S. (2020). Building the Transdisciplinary Resistance Collective for Research and Policy: Implications for Dismantling Structural Racism as a Determinant of Health Inequity. *Ethnicity & Disease*, *30*(3), 381–388. https://doi.org/10.18865/ed.30.3.381

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., … Tugwell Laurence J.; ORCID: http://orcid.org/0000-0002-6228-1739, P. A. I.-O. http://orcid. org/Kirmaye. (2011). Evidence-based clinical guidelines for immigrants and refugees. *Canadian Medical Association Journal*, *183*(12), e824–e925. https://doi.org/http://dx.doi.org/10.1503/cmaj.090313

Reitmanova, S., & Gustafson, D. L. (2009a). Mental health needs of visible minority immigrants in a small urban center: Recommendations for policy makers and service providers. *Journal of Immigrant and Minority Health*, *11*(1), 46–56. https://doi.org/http://dx.doi.org/10.1007/s10903-008-9122-x

Reitmanova, S., & Gustafson, D. L. (2009b). Primary mental health care information and services for St. John's visible minority immigrants: gaps and opportunities. *Issues in Mental Health Nursing*, *30*(10), 615–623. https://doi.org/https://dx.doi.org/10.1080/01612840903033733

Rink, N., Muttalib, F., Morantz, G., Chase, L., Cleveland, J., Rousseau, C., & Li, P. (2017). The gap between coverage and care-what can Canadian paediatricians do about access to health services for refugee claimant children?. *Paediatrics & Child Health*, *22*(8), 430–437. https://doi.org/https://dx.doi.org/10.1093/pch/pxx115

Rivera, J., Puyat, J., Wiedmeyer, M.-L., & Lavergne, R. (2020). Primary Care and Access to Mental Health Consultations among Immigrants and Nonimmigrants with Mood or Anxiety Disorders. *Canadian Journal of Psychiatry*. https://doi.org/http://dx.doi.org/10.1177/0706743720952234

Roberts, D. E. (1999). *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. Vintage Books. Retrieved from https://books.google.ca/books?id=gmeqPwAACAAJ

Rodney, P., & Copeland, E. (2009). The Health Status of Black Canadians: Do Aggregated Racial and Ethnic Variables Hide Health Disparities? *Journal of Health Care for the Poor and Underserved*, *20*, 817–823. https://doi.org/10.1353/hpu.0.0179

Rothe, E. M., Tzuang, D., & Pumariega, A. J. (2010). Acculturation, development, and adaptation. *Child and Adolescent Psychiatric Clinics of North America*, Vol. 19, pp. 681–696. Elsevier Science. https://doi.org/10.1016/j.chc.2010.07.002

Rousseau, C., Johnson-Lafleur, J., & Papazian-Zohrabian, G. (2020). Interdisciplinary case discussions as a training modality to teach cultural formulation in child mental health. *Transcultural Psychiatry*, *57*(4), 581–593. https://doi.org/http://dx.doi.org/10.1177/1363461518794033

Salami, B., Hegadoren, K., Kirova, A., Meherali, S., Nsaliwa, C., & Chiu, Y. (2018). “And when a certain health issue happen, they try to cover it”: Stakeholder perspectives on the health of temporary foreign workers and their families. *Social Work in Health Care*, *57*(1), 13–26. https://doi.org/http://dx.doi.org/10.1080/00981389.2017.1379458

Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *International Journal of Mental Health Nursing*, *28*(1), 152–161. https://doi.org/http://dx.doi.org/10.1111/inm.12512

Saunders, N. R., Gill, P. J., Holder, L., Vigod, S., Kurdyak, P., Gandhi, S., & Guttmann, A. (2018). Use of the emergency department as a first point of contact for mental health care by immigrant youth in Canada: a population-based study. *CMAJ : Canadian Medical Association Journal = Journal de l’Association Medicale Canadienne*, *190*(40), E1183–E1191. https://doi.org/https://dx.doi.org/10.1503/cmaj.180277

Sethi, B. (2013). Newcomers health in Brantford and the counties of Brant, Haldimand and Norfolk: perspectives of newcomers and service providers. *Journal of Immigrant and Minority Health / Center for Minority Public Health*, *15*(5), 925–931. https://doi.org/https://dx.doi.org/10.1007/s10903-012-9675-6

Simich, L., Maiter, S., Moorlag, E., & Ochocka, J. (2009). Taking culture seriously: Ethnolinguistic community perspectives on mental health. *Psychiatric Rehabilitation*

Journal, *32*(3), 208–214. https://doi.org/http://dx.doi.org/10.2975/32.3.2009.208.214

Statistics Canada. (2017a). Focus on Geography Series, 2016. Retrieved from https://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-can-eng.cfm?Lang=Eng&GK=CAN&GC=01&TOPIC=7

Statistics Canada. (2017b). Study: A look at immigration, ethnocultural diversity and languages in Canada up to 2036, 2011 to 2036. Retrieved from https://www150.statcan.gc.ca/n1/daily-quotidien/170125/dq170125b-eng.htm

Steele, L. S., Lemieux-Charles, L., Clark, J. P., & Glazier, R. H. (2002). The impact of policy changes on the health of recent immigrants and refugees in the inner city. A qualitative study of service providers' perspectives. *Canadian Journal of Public Health = Revue Canadienne de Sante Publique*, *93*(2), 118–122. https://doi.org/10.1007/BF03404551

Teng, L., Blackmore, E. R., & Stewart, D. E. (2007). Healthcare worker's perceptions of barriers to care by immigrant women with postpartum depression: An exploratory qualitative study. *Archives of Women's Mental Health*, *10*(3), 93–101. https://doi.org/http://dx.doi.org/10.1007/s00737-007-0176-x

Tieu, Y., & Konnert, C. A. (2014). Mental health help-seeking attitudes, utilization, and intentions among older Chinese immigrants in Canada. *Aging & Mental Health*, *18*(2), 140–147. https://doi.org/http://dx.doi.org/10.1080/13607863.2013.814104

Urbanoski, K., Inglis, D., & Veldhuizen, S. (2017). Service Use and Unmet Needs for Substance Use and Mental Disorders in Canada. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *62*(8), 551–559. https://doi.org/10.1177/0706743717714467

Whitley, R., Kirmayer, L. J., & Groleau, D. (2006). Understanding Immigrants' Reluctance to Use Mental Health Services: A Qualitative Study From Montreal. *The Canadian Journal of*

Psychiatry / La Revue Canadienne de Psychiatrie, *51*(4), 205–209. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc5&NEWS=N&AN=2006-11307-001

Chapter 4: Racialized immigrants' encounters of barriers and facilitators in seeking mental healthcare services in Ontario, Canada

Author Order: Zoha Salam, Mirna Carranza, Olive Wahoush, Bruce Newbold, Ameil Joseph

Preface

This chapter aims to understand what factors racialized immigrants encounter when accessing mental healthcare services in Ontario. It draws from interviews conducted with immigrants from a variety of backgrounds to document barriers and facilitators. This study emphasizes how both individual and systemic-level factors play a role in understanding access to care.

This manuscript was completed between June 2022 and November 2023.

This manuscript will be adapted for publication based on journal guidelines and will be submitted to the Community Mental Health Journal.

Contributions

Zoha Salam conceptualized the study, developed the interview protocols, conducted the interviews, analyzed the data, and wrote the manuscript. Mirna Carranza, Olive Wahoush, Bruce Newbold, and Ameil Joseph (the dissertation committee) provided feedback to the study's materials and also to the manuscript.

Declarations

Funding

The authors have no relevant financial or non-financial interests to disclose.

Conflicts of Interest/Competing Interests

The authors have no conflicts of interest to declare that are relevant to the content of this article.

Abstract

Background: Racialized immigrants as a broad group are considered to be a clinically underserved population in Canada due to their low rates of accessing mental healthcare services. However, there are notable differences in accessing care among immigrant groups (e.g., student, settled refugee, asylum claimant) which reifies that they are not a monolith. The aim of this study is to understand racialized immigrants' experiences of accessing mental healthcare services at both the systemic and individual levels.

Methods: Through a qualitative descriptive methodology, interviews were conducted in English with 16 racialized immigrants to understand barriers and facilitators encountered when accessing mental healthcare services. There was also an emphasis on understanding how cultural and social conceptualizations play a role in attitudes towards mental healthcare services. Interviews were analyzed through Braun & Clarke's (2021) six-step method to reflexive thematic analysis in identifying both individual and systemic level factors.

Findings: Barriers and facilitators were consistent with what has been documented within the literature. Three major themes were identified: structural constraints, individual influences, and appraisal of services. With the first theme, racialized immigrants signaled to issues related to the systemic level that included affordability, wait times, and trust in the system. Individual influences highlighted individual-level characteristic factors of mental health literacy, social supports, stigma, severity of the issues, and awareness of services themselves. Lastly, extending on the previous theme, participants' appraisal of services was reflective of how social and cultural ideals shaped attitudes towards services received through the appropriateness of the provider or recognizing that services may have been inappropriate based on their needs.

Conclusion: The findings from this paper emphasize that racialized immigrants are not homogenous in their experiences and attitudes towards mental healthcare services. While there were similarities across different groups in the individual and systemic factors identified as barriers and facilitators in accessing care, there were key distinctions driven by appraisal of services themselves and if they were congruent based on their needs, more specifically, what was contributing to their negative mental health status.

Introduction

Racialized immigrants and refugees within Canada comprise a rapidly growing population (Statistics Canada, 2017a, 2017b). One fifth of Canada's population roughly consists of people identified as "immigrant" (Statistics Canada, 2017a, 2017b). Both immigrant groups experience a wide variety of settlement related stressors (e.g., finding housing, establishing social networks, learning new norms), and some stressors are unique based on reasons for departure and quality of support received from the government or local communities (El-Bialy & Mulay, 2015; Kirmayer et al., 2011; Wang, 2014). Migration itself is a demanding process that involves social, psychological, and economic adaptation, and this consequently has impacts on one's mental health that can be potentially negative (Berry, 1997; Ryan et al., 2008; Wong et al., 2007). Additionally, racialized immigrant groups experience a unique challenge in Canada due to their new ascribed identities of belonging to a racialized group (Hyman, 2009; Hynie, 2018). This process often brings various forms of discrimination related to their identities, namely, racism being a salient one (Ford & Airhihenbuwa, 2010b, 2010a). Some manifestations of this include discrimination within social interactions, employment, or in the healthcare setting (Hynie, 2018). Forms of discrimination experienced by racialized immigrant groups also impact one's health (Castañeda et al., 2015; Hyman, 2009; Hynie, 2018). Within the context of healthcare settings, this can lead into receiving lower quality of care, a misdiagnosis, or traumatization (Edge & Newbold, 2013; Ford & Airhihenbuwa, 2010b, 2010a; Jones, 2000).

Given the cumulative impacts of stressors from migration and settlement, racialized immigrant groups tend to have variable levels of mental health related stressors (Berry & Hou, 2019; Kirmayer et al., 2011). Some studies point to mental health differences being shaped by circumstances of departure to explain variability (Kirmayer et al., 2011; Ng & Zhang, 2021). For example, refugees tend to have more exposure to violence given their circumstances (e.g., forced displacement, detainment, natural disasters), thus instances of trauma are noted to be higher among this broad population group (Kirmayer et al., 2011; Ng & Zhang, 2021; Salami, Salma, & Hegadoren, 2019). Additionally, racialized immigrants and refugees are noted within Canada as a broad group that is generally underserved for receiving mental healthcare services (Ng & Zhang, 2020, 2021). However, there are considerable differences in mental health outcomes and needs among different groups. Regarding the influences in receiving mental healthcare services in Canada, the literature points to how structurally-driven factors such as financial capacity, geography, language differences, and wait times play a role (Salam et al., 2022; Thomson et al., 2015). Additionally, there are also individual level factors that include the following: understandings of mental health, perceived need, and social networks (Salam et al., 2022; Thomson et al., 2015). It is important to note that these may be patterned differently for those with various immigration backgrounds as generally there are admission requirements unique to each category (Anderson et al., 2017; Hynie, 2018; McKenzie, 2019; McKenzie et al., 2014; Oda et al., 2019). With the layering of both structural and individual level factors, this understandably produces unique experiences for racialized immigrants and refugees when seeking mental healthcare services (McKenzie, 2019; Salam et al., 2022; Thomson et al., 2015). These contextual factors shape barriers and facilitators when accessing mental healthcare services in Canada (Salam et al., 2022; Thomson et al., 2015). Ontario as a province is home to the largest amount of immigrant groups in Canada, therefore playing an important role in facilitating opportunities to improving access of mental healthcare services for this broad group (McKenzie et al., 2014; Moroz et al., 2020).

Mental health itself is a multidimensional construct that include life satisfaction, material needs, spirituality, and health outcomes (Fernando, 2019; Kirmayer, 2014; Kirmayer & Jarvis, 2019; Marsella & Yamada, 2000). Globally, there are different approaches to understanding mental health that reside within sociocultural norms (Fernando, 2019; Kirmayer, 2012b, 2014). Culture imparts specific schemas for how individuals navigate their world and makes meaning of experiences like healing, illness, and wellness (Kleinman, 1980, 1987). Mental health itself is a nebulous construct that holds various meanings across contexts, such as historical, cultural, and social (Bemme & D'Souza, 2014; Kirmayer & Jarvis, 2019; Marsella & Yamada, 2000). Therefore, one's understandings of mental health shapes the appraisals of treatment which is deemed to be appropriate based on the individual's needs (Kirmayer, 2012b; Kirmayer & Jarvis, 2019; Kleinman, 1980, 1987). Modern and Western psychiatric models of mental health and treatment may not hold universally true depending on sociocultural, economic, and political ideas that are specific to an individual's environment and needs (Joseph & Double, 2020; Kleinman, 1980). Research does highlight how the congruence between ideas of health, need, and treatment play an important role in determining health outcomes and perceived satisfaction of care (Kirmayer, 2001; Kirmayer & Jarvis, 2019; Kleinman, 1980). The construct of "mental health" within the confines of Western society is highly shaped by medical approaches to health that lie within biomedical paradigms (Joseph & Double, 2020; Kirmayer & Swartz, 2013; Williams et al., 2022). This approach has been critiqued as it discounts the presence of socioeconomic, spiritual, and political influences on understanding health and healing (Joseph & Double, 2020; Kirmayer & Swartz, 2013). More specifically, it has been argued to centre health as an individualized outcome and something divorced from broader ecological influences where an individual interacts with in their daily life (Kirmayer, 2012b, 2012a; Kirmayer et al., 2015).

For racialized immigrant groups in Canada, a change in environment and a new healthcare system can become a challenge and produce negative impacts on their wellbeing and mental health (Robert & Gilkinson, 2012; Simich, Maiter, Moorlag, et al., 2009; Simich, Maiter, & Ochocka, 2009). Encountering differences and similarities between understandings of health and care in Canada can produce certain attitudes towards seeking care services, such as services related to mental health (Chen, 2010; Kirmayer et al., 2011). For example, some individuals may want to seek services that are more considerate to one's cultural background (Kirmayer, 2001; Kirmayer & Jarvis, 2019; Simich, Maiter, & Ochocka, 2009). This misalignment or alignment consequently can contribute to lower rates of service uptake or challenges in seeking care services that are appropriate to their own needs (O'Mahony & Donnelly, 2007; Thomson et al., 2015). Racialized immigrant groups in Canada have been noted to have variable rates of mental health outcomes and service usage patterns that may be dependent on their immigration pathways (Ng & Zhang, 2020, 2021). Generally, results have indicated that immigrants on average are less likely than their Canadian born counterparts to have mental health consultations (Durbin et al., 2014; Ng & Zhang, 2021; Rivera et al., 2020). In comparison with other immigrant groups, there have been mixed results that refugees generally have more mental health consultations or access to services (Ng & Zhang, 2021) However, it is important to acknowledge that many racialized immigrant groups arrive from locations outside of Canada that have similar healthcare systems and services and therefore they are not homogenous within the context of the uptake of mental healthcare services upon arrival to Canada (Beiser, 2009; Emerson et al., 2021; Kuile et al., 2007; Simich, 2010; Simich, Maiter, Moorlag, et al., 2009). Seeking mental healthcare services among racialized immigrants is a complex process that centres on the alignment between perceived need from internalizations of mental health and ideas of appropriate care (Donnelly et al., 2011; Higginbottom et al., 2015; Simich, Maiter, & Ochocka, 2009). The connection between understanding conceptualizations of mental health and their impacts on self-appraisals of mental healthcare services becomes an important point of interrogation in identifying the underlying factors that shape mental healthcare service utilization among racialized immigrant groups (Kirmayer et al., 2003, 2011; Kleinman, 1980, 1987).

This paper seeks to report on further interrogation into understanding racialized immigrants' and refugees' experiences of accessing mental healthcare services in Ontario. Additionally, it aims to signal how systemic and individual level factors produce certain experiences in the help-seeking process for this broad population group. A key element of this paper is that it attends to how attitudes and conceptualizations of mental health shape barriers and facilitators in accessing care. Ethics approval to conduct this study was granted through McMaster University's Hamilton Integrated Research Ethics Board (HiREB) on September 13, 2021, under project number 13736.

Methods

Guiding Frameworks

The two conceptual frameworks used to guide the development and consequent analysis of this study were Andersen's Behavioural Model of Health Care Utilization (ABMHCU) (Andersen, 1995) and Kleinman's Explanatory Model (KEM) (Kleinman, 1980). The ABMHCU seeks to understand an individual's healthcare utilization through three factors at the population characteristic's level in the model: predisposing (demographic), enabling (resources), and need (self-appraisal for health status and service usage). It also considers broader aspects, such as the healthcare system itself (Andersen, 1995). KEM is specific to understanding an individual's appraisal and experience of "illness" and treatment by identifying culturally contextual details that are relevant, such as the need for specific treatment and appraisal of it (Kleinman, 1980). Additionally, the KEM contextualizes the structures with which the individual interacts, such as healthcare, society, and culture, as they shape their knowledge and language associated with the particular "illness" but also treatment that is deemed to be appropriate (Kleinman, 1980). For this paper's purpose, it affords nuance in unraveling how racialized immigrants describe their mental health, construct wellbeing, and appraise treatment from mental healthcare providers in relation to broader structural factors and social norms (Kleinman, 1980, 1987). In the present study, both the ABMHCU and KEM layer together and guide the development of this study to produce an understanding of how systemic and individual factors play a role in shaping the participant's mental health help seeking journey, identifying barriers and facilitators. For example, the "need" factor in the ABMHCU can be influenced by individual values as one's appraisal and perception of their mental health status could potentially be influenced by cultural norms (Andersen, 1995).

Methodology

This study takes a qualitative approach rooted in constructivism to understand racialized immigrants' experiences in seeking out mental healthcare services in Ontario. The selected methodology for this study is Sandelowski's conceptualization of qualitative description (QD) research (Sandelowski, 1995, 2000, 2010). QD, through Sandelowski's approach, aims to explore a phenomenon by remaining close to the accounts presented by participants; however, with a level of interpretation that acknowledges that inquiry is not entirely atheoretical. This description acknowledges QD's roots being in constructivism. Thus, QD supports the usage of theoretical and conceptual frameworks as part of its methodology, but the goal is mainly to situate the findings based on the research question (Sandelowski, 1995, 2000, 2010). QD is an appropriate methodology to explore racialized immigrants' experiences when accounting for how various factors can shape their access of mental healthcare services in Ontario.

Recruitment and Participants

The participants were recruited on the following criteria: they had arrived in Canada at any point in their lives as an immigrant (e.g., refugee, student, worker, sponsored through family), currently live in Ontario, self-identified themselves as a "visible minority," used mental health services in Ontario at any point in their lives, and were comfortable having a conversation in English. Recruitment began in November 2021 and finished in April 2022 when the last participant was interviewed.

Recruitment occurred through various methods of outreach, such as digital flyers and emails sent out to local community health centres, settlement agencies, and professional research networks. In addition, recruitment included snowballing with participants who partook in the study to increase participant numbers and variety. The community health centres and settlement agencies were located primarily with the Greater Toronto Area, as this region is notably a "catchment" area where the largest numbers of immigrant and racialized groups reside in Ontario. Therefore, an emphasis was made on emailing agencies within this area. Additionally, agencies located in other larger Ontario cities such as Hamilton, London, Guelph, and Windsor were also contacted as they have large immigrant and racialized populations. Agencies were only contacted once and not followed up with if there was no response received, as understandably these agencies may be overburdened or have an internal policy not to participate in research studies. Regarding what is meant by "professional networks," this entailed a listserv that is hosted by an Ontario university with a notable research centre focused on refugees. This listserv often circulates research flyers for participation, grant opportunities, academic conferences, petitions, and newly produced research. Access to this listserv was granted for distributing this study's flyers given the first author's own professional affiliation with the university. Part of the "professional network" also included faculty that the first author had connections with, who could distribute the study's flyers.

A total of 16 individuals participated in the study. All participants fully finished the interview. See table below for participant demographics.

Table 1

Overview of Participant Demographics

Participant	Gender	Age	Landing Status in Canada	Years Since Arrival
1	Male	26	Government Sponsored Refugee	11 months
2	Male	25	International Student	5
3	Female	26	International Student	5
4	Female	27	Refugee Claimant	24
5	Male	26	International Student	7
6	Female	53	Spouse	20
7	Female	33	Spouse	8
8	Female	27	International Student	10
9	Female	27	International Student	11
10	Male	22	International Student	6
11	Non-binary	21	Child Dependant	10

12	Male	27	International Student	1
13	Female	41	Government Sponsored Refugee	4
14	Male	33	Privately Sponsored Refugee	7
15	Female	27	Refugee Claimant	15
16	Female	26	Refugee Claimant	5

Data Collection

Data was collected through a semi-structured interview guide in English which included questions surrounding their help-seeking journey. These questions were developed through identifying key concepts explored in the ABMHCU and KEM. From the ABMHCU, this included questions that asked about demographics (e.g., gender, age, landing status in Canada), perceived need, and general resources available. Within the interview guide, the following areas from the ABMHCU were developed: such as when they realized they needed to seek help, how did they go about seeking help, and what were their appraisals of the services they received. Specific questions related to identifying barriers and facilitators were asked. This also included a question on whether their legal status at the time played a role in the process and experience. The influence of the KEM on the interview guide, included the full set of questions asked to provide insight into the participant's self-appraisals and potentially more culturally specific details relevant to understanding their experiences. The interview guide was first drafted and then circulated to the dissertation committee for feedback on length, clarity, and accessibility for varying degrees of English proficiency. The interview guide was structured in five phases:

introduction (e.g., introducing the researcher/interviewer, highlighting the rights of a participant, what is expected in the interview, and re-iterating the consent form's details), demographic data collection, asking participant ideas about well-being, what they felt like they needed help for, and barriers and facilitators in their experience.

Participants reached out to the first author through email to indicate their interest and they were greeted with a standard script and were given opportunities to ask any questions related to the study. If they were still interested in participating after being satisfied with answers to their questions or had none, a consent form was provided to them electronically through their email and were given an opportunity to review it and ask any questions. There was no deadline imposed on when they should sign it to give them the opportunity to take their time to read it in order to make an informed choice to participate. The consent form borrowed standard language and guidance provided by HiREB on their website and was approved from their review process. If they had no questions or their questions were satisfied, they sent a signed consent form to the researcher, and a final copy was returned for record keeping. A time and date were selected based on their preferences, and a Zoom link with a passcode was emailed to them.

The interviews were conducted through Zoom with only the audio and video off to provide participants privacy and also prevent strains to their internet connectivity. Zoom was selected because it is approved by HiREB as a videoconferencing platform to be used for research purposes. All interviews were recorded through Zoom's built-in available feature. Interviews were to last a maximum of an hour and 30 minutes, and generally did not go over an hour. After every phase of the interview was completed, participants were given the opportunity to take a break before moving on to the next set of questions and asked if they would like to continue participating in the interview. The latter was done to continue the process of informed consent, as participants had every right to finish the interview whenever they wished. Participation was recognized with a $20 Canadian dollar e-gift card to any vendor they preferred. Additionally, a curated list of free to access psychosocial and social welfare resources available in Ontario and Canada was shared with all the participants once the interviews were over. This list was developed in case participants would benefit from resources, and they were to use them on their own discretion.

Analysis

The recorded audio files from the interviews were automatically transcribed by Zoom's software. While transcripts were not fully transcribed and cleaned or used for analysis, the audio records served as a key touch point when going over notes and summaries that were produced during the interviews by the interviewer. However, the audio recordings were relied on heavily and re-listened to as part of the analytic process. The data was analyzed independently by the interviewer using Braun and Clarke's (2021) approach to thematic analysis which included the six steps: familiarization with data, generating codes, searching for themes, reviewing themes, definition of themes, and writing it up. A more fulsome discussion of how the six-step approach was followed and how reflexivity was practised can be found in Chapter 2 of this dissertation. Key areas of exploration within the transcripts derived from the domains in the ABMHCU and KEM, and this included identifying barriers and facilitators to accessing services, participants' appraisals of seeking services, and ideas surrounding mental health. In analyzing the data, careful consideration was given to how the participants articulated their ideas and experiences of mental health and well-being, but also how this informed their ideas towards receiving mental healthcare services. The analysis of the data was aligned with the ABMHCU and KEM, and contextualization was given to culture, and how wider structural influences may have shaped the participants' experiences.

Findings

While the goal of this study was not to essentially map the findings directly onto the ABMHCU and KEM, they loosely guided the analysis process by identifying how both structural and individual level factors produce specific experiences among racialized immigrants in Ontario as part of their help-seeking process.

The list of themes and their corresponding subthemes identified from the analysis process can be found in Table 2. This following section will elaborate on the themes and provide an overview with selected quotes from the interviews.

Table 2

List of Themes

Theme	Subtheme
Structural constraints	Affordability
	Wait times
	Trust in the system
Individual influences	Knowledge of "mental health"
	Social supports
	Associated stigma
	Severity of issue

	Awareness of services
Appraisal of services	Appropriateness of provider
	Just a Band-Aid
	What I needed

Structural Constraints

This theme broadly encompasses participants' experiences of accessing services and how structural level influences, such as economic feasibility, wait times, and trust in the system became barriers and facilitators in accessing mental healthcare services.

Affordability

While an obvious one, there were several participants who indicated that finances and their ability to afford such services impacted their access. Participants identified coverages such as what their university provided under their student health plan or their work benefits, and this was considered to be both a privilege and a burden. For some, the financial aspect was not an issue as they were able to pay for these services through their extended health insurance from their employment that also covered mental healthcare services. The quote below is an example of how services through one's work was a key resource when accessing services. It is important to note that this individual, once an international student, now had permanent residency status and was employed.

“Yeah, because the insurance from my work covered it”- Participant 8

However, some noted that their extended health insurance via their work benefits would only cover a limited number of psychotherapy sessions and therefore this was a constraint. In the quote below, this is demonstrated as the participant shares that the sessions would be costly, and they would potentially pay out of pocket if they needed more sessions.

“I found out that my benefits from my work would cover it, but it was fairly expensive, so I was going to have to either do a limited number of sessions or, like, pay out of pocket, like, once it ran out” – Participant 2

For others who did not have access to extended insurance or benefits of any kind, this became a difficult process. Participants within this scenario waited until they were able to financially afford mental healthcare services or relied on free-to-access psychotherapy services offered at local community health centres. In situations where participants were prescribed medication for their mental health symptoms, some had to pay out of pocket because they did not have coverage at all or had varying levels (e.g., none or partial) of coverage through their work or student health care plan. Specifically, in the quote below, a participant who was an international student at the time shares his difficulty as this expense was something he “had not planned.”

“It was costly. The visitation for the doctor was on and off, and the medication for me it was a bit costly, you know, it’s something you haven’t planned” - Participant 10

This experience underpins the idea that those with a temporary visa status, such as international students, are placed in a position of precarity or vulnerability due to their limited ability to access certain services as they may not have full coverage or access in the first place.

Wait times

For a few participants, finding services that accommodated their work schedules became a hassle in seeking care. More specifically, for those who were juggling multiple jobs or also had family obligations themselves this was a difficult experience. This barrier was not specific to any immigration class, as some were able to access services in a time that was acceptable to them. As described by the participant in the quote below, she shares her frustration in seeking an appointment that was aligned with her routines.

“You know, there were hardly any appointments that were available, you know, it didn't work with my schedule or my routine and there were very limited options in terms of what kind of help I had access to at the time. And so, I ended up not seeing a social worker or a therapist because, again, the appointments were booked like eight weeks out.” – Participant 7

Another participant shared that the services offered through her campus had a wait time due to the timing of the semester. During the wait time, she described that her mental health became worse which exacerbated the issues she was experiencing.

"So, I wanted to talk to the counselor, but that was when the new academic year and new semesters started, so there was like so much demand, so I had to wait, like, three weeks before I was able to speak to the counselor. And, and in that three weeks my mental health was really, like, gone bad." – Participant 3

Given the quote above coming from an international student, there were other international students who were accessing services through their university campuses that did not experience issues with wait times. This highlights the variability in services available on campuses – as some may be more efficient with triaging cases or have more mental health providers and resources available due to funding or structural organization.

Trust in the system

When elaborating on their reluctances to receive care in the first place, a few participants had hesitations that stemmed from the "system." The system could be described by some participants as the healthcare system intertwined with the legal and immigration system or the healthcare system as a form of institutionalization. Broadly, it could be understood that the mental healthcare system acted as a form of policing for some participants due to their precarious legal status.

For participants in the present study who arrived in Canada as children, they note experiences of how their elementary school or high school staff would alert their parents when there were concerns of mental health issues and would offer to connect them with services via child welfare. This was described as a "traumatic" experience as they later encountered negative consequences at home. In the quote below, a participant with a refugee claimant background describes that she "lost trust in the system" and ended up learning how to take care of herself through self-researching her symptoms. For this participant, she did not want child welfare involvement as it would potentially impact her family's residency in Canada.

"So, I just lost all trust in the system and still have no trust in the system. I'm managing my symptoms, through my own research, and I am doing much better, so there must be some success to it, but I feel like the system consistently fails." – Participant 4

Another participant with a refugee claimant background in the quote below recollects her experiences of seeking care at a hospital's emergency room after experiencing a panic attack. She notes that she was fearful of being jailed or having medications pushed on her and this highlights her trust towards the medical system.

"I was at that point, I was ready to be helped in a way, yet at the same time, culturally speaking, I don't want to be talking to a psychiatrist. Are you gonna put me on pills? That's the first thing that came to my mind, right? Second, are you going to, uh, isolate me? The way I see it, are you going to put me in jail? You know?" - Participant 15

This subtheme demonstrates how mental healthcare services as they exist are intertwined within other structures which may limit access to care. Specifically, for those individuals who are already systemically vulnerable due to their status, this produces experiences resulting in further distrust.

Individual Influences

There were various factors that could be understood which operated at the individual level of the participant that centred on their own knowledge, personal social resources, stigma, and perceived severity of issues. It is important to note that the subthemes identified from the data encompass a variety of complex experiences noted by participants in becoming either barriers or facilitators in seeking mental healthcare services.

Knowledge of "mental health"

When participants were asked if they previously heard of any other individual experiencing the same phenomena or set of symptoms, many of them noted that their knowledge came from various areas, such as their formal education, the internet, or through their friends. For some, they held degrees related to psychology or studied medicine previously before coming to Canada and therefore they were aware of their symptoms being a concern for a larger thing.

"Taking a psychology class in undergraduate gave me a lot of vocabulary that I just did not have previously for the things that I knew I was experiencing, like, the dots just connected." – Participant 4

"Like, thinking back to that and, like, thinking that all this is similar to what I remember reading about that time and now I just do research on my own" – Participant 5

Some other participants shared that they relied on searching their symptoms on the internet to understand more on what they were experiencing. These particular participants also relied on seeking out on educating themselves by watching videos online related to their symptoms. This included accessing content within their language of choice which made it easier for them to understand. The internet became a great self-help tool for them in developing mental health literacy because it provided knowledge in accessible formats.

Others learned about what "mental health" was through sharing their experiences of symptoms with their close and trusted friends in Canada and back in their birth country. For some, this was an approach to learning more about their mental health issues as their friends in Canada also were experiencing the same challenges.

"It wasn't a medical concern, it just felt wrong. I didn't know that it was not normal, and I only realized that when I started speaking about my problems with my friends" - Participant 11

The quote above emphasizes how social networks play an important role in helping individuals learn about mental health and broader concepts related to it that exist as norms within Canada. For some, this included seeking support from their friends to help them cope with stressors they were experiencing. More on social supports as a subtheme will be elaborated in the following section.

Social supports

In related fashion to the previous subtheme, social networks became a complex resource in shaping participant experiences of seeking out mental healthcare services. Social networks included immediate or extended family members, partners, friends, professors, and religious leaders. While some participants were separated from their family and friends as they were living alone in Canada, they often relied on staying connected via phone calls or texting. These individuals generally were identified as being "close" to the participants.

Participants in this study who belonged to religious organizations often confided in their religious leaders when discussing their mental health concerns. Their religious organizations also were described as "pro-mental health" and sometimes had religious services in discussing such topics, and therefore there was a positive regard towards this topic. For some participants, their religious leaders held related degrees, such as social work, and were able to provide relevant information in accessing services by making referrals to resources. It can be understood that religious organizations are a useful base for contact and access to care for those who are newcomers to a community. One participant below describes how she felt that her pastor was approachable, and therefore this helped her in sharing the mental health challenges she was experiencing as a way to seek out support.

"I went and talked to my pastor about it, like, it is amazing because she's someone that I felt that I could talk to a lot about things and she's such an open person" – Participant 8

For those participants who were partnered, some felt secure in sharing their mental health challenges. They shared that there was no fear of experiencing negative consequences from their disclosure. Some partners were described as being persistent in helping their loved one access care, as shared in the quote below.

"After I spoke to her about all of this, she was, like, 'you need to see somebody about this, like a therapist or a counselor or whatever,' and initially I was, like, 'no it's fine like it's not a big deal,' but she she's a very, very persistent human being very persistent" – Participant 3

However, not all experiences related to relying on social support networks were positive as some mentioned complex experiences from their families. Some participants described this as a "balancing act" of not alerting their parents by not delving into their mental health challenges too much due to past conversations ending negatively.

"And you know they told me that they wanted to help me access certain services, but they would need like consent from my guardian, and I was, like, 'no I refuse I'm not going to get consent from my guardian this isn't going to happen'" – Participant 4

"The aspect of having to hide this from my family, like, I feel like I'm on thin ice" - Participant 11

It is important to note that the two individuals were within their adolescence in reference to when they were experiencing mental health challenges and their schools tried intervening. Given certain family dynamics, it can be understood that this may have exacerbated their issues at the time and prevented them from seeking help at all.

Associated stigma

The stigma surrounding mental health became a key deterrent to seeking out care for some individuals. Participants identified a variety of domains they felt where the stigma was either perpetuated or came from. In the quote below, a participant notes that the lack of information on mental health services in Ontario is a failure of the "system," referencing the health system not fully integrating such services. He later emphasizes that while mental health services are not taboo here, there is still a stigma towards services that stems from society. This perceived stigma may have contributed to the lack of awareness of services for him. It is important to note that participants shared that they felt that there was stigma in their home countries and also within Canada in relation to accessing mental health services.

"Mostly, me, like, not having information, I think that's, I don't know, if that's a failure of the system itself, or maybe, just like as a society and mental health still being maybe not taboo - it's not quite the right word anymore, but still being a little bit, like, little stigmatized." – Participant 2

Other participants shared how perceptions of gender and expectations related to that impacted their ability to seek out help. The participant below shares how they were prevented from seeking out help for mental health issues because it would reflect poorly on themselves as a potential marriage candidate but also on their family. As a woman, she felt that there was more stigma towards her due to gender norms within her environment.

"Because those are the priorities, right, like, *shaadi ka time hoy gay* (translation: it's time for marriage). You know when by the time you're older and it's time for you to get married off. It looks bad it reflects poorly upon our family, you know, there's that whole concept of *izzat* (translation: shame) which is intrinsically tied to you know how I present myself in society." - Participant 7

It can be understood that stigma towards mental health is not uniform, as it is shaped by gender norms and perceptions of disability. The following participant below describes how having mental health problems within their upbringing was akin to being perceived as a disability and therefore they were not seen as favourable in society and not worthy of care or affection. Similar to the previous participant above, as she would be perceived negatively by a potential suitor. This highlights how stigma associated with mental health is sometimes rooted in ideas of disability.

"You're just weak, you're just lazy, and that was, like, the narrative surrounding mental health. It was very much you are a person being unable to function as a human being, like, it is a disability. A person being unworthy, of you know, care and affection, because they didn't have real problems." – Participant 4

However, it is important to understand that not all participants held views towards "mental health" that involved stigma, as some viewed it as a legitimate concern that needed attention. For example, a participant below describes how she was raised in a family where mental health was something that was taken seriously. It is important to note that she emphasizes that while her family were more “traditional,” they still understood “mental health” as an issue to be attended to.

“I grew up in a family, despite the fact that they follow culture, tradition, and beliefs, they are also quite aware of mental health. They could detect an issue. I just grew up knowing that people get sick, like mental health, and action needs to be taken seriously.” - Participant 9

Severity of issue

An unfortunate consequence for many participants was ignoring their mental health concerns and other associated symptoms, such as loss/increase of sleep, decreased appetite, or emotional dysregulation. When participants described that they felt as if they were at their “breaking points,” or as described by the participant in the quote below that they could not “trust themselves,” this feeling became a catalyst for them in seeking help.

“I no longer trusted myself to do the right thing, or be okay” - Participant 11

“And it's that thing, where you think it's not going to affect me, and so I didn't really give it much thought in terms of pathologizing it until it got to a point where you know, I was really, really, feeling low, and it was you know sort of getting out of bed was really difficult, eating food was really difficult.” - Participant 15

It is important to indicate that many participants stressed the physical consequences on their bodies as well as their ability to carry out daily tasks in their lives, such as domestic, hygiene, or work/school demands.

Awareness of services

Participants noted that one of the factors that facilitates help-seeking was the awareness of such services and their availability. While some were students on university or college campuses, they were acquainted with services because they were advertised on campuses or made aware through peer mentorship programs for international students. For others, they became acquainted through advertisements around their city, for example, Centre for Addiction and Mental Health advertising on Toronto billboards and posters. The two quotes below come from two international students who found resources through services on their campuses.

“There was a mentor support system, and uhm, I went there and shared my story, and the person shared some materials, advice, and linked me to a website. They also gave me a number for contact to get support. - Participant 12

“One of the friends, I met in Canada, told me she actually went to the counseling service in like at [REMOVED] in the university that they offer to graduate students so she mentioned it once before, like, I had to like saying like I had to see a counselor while I was writing my thesis, so I knew I had that resource, too” – Participant 3

One participant who arrived as a settled refugee notes in a quote below that she was immediately connected with a physician upon arrival, and this helped her in her continuity of receiving care as she was on medication for various health issues. For other refugee participants in the present study, they had been on medication before arriving to Canada while in transit countries (e.g., Jordan) and therefore were aware of services in general and what they needed once arrived. This highlights how individuals arrive from highly developed health systems and suggest that certain mental health services are acceptable and appropriate based on their needs and familiarity. Additionally, this may be facilitated by the communication to refugees to upon their arrival in Canada.

"When I came here on the first day, I was so anxious, I met my family doctor and I told him I need to see a psychiatrist." – Participant 13

Appraisal of Services

In the process of having accessed the mental healthcare services, participants described their experiences and appraisals. Two sub-themes of "trust in the system" and "appropriateness of provider" were identified.

Appropriateness of provider

There were assumptions of the provider's competence as a potential barrier and facilitator in seeking care among some participants. Many participants did not actively select a mental healthcare professional, but were assigned one through an organization or practice that was available to them at the hospital, through their work, or at campus. For some participants who actively chose their provider, they often discussed why a match in cultural and language background was important to them as they felt that they did not have to work as hard to explain to their mental health provider about their contextual background and life history. Others were not so fortunate, as noted by the participants below:

“I don't know. I think I would say yes, I am satisfied with it, um, but I still have that lingering you can hear it in my voice, but I still have that lingering would like to try other therapists, like, I could get better” – Participant 8

“And yeah not to say it, but she's very good at what she does, but it was very obvious to me that none of that was actually going to help me because none of it took into account all the cultural considerations.” - Participant 16

While cultural and linguistic fit was something important to the participants. One participant did not have a positive experience when seeing a physician who was culturally congruent. In the quote below, she experienced stigma from a family physician she went to regarding the symptoms of mental distress that were occurring. She notes his ethno-cultural background in providing more information as to why he may have laughed. It could be interpreted that in their shared cultures, it is a stigmatized topic and his attitude reflected that through inappropriate behaviours (i.e., laughing) which made her later engage in self-censure of her problems.

“And so I did have a South Asian doctor and he very much would laugh off any suggestion of mental health issues as well and it kind of shamed mentioned never bring it up again.” – Participant 4

Just a Band-Aid

For participants who described their mental health symptoms being more notable around the time they had started encountering financial hardships and other issues where their basic material needs were not being met, they often described the "mental health services" they had received as a "Band-Aid" to help solve their problems. Essentially, a temporary fix for more broader and overarching issues that were systemically driven and producing distress to the individuals.

"It's just a lot of band aids, no real solutions or actual healing" – Participant 11

"I feel like all of those things that drove me here aren't still resolved. Like, housing and employment." – Participant 14

Both participants above share how their core issues (e.g., housing, employment, income) are key drivers of their mental health challenges and the mental health services they received were limited in supporting their broader needs. This exemplifies how economic precarity experienced by racialized immigrants is a particular challenge due to resettlement which may be more intensified for those with more precarious backgrounds related to their legal status or financial stability.

It is important to note that many participants described experiencing financial issues within their first years of arrival in Canada. This cascaded into housing and food insecurity which impacted their mental health severely. As newcomers, some were in precarious positions while being students who could only work limited hours. These quotes highlight the importance of the social determinants of health in influencing their wellbeing and specifically how international students are in precarious financial positions within the first few years of their arrival or settlement to Canada.

What I needed

This statement was shared by participants who believed that psychotherapy or medication were the appropriate forms of support needed to help them overcome their symptoms and challenges. For some participants, their ideas and attitudes towards such services were shaped by previous experiences involving their immediate and extended family or friends who had gone through similar events. Therefore, psychotherapy or medication became a solution that was favourably appraised as it was familiar to them.

"So, when I went in, when I started, like, school again I pretty much knew I had a rough idea of what I was going through, and I knew what I needed, what kind of help I needed to get" – Participant 5

"I believe I needed a therapist, who gives me skills, like breathing, how to breathe, and how to exercise" – Participant 13

Participants' familiarity with such services helped to make it easier for them to approach and receive services. This included what to expect, what to ask for, and how to advocate for themselves in order to receive the care they believed they needed. Additionally, for some participants, this involved self-researching through books or resources found online. Some participants went as far as selecting a mental healthcare provider based on issues they believed were important to them, such as their symptoms, a cultural or linguistic match, or a gender or sexuality match.

"To me it was very important that she was Latin American, like, she was Colombian. She understood the cultural component of my disorder and struggle that I had" – Participant 16

Discussion

The goal of this paper was to identify what racialized immigrants perceive as barriers and facilitators when accessing mental healthcare services in Ontario, Canada. From conducting the interviews and analyzing the data, it can be understood that factors at various levels exist in producing such experiences. However, while there were commonalities noted by participants, there were also considerable differences that influenced accessing mental health services. These impacts might be magnified for some populations based on their legal status or generally being a newcomer to Canada. Broadly, three themes were identified: structural constraints, individual influences, and the appraisal of services. Implications for researchers will be addressed throughout.

Within the theme of structural constrains, subthemes such as "affordability," "wait times," and "trust in the system" were identified. In signaling to the study's frameworks, in the ABMHCU, one of the key factors is "enabling" resources which identifies assets an individual has or does not have access to when seeking out services (Andersen, 1995). These resources could be financial, tangible, geographic, or temporal (Andersen, 1995). In the present study, one's legal status also became an enabling resource as it afforded them certain privileges or became a burden.

The "affordability" subtheme highlighted how participants were able to afford such services in the first place and how economic status coupled with legal status sometimes played a role (Campbell et al., 2014). For example, those who had permanent residency, they were able to obtain benefits through their employer that covered mental healthcare services (Kuile et al., 2007; Rajkumar et al., 2012). However, for those who were on a temporary visa, such as being an international student, they were entitled to certain coverages which may have been limited in the services they could receive (Brabant & Raynault, 2012). For example, some individuals noted that health care coverage through their university did not fully cover their medications. This signals how affordability can sometimes be offset through one's ability to legally work or receive particular benefits in Ontario given their legal status (Campbell et al., 2014; McKenzie, 2019).

In the "wait times" subtheme, some participants shared that they were unable to find appointments that aligned with their work schedules or how the services they were receiving via campus health services were backlogged. As a consequence, some felt that their mental health symptoms and issues worsened as they were waitlisted. For newly arrived immigrants in general, finances are an important aspect that shape settlement experiences (Salami, Salma, & Hegadoren, 2019). Given noted issues of structural constraints, there needs to be increased funding and expansion of mental healthcare services considered by the provincial government (Moroz et al., 2020). This also highlights the need for more community health centres to be adequately funded and staffed to provide services (Aery, 2018; Lane & Vatanparast, 2022; Nerad & Janczur, 2000). Going back to the ABHMCU, time itself is an enabling resource and also has been argued to be a social determinant of health among researchers (Benjamen et al., 2021; Strazdins et al., 2016). It is well established that those with lower income and those with none or poorer healthcare insurance plans wait longer to receive services generally of any kind (Currie et al., 2024; Gotlieb et al., 2021; Hajizadeh, 2018; Ho et al., 2017). Access to services in a timely manner deemed appropriate to an individual becomes an important consideration for interventions (Hajizadeh, 2018; Hynie et al., 2016).

The findings in this study highlight the last subtheme's importance, more specifically how legal status shaped some participants' experiences of seeking care as this could potentially jeopardize their stay in Canada (Bernhard et al., 2007; Villegas, 2015). Some participants raised concerns about detainment or surveillance as a consequence when seeking out services, which emphasizes how both the medical and legal immigration systems intersect together for them (McKenzie et al., 2014). While not just limited to seeking care from the medical system (i.e., hospital), the idea of surveillance also extended to the education system. For other participants who were offered mental health services at a young age via the school system, they described how this was an inappropriately intrusive approach given their caregivers' attitudes and worries towards potential surveillance (Ahn et al., 2014). This highlights the need for more contextually and ethically appropriate interventions within school systems, as some youth may not be able to access services without their caregivers' consent but would still like to receive them (Ahn et al., 2014). Signaling back to one's legal status as a key area of concern, one participant who arrived in Canada as an asylum claimant at a young age felt that the intervention posed by their school made them feel uncomfortable as it could have placed their family at risk for surveillance. Mental health related referrals from the education system in Ontario could bring child welfare involvement (Fong et al., 2018; Reid et al., 2021). It is well established that the child welfare system disproportionally negatively impacts racialized children and families in Ontario, such as "criminalizing" practices of parenting due to the intersections of racism, xenophobia, and ableism (Ontario Human Rights Commission, 2018). Layered with concerns of one's legal status being precarious, this produces further distrust towards social services which may prevent families from seeking out care for their children or themselves (Ahn et al., 2014).

In the broad theme of individual influences, this included subthemes of "knowledge of mental health," "social supports," "associated stigma," "severity of issues," and "awareness of services" in shaping barriers and facilitators of seeking care. These subthemes relate to the ABMHCU under the population characteristic factors of "enabling" and "need."

With the population characteristic factors, the subthemes of "social supports" and "associated stigma" are reflected as the key factor that "enable" health care use in the present study's findings. All participants within this study brought in their unique perspectives of mental health which were sometimes layered with past experiences of receiving such services in their country of origin. Therefore, the experiences noted within these subthemes were contradicting and rich, and it highlights that not all racialized immigrants are monoliths or homogenous in their attitudes towards mental health or care (Kirmayer, 2012b; Kirmayer & Jarvis, 2019).

From the findings, given that the concept of "mental health" has a multitude of meanings among various communities and individuals, there must be consideration of understanding how this may manifest in increasing mental health promotion (Corrigan et al., 2014, 2016). There is research using labels such as "mental well-being" and "psychosocial wellness" that departs from more medicalized, and often more stigmatized, understandings of mental health (Corrigan et al., 2014, 2016). Such labels may promote demystification of services themselves, but also education around the broad spectrum of what constitutes as mental health among different cultures (Kirmayer, 2012a; Kirmayer & Swartz, 2013; Simich, Maiter, & Ochocka, 2009).

For some participants, the three subthemes of “social supports,” “associated stigma,” and “awareness of services” contributed to each other. Their social networks were influential in shaping ideas of mental health, such as stigma or seeing it as a legitimate concern (Donnelly et al., 2011). Consequently, some participants only knew about the services through their peers or colleagues. This finding highlights how social networks, and more specifically, perceived quality of social networks and support plays a key role in either being a barrier or facilitator when seeking mental healthcare services (Maulik et al., 2011). For racialized immigrants, forming new social networks is an important aspect of resettlement; however, some immigrants stay in connection with their loved ones back home via technology (Hiller & Franz, 2004). The key role of social networks should not be underestimated, as for those newly arrived, this becomes an important resource for facilitating settlement (Hanley et al., 2018; Lamba & Krahn, 2003; Nakhaie & Kazemipur, 2013). It is important to note that the peer groups referenced by participants were composed of individuals who came from a similar background as them. Social relationships were key resources in the participants’ lives, as social capital helps an individual cope with stressors (Ellis et al., 2015; Hynie et al., 2011). For many, moving to a new country drastically changed this experience, and forming relationships in their new setting was a concern and sometimes impacted their mental health (Chadwick & Collins, 2015; Salami, Salma, Hegadoren, et al., 2019). Participants within the study found community within local religious organizations or places of worship that often had their ethnocultural group (Agyekum & Newbold, 2016) or made friends at their college or university programs (de Moissac et al., 2020; Thomson & Esses, 2016).

The subtheme of “severity of issues” supports the broadening of alternative forms of care that are not acute mental healthcare services that someone would access when in crisis. This can be based on a triage system of preventative care, where depending on the individual’s needs and issues, they can be referred elsewhere to the appropriate services (Chiu et al., 2018; Ford-Jones & Daly, 2022; Mowbray et al., 2019).

Lastly, in the subtheme of “awareness of services,” it brings attention to how important it is to widely advertise such services in public, which helps promote visibility and access (Kelly et al., 2007; Sampogna et al., 2017). Some examples provided by participants included services being advertised on campus through promotional flyers or news bulletins or billboards around their city that included a telephone number. This proposes the need for targeted advertising campaigns for mental health services on campus for international students, or broadly newcomers to Canada (Minutillo et al., 2020).

Lastly, the “appraisal of services” theme involved the following subthemes: “appropriateness of provider,” “just a Band-Aid,” and “what I needed,” in understanding the participants’ appraisals of the services they received. This theme draws from the KEM, as it signals to what an individual may deem appropriate care is rooted within their context and environment (Kleinman, 1980). Therefore, there is no one size solution for a broad population group who may encounter similar experiences during settlement.

Regarding the first subtheme of “appropriateness of provider,” the findings indicate how important a provider’s personality, perceived competence, and general demeanour is when seeking care. For some participants who selected providers themselves, they intentionally found someone who was their cultural and linguistic match to overcome barriers (Farsimadan et al., 2011). This finding highlights how more non-white providers are needed within the mental health profession as some individuals feel that this is a key component for what constitutes appropriate care for them (McDowell, 2004; Wieling & Rastogi, 2004). Additionally, this arguably supports the need for more culturally reflexive training to help provide services that are more appropriate (Kirmayer, 2012b, 2012a; Kirmayer & Jarvis, 2019).

The subtheme of “just a Band-Aid,” described how some participants felt that the forms of care they have received (e.g., psychotherapy or medication) still did not fully address the reasons for their mental health concerns (Hansen & Metzl, 2019; Metzl & Hansen, 2014; Reitmanova & Gustafson, 2009). Their responses signaled to how their material needs were not being met in the form of lack of employment, inadequate income, or precarious housing. While this was not an appraisal of services specific to one migration group, this idea was shared by individuals who came from more financially precarious backgrounds. The findings support holistic models of care that encompass a wide variety of services, such as referrals to have their material needs being met (e.g., employment, housing, food) as this underscores departing from solely focusing on a biomedical paradigm where access to medical services is the first line of treatment (Hansen & Metzl, 2019; Joseph & Double, 2020). Community-based services are also important as key solutions, specifically for newly arrived immigrants of all backgrounds who will encounter settlement based stressors (Aery, 2018; Lane & Vatanparast, 2022; Nerad & Janczur, 2000).

Lastly, the subtheme of “what I needed” is not a contradiction to the previous subthemes, rather, it highlights how based on one’s needs and appraisals, certain mental healthcare services are actively sought out as important solutions. For several participants in the present study, receiving psychotherapy or starting medication were reported as the best fit for their issues (Kirmayer & Jarvis, 2019; Kleinman, 1980). This may have been shaped by their ideas and knowledge of mental health and what constitutes as appropriate treatment for such issues (Kirmayer, 2012a, 2014; Kirmayer et al., 2011; Pottie et al., 2011).

Limitations and Recommended Areas for Future Research

The study described here has limitations that must be noted in order to help with interpretation and appraisal of the findings. Key limitations include the geographical constraints and the demographic profiles of participants. Within the former limitation, participants who were included were mainly from larger cities in Ontario that consequently had increased resources to such services in the first place. Future research should focus on those living within rural or smaller locations, as this constraint would influence the number of resources available. In regard to demographics, while the participants were from a variety of backgrounds (e.g., ethnoracial, migration status, disability, gender and sexuality), there should be more targeted research that centres the experiences of those who have been underserved including those who self-identify as having disabilities, belong to more precarious legal statuses, and self-identify as LGBTQ+. Their unique life experiences will impart a more nuanced understanding of barriers and facilitators to seeking services. Even though there were a handful of participants in the present study who self-identified with belonging with the aforementioned groups, they still constituted a minority of the sample size. Majority of participants in the present study were international students at universities, whereas those at colleges may have different access to mental healthcare services.

This study was qualitative in nature, and as such 16 participants may be considered to be a small sample size within a quantitative context. However, given the methodology and selected analysis approach, there is an emphasis on depth of interviews rather than concepts like data saturation (Braun & Clarke, 2021). However, we did not aim to offer findings that are generalizable to other contexts, but that are transferrable instead. Interviews were conducted in English and although the recruitment requirements were posed as "comfortable having a conversation in English," this may have limited some participants in their ability to fully express ideas of mental health that may be more relevant within their own languages. Some participants did use phrases in their own languages and provided a breakdown of the term. In an ideal context, an interpreter would have helped but that was not practically or financially feasible given the range of languages and backgrounds present. Additionally, the interviews were conducted online, and this may have prevented some people from participating due to concerns of privacy, surveillance, or a lack of access to technology (Salam et al., 2021).

Conclusion

Racialized immigrants experience a multitude of barriers when accessing mental healthcare services in Ontario which are driven by factors at both systemic and individual levels. This has been well documented within research conducted not just conducted in Ontario, but also across other areas in Canada (Salam et al., 2022; Thomson et al., 2015). This study highlights that while racialized immigrants experience common challenges in accessing services, there exists variabilities based on social and contextual factors (Ng & Zhang, 2020, 2021; Oda et al., 2019). This point affirms that this broad population, while often lumped together, should not be understood as a monolith. Future research should emphasize understanding the experiences of multiply marginalized individuals, as this will provide further nuance and much needed complexity on the topic.

References

Aery, A. (2018). *Facilitators to Accessing Primary and Preventive Care for Immigrants and Refugees in Canada*. Wellesley Institute.

Agyekum, B., & Newbold, B. K. (2016). Religion/spirituality, therapeutic landscape and immigrant mental well-being amongst African immigrants to Canada. *Mental Health, Religion & Culture*, *19*(7), 674–685.

Ahn, Y., Miller, M. M., Wang, L., & Laszloffy, T. (2014). "I didn't understand their system, and I didn't know what to do": Migrant Parents' Experiences of Mandated Therapy for Their Children. *Contemporary Family Therapy*, *36*(1), 25–40.

Andersen, R. M. (1995). Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? *Journal of Health and Social Behavior*, *36*(1), 1–10. https://doi.org/10.2307/2137284

Anderson, K., McKenzie, K., & Kurdyak, P. (2017). Examining the impact of migrant status on ethnic differences in mental health service use preceding a first diagnosis of schizophrenia. *Social Psychiatry and Psychiatric Epidemiology*, *52*(8), 949–961. http://dx.doi.org/10.1007/s00127-017-1403-z

Beiser, M. (2009). Resettling refugees and safeguarding their mental health: Lessons learned from the Canadian Refugee Resettlement Project. *Transcultural Psychiatry*, *46*(4), 539–583.

Bemme, D., & D'souza, N. A. (2014). Global mental health and its discontents: An inquiry into the making of global and local scale. *Transcultural Psychiatry*, *51*(6), 850–874. http://dx.doi.org/10.1177/1363461514539830

Benjamen, J., Girard, V., Jamani, S., Magwood, O., Holland, T., Sharfuddin, N., & Pottie, K. (2021). Access to refugee and migrant mental health care services during the first six months of the COVID-19 pandemic: A Canadian refugee clinician survey. *International Journal of Environmental Research and Public Health*, *18*(10), 5266.

Bernhard, J. K., Goldring, L., Young, J., Berinstein, C., & Wilson, B. (2007). Living with precarious legal status in Canada: Implications for the well-being of children and families. *Refuge*, *24*, 101.

Berry, J. W. (1997). Immigration, Acculturation, and Adaptation. *Applied Psychology*, *46*(1), 5–34. https://doi.org/10.1111/j.1464-0597.1997.tb01087.x

Berry, J. W., & Hou, F. (2019). Multiple belongings and psychological well-being among immigrants and the second generation in Canada. *Canadian Journal of Behavioural Science / Revue Canadienne Des Sciences Du Comportement*, *51*(3), 159–170. http://dx.doi.org/10.1037/cbs0000130

Brabant, Z., & Raynault, M.-F. (2012). Health of Migrants with Precarious Status: Results of an Exploratory Study in Montreal—Part B. *Social Work in Public Health*, *27*(5), 469–481. https://doi.org/10.1080/19371918.2011.592079

Braun, V., & Clarke, V. (2021). *Thematic Analysis: A Practical Guide*. SAGE Publications. https://books.google.ca/books?id=eMArEAAAQBAJ

Campbell, R. M., Klei, A. G., Hodges, B. D., Fisman, D., & Kitto, S. (2014). A Comparison of Health Access Between Permanent Residents, Undocumented Immigrants and Refugee Claimants in Toronto, Canada. *Journal of Immigrant and Minority Health*, *16*(1), 165–176. https://doi.org/10.1007/s10903-012-9740-1

Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M.-E. D., Beyeler, N., & Quesada, J. (2015). Immigration as a Social Determinant of Health. *Annual Review of Public Health*, *36*(1), 375–392. https://doi.org/10.1146/annurev-publhealth-032013-182419

Chadwick, K., & Collins, P. (2015). Examining the relationship between social support availability, urban center size, and self-perceived mental health of recent immigrants to Canada: A mixed-methods analysis. *Social Science and Medicine*, *128*, 220–230. http://dx.doi.org/10.1016/j.socscimed.2015.01.036

Chen, A. W. (2010). Immigrant access to mental health services: Conceptual and research issues. *Canadian Issues*, 51.

Chiu, M., Gatov, E., Vigod, S. N., Amartey, A., Saunders, N. R., Yao, Z., Pequeno, P., & Kurdyak, P. (2018). Temporal trends in mental health service utilization across outpatient and acute care sectors: A population-based study from 2006 to 2014. *The Canadian Journal of Psychiatry*, *63*(2), 94–102.

Corrigan, P. W., Bink, A. B., Schmidt, A., Jones, N., & Rüsch, N. (2016). What is the impact of self-stigma? Loss of self-respect and the “why try” effect. *Journal of Mental Health*, *25*(1), 10–15.

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(2), 37–70.

Currie, J., Kurdyak, P., & Zhang, J. (2024). Socioeconomic status and access to mental health care: The case of psychiatric medications for children in Ontario Canada. *Journal of Health Economics*, *93*, 102841.

de Moissac, D., Graham, J. M., Prada, K., Gueye, N. R., & Rocque, R. (2020). Mental health status and help-seeking strategies of international students in Canada. *Canadian Journal of Higher Education/Revue Canadienne d'enseignement Supérieur*, *50*(4), 52–71.

Donnelly, T. T., Hwang, J. J., Este, D., Ewashen, C., Adair, C., Clinton, M., T.T., D., J.J., H., D., E., C., E., & C., A. (2011). If I was going to kill myself, I Wouldn't be calling you. I am asking for help: Challenges influencing immigrant and refugee women's mental health. *Issues in Mental Health Nursing*, *32*(5), 279–290. http://dx.doi.org/10.3109/01612840.2010.550383

Durbin, A., Lin, E., Moineddin, R., Steele, L. S., & Glazier, R. H. (2014). Use of mental health care for nonpsychotic conditions by immigrants in different admission classes and by refugees in Ontario, Canada. *Open Medicine : A Peer-Reviewed, Independent, Open-Access Journal*, *8*(4), e136–e146.

Edge, S., & Newbold, B. (2013). Discrimination and the health of immigrants and refugees: Exploring Canada's evidence base and directions for future research in newcomer receiving countries. *Journal of Immigrant and Minority Health*, *15*(1), 141–148. https://dx.doi.org/10.1007/s10903-012-9640-4

El-Bialy, R., & Mulay, S. (2015). Two sides of the same coin: Factors that support and challenge the wellbeing of refugees resettled in a small urban center. *Health & Place*, *35*, 52–59. http://dx.doi.org/10.1016/j.healthplace.2015.06.009

Ellis, A. M., Bauer, T. N., Mansfield, L. R., Erdogan, B., Truxillo, D. M., & Simon, L. S. (2015). Navigating uncharted waters: Newcomer socialization through the lens of stress theory. *Journal of Management*, *41*(1), 203–235.

Emerson, S. D., Ritland, L., & Guhn, M. (2021). A scoping review of associations between ethno-cultural context and mental health in Canada. *Canadian Journal of Community Mental Health*, *40*(2), 23–48.

Farsimadan, F., Khan, A., & Draghi-Lorenz, R. (2011). On ethnic matching: A review of the research and considerations for practice, training and policy. *The Handbook of Transcultural Counselling and Psychotherapy*, 65–80.

Fernando, S. (2019). Developing mental health services in the global south. *International Journal of Mental Health*, *48*(4), 338–345. https://doi.org/10.1080/00207411.2019.1706237

Fong, H.-F., Alegria, M., Bair-Merritt, M. H., & Beardslee, W. (2018). Factors associated with mental health services referrals for children investigated by child welfare. *Child Abuse & Neglect*, *79*, 401–412.

Ford, C., & Airhihenbuwa, C. (2010a). *Critical Race Theory, race equity, and public health: Toward antiracism praxis.* https://doi.org/10.2105/AJPH.2009.171058

Ford, C., & Airhihenbuwa, C. (2010b). The public health critical race methodology: Praxis for antiracism research. *Social Science & Medicine*, *71*(8), 1390–1398. https://doi.org/10.1016/j.socscimed.2010.07.030

Ford-Jones, P. C., & Daly, T. (2022). Filling the gap: Mental health and psychosocial paramedicine programming in Ontario, Canada. *Health & Social Care in the Community*, *30*(2), 744–752.

Gotlieb, E. G., Rhodes, K. V., & Candon, M. K. (2021). Disparities in primary care wait times in Medicaid versus commercial insurance. *The Journal of the American Board of Family Medicine*, *34*(3), 571–578.

Hajizadeh, M. (2018). Does socioeconomic status affect lengthy wait time in Canada? Evidence from Canadian Community Health Surveys. *The European Journal of Health Economics*, *19*, 369–383.

Hanley, J., Al Mhamied, A., Cleveland, J., Hajjar, O., Hassan, G., Ives, N., Khyar, R., & Hynie, M. (2018). The Social Networks, Social Support and Social Capital of Syrian Refugees Privately Sponsored to Settle in Montreal: Indications for Employment and Housing During Their Early Experiences of Integration. *Canadian Ethnic Studies*, *50*, 123–148. https://doi.org/10.1353/ces.2018.0018

Hansen, H., & Metzl, J. M. (2019). *Structural competency in mental health and medicine: A case-based approach to treating the social determinants of health*. Springer.

Higginbottom, G. M. A., Morgan, M., Alexandre, M., Chiu, Y., Forgeron, J., Kocay, D., & Barolia, R. (2015). Immigrant women's experiences of maternity-care services in Canada: A systematic review using a narrative synthesis. *Systematic Reviews*, *4*(1), 13. https://doi.org/10.1186/2046-4053-4-13

Hiller, H. H., & Franz, T. M. (2004). New ties, old ties and lost ties: The use of the internet in diaspora. *New Media & Society*, *6*(6), 731–752.

Ho, J. W., Kuluski, K., & Im, J. (2017). "It's a fight to get anything you need"—Accessing care in the community from the perspectives of people with multimorbidity. *Health Expectations*, *20*(6), 1311–1319.

Hyman, I. (2009). *Racism as a determinant of immigrant health*.

Hynie, M. (2018). The social determinants of refugee mental health in the post-migration context: A critical review. *The Canadian Journal of Psychiatry*, *63*(5), 297–303.

Hynie, M., Ardern, C. I., & Robertson, A. (2016). Emergency room visits by uninsured child and adult residents in Ontario, Canada: What diagnoses, severity and visit disposition reveal about the impact of being uninsured. *Journal of Immigrant and Minority Health*, *18*, 948–956.

Hynie, M., Crooks, V. A., & Barragan, J. (2011). Immigrant and refugee social networks: Determinants and consequences of social support among women newcomers to Canada. *Canadian Journal of Nursing Research Archive*, 26–47.

Jones, C. (2000). *Levels of racism: A theoretic framework and a gardener's tale.* https://doi.org/10.2105/AJPH.90.8.1212

Joseph, A., & Double, D. (2020). *Critical perspectives in mental health*.

Kelly, C. M., Jorm, A. F., & Wright, A. (2007). Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Medical Journal of Australia*, *187*(S7), S26–S30.

Kirmayer, L. J. (2001). Cultural variations in the clinical presentation of depression and anxiety: Implications for diagnosis and treatment. *Journal of Clinical Psychiatry*, *62*, 22–30.

Kirmayer, L. J. (2012a). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine*, *75*(2), 249–256.

Kirmayer, L. J. (2012b). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149–164.

Kirmayer, L. J. (2014). Critical psychiatry in Canada. *Critical Psychiatry and Mental Health: Exploring the Work of Suman Fernando in Clinical Practice.*, 170–181.

Kirmayer, L. J., Groleau, D., Guzder, J., Blake, C., & Jarvis, E. (2003). Cultural consultation: A model of mental health service for multicultural societies. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *48*(3), 145–153.

Kirmayer, L. J., & Jarvis, G. E. (2019). Culturally Responsive Services as a Path to Equity in Mental Healthcare. *HealthcarePapers*, *18*(2), 11–23. https://dx.doi.org/10.12927/hcpap.2019.25925

Kirmayer, L. J., Lemelson, R., & Cummings, C. A. (2015). *Re-visioning psychiatry: Cultural phenomenology, critical neuroscience, and global mental health*. Cambridge University Press.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., Pottie, K., & (CCIRH), C. C. for I. and R. H. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *183*(12), E959–E967. https://doi.org/10.1503/cmaj.090292

Kirmayer, L. J., & Swartz, L. (2013). Culture and global mental health. *Global Mental Health: Principles and Practice*, 41–62.

Kleinman, A. (1980). *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry*. University of California Press. https://books.google.ca/books?id=ZRVbw6-UyucC

Kleinman, A. (1987). Anthropology and Psychiatry: The Role of Culture in Cross-Cultural Research on Illness. *British Journal of Psychiatry*, *151*(4), 447–454. https://doi.org/DOI: 10.1192/bjp.151.4.447

Kuile, S., Rousseau, C., Munoz, M., Nadeau, L., & Ouimet, M. (2007). The universality of the Canadian health care system in question: Barriers to services for immigrants and refugees. *International Journal of Migration, Health and Social Care*, *3*(1), 15–26.

Lamba, N. K., & Krahn, H. (2003). Social capital and refugee resettlement: The social networks of refugees in Canada. *Journal of International Migration and Integration/Revue de l'integration et de La Migration Internationale*, *4*, 335–360.

Lane, G., & Vatanparast, H. (2022). Adjusting the Canadian healthcare system to meet newcomer needs. *International Journal of Environmental Research and Public Health*, *19*(7), 3752.

Marsella, A. J., & Yamada, A. M. (2000). Culture and mental health: An introduction and overview of foundations, concepts, and issues. In *Handbook of multicultural mental health* (pp. 3–24). Elsevier.

Maulik, P. K., Eaton, W. W., & Bradshaw, C. P. (2011). The effect of social networks and social support on mental health services use, following a life event, among the Baltimore Epidemiologic Catchment Area cohort. *The Journal of Behavioral Health Services & Research*, *38*, 29–50.

McDowell, T. (2004). Exploring the Racial Experience of Therapists in Training: A Critical Race Theory Perspective. *The American Journal of Family Therapy*, *32*(4), 305–324. https://doi.org/10.1080/01926180490454791

McKenzie, K. (2019). Improving Mental Health Services for Immigrant, Racialized, Ethno-Cultural and Refugee Groups. *HealthcarePapers*, *18*(2), 4–9. https://dx.doi.org/10.12927/hcpap.2019.25926

McKenzie, K. J., Tuck, A., & Agic, B. (2014). Mental healthcare policy for refugees in Canada. *Refuge and Resilience: Promoting Resilience and Mental Health among Resettled Refugees and Forced Migrants.*, 181–194. http://dx.doi.org/10.1007/978-94-007-7923-5_12

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine (1982)*, *103*, 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032

Minutillo, S., Cleary, M., P. Hills, A., & Visentin, D. (2020). Mental health considerations for international students. *Issues in Mental Health Nursing*, *41*(6), 494–499.

Moroz, N., Moroz, I., & D'Angelo, M. S. (2020). Mental health services in Canada: Barriers and cost-effective solutions to increase access. *Healthcare Management Forum*, *33*(6), 282–287.

Mowbray, F. I., Omar, A. E., Pfaff, K., & El-Masri, M. M. (2019). Exploring the factors associated with non-urgent emergency department utilisation for mental health care. *Journal of Research in Nursing*, *24*(8), 663–674.

Nakhaie, M. R., & Kazemipur, A. (2013). Social capital, employment and occupational status of the new immigrants in Canada. *Journal of International Migration and Integration*, *14*, 419–437.

Nerad, S., & Janczur, A. (2000). Primary health care with immigrant and refugee populations: Issues and challenges. *Australian Journal of Primary Health*, *6*(4), 222–229.

Ng, E., & Zhang, H. (2020). The mental health of immigrants and refugees: Canadian evidence from a nationally linked database. *Health Reports*, *31*(8), 3–12. https://dx.doi.org/10.25318/82-003-x202000800001-eng

Ng, E., & Zhang, H. (2021). *Access to mental health consultations by immigrants and refugees in Canada*.

Oda, A., Hynie, M., Tuck, A., Agic, B., Roche, B., & McKenzie Kwame; ORCID: http://orcid.org/0000-0001-6419-8130, K. A. I.-O. http://orcid.org/McKenzie. (2019). Differences in self-reported health and unmet health needs between government assisted and privately sponsored Syrian refugees: A cross-sectional survey. *Journal of Immigrant and Minority Health*, *21*(3), 439–442. http://dx.doi.org/10.1007/s10903-018-0780-z

O'Mahony, & Donnelly, T. T. (2007). The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers. *Issues in Mental Health Nursing*, *28*(5), 453–471. http://dx.doi.org/10.1080/01612840701344464

Ontario Human Rights Commission. (2018). *Interrupted childhoods: Overrepresentation of Indigenous and Black children in Ontario child welfare. Ontario Human Rights Commission*.

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., Narasiah, L., Kirmayer, L. J., Ueffing, E., MacDonald, N. E., Hassan, G., McNally, M., Khan, K., Buhrmann, R., Dunn, S., Dominic, A., McCarthy, A. E., Gagnon, A. J., Rousseau, C., & Tugwell Laurence J.; ORCID: http://orcid.org/0000-0002-6228-1739, P. A. I.-O. http://orcid.org/Kirmayer. (2011). Evidence-based clinical guidelines for immigrants and refugees. *Canadian Medical Association Journal*, *183*(12), e824–e925. http://dx.doi.org/10.1503/cmaj.090313

Rajkumar, D., Berkowitz, L., Vosko, L. F., Preston, V., & Latham, R. (2012). At the temporary–permanent divide: How Canada produces temporariness and makes citizens through its security, work, and settlement policies. *Citizenship Studies*, *16*(3–4), 483–510. https://doi.org/10.1080/13621025.2012.683262

Reid, G. J., Stewart, S. L., Barwick, M., Cunningham, C., Carter, J., Evans, B., Leschied, A., Neufeld, R. W., St Pierre, J., & Tobon, J. (2021). Exploring patterns of service utilization within children's mental health agencies. *Journal of Child and Family Studies*, *30*, 556–574.

Reitmanova, S., & Gustafson, D. L. (2009). Mental health needs of visible minority immigrants in a small urban center: Recommendations for policy makers and service providers. *Journal of Immigrant and Minority Health*, *11*(1), 46–56. http://dx.doi.org/10.1007/s10903-008-9122-x

Rivera, J., Puyat, J., Wiedmeyer, M.-L., & Lavergne, R. (2020). Primary Care and Access to Mental Health Consultations among Immigrants and Nonimmigrants with Mood or Anxiety Disorders. *Canadian Journal of Psychiatry*. http://dx.doi.org/10.1177/0706743720952234

Robert, A., & Gilkinson, T. (2012). Mental health and well-being of recent immigrants in Canada: Evidence from the longitudinal survey of immigrants to Canada. *Immigrant Integration: Research Implications for Future Policy*, 191–210.

Ryan, D., Dooley, B., & Benson, C. (2008). Theoretical Perspectives on Post-Migration Adaptation and Psychological Well-Being among Refugees: Towards a Resource-Based Model. *Journal of Refugee Studies*, *21*(1), 1–18. https://doi.org/10.1093/jrs/fem047

Salam, Z., Nouvet, E., & Schwartz, L. (2021). Reflections of methodological and ethical challenges in conducting research during COVID-19 involving resettled refugee youth in

Canada. *Journal of Medical Ethics*, medethics-2021-107291. https://doi.org/10.1136/medethics-2021-107291

Salam, Z., Odenigbo, O., Newbold, B., Wahoush, O., & Schwartz, L. (2022). Systemic and Individual Factors That Shape Mental Health Service Usage Among Visible Minority Immigrants and Refugees in Canada: A Scoping Review. *Administration and Policy in Mental Health and Mental Health Services Research*, 1–23.

Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *International Journal of Mental Health Nursing*, *28*(1), 152–161. http://dx.doi.org/10.1111/inm.12512

Salami, B., Salma, J., Hegadoren, K., Meherali, S., Kolawole, T., & Diaz B.; ORCID: http://orcid.org/0000-0003-1030-0464, Diaz, E.; ORCID: http://orcid.org/0000-0001-7698-4331, E. A. I.-O. http://orcid.org/Salami. (2019). Sense of community belonging among immigrants: Perspective of immigrant service providers. *Public Health*, *167*, 28–33. http://dx.doi.org/10.1016/j.puhe.2018.10.017

Sampogna, G., Bakolis, I., Evans-Lacko, S., Robinson, E., Thornicroft, G., & Henderson, C. (2017). The impact of social marketing campaigns on reducing mental health stigma: Results from the 2009–2014 Time to Change programme. *European Psychiatry*, *40*, 116–122.

Sandelowski, M. (1995). Qualitative analysis: What it is and how to begin. *Research in Nursing & Health*, *18*(4), 371–375. https://doi.org/10.1002/nur.4770180411

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*(4), 334–340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health*, *33*(1), 77–84. https://doi.org/10.1002/nur.20362

Simich, L. (2010). HEALTH LlTERACY, lMMlGRANTS AND MENTAL HEALTH. *Immigrant Mental Health La Santé Mentale Des Immigrants*, 17.

Simich, L., Maiter, S., Moorlag, E., & Ochocka, J. (2009). Taking culture seriously: Ethnolinguistic community perspectives on mental health. *Psychiatric Rehabilitation Journal*, *32*(3), 208–214. http://dx.doi.org/10.2975/32.3.2009.208.214

Simich, L., Maiter, S., & Ochocka, J. (2009). From social liminality to cultural negotiation: Transformative processes in immigrant mental wellbeing. *Anthropology & Medicine*, *16*(3), 253–266. http://dx.doi.org/10.1080/13648470903249296

Statistics Canada. (2017a). *Focus on Geography Series, 2016*. https://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-can-eng.cfm?Lang=Eng&GK=CAN&GC=01&TOPIC=7

Statistics Canada. (2017b). *Study: A look at immigration, ethnocultural diversity and languages in Canada up to 2036, 2011 to 2036*. https://www150.statcan.gc.ca/n1/daily-quotidien/170125/dq170125b-eng.htm

Strazdins, L., Welsh, J., Korda, R., Broom, D., & Paolucci, F. (2016). Not all hours are equal: Could time be a social determinant of health? *Sociology of Health & Illness*, *38*(1), 21–42.

Thomson, C., & Esses, V. M. (2016). Helping the transition: Mentorship to support international students in Canada. *Journal of International Students*, *6*(4), 873–886.

Thomson, M. S., Chaze, F., George, U., & Guruge, S. (2015). Improving Immigrant Populations' Access to Mental Health Services in Canada: A Review of Barriers and

Recommendations. *Journal of Immigrant and Minority Health*, *17*(6), 1895–1905. https://doi.org/10.1007/s10903-015-0175-3

Villegas, P. E. (2015). Fishing for precarious status migrants: Surveillant assemblages of migrant illegalization in Toronto, Canada. *Journal of Law and Society*, *42*(2), 230–252.

Wang, L. (2014). Immigrant health, socioeconomic factors and residential neighbourhood characteristics: A comparison of multiple ethnic groups in Canada. *Applied Geography*, *51*, 90–98. https://doi.org/10.1016/j.apgeog.2014.03.010

Wieling, E., & Rastogi, M. (2004). Voices of marriage and family therapists of color: An exploratory survey. *Journal of Feminist Family Therapy*, *15*(1), 1–20.

Williams, M. T., Faber, S. C., & Duniya, C. (2022). Being an anti-racist clinician. *The Cognitive Behaviour Therapist*, *15*.

Wong, S. T., Yoo, G. J., & Stewart, A. L. (2007). An empirical evaluation of social support and psychological well-being in older Chinese and Korean immigrants. *Ethnicity & Health*, *12*(1), 43–67.

Chapter 5: Immigrants are not made equal: Understanding mental healthcare access among racialized immigrants in Ontario, Canada

Author Order: Zoha Salam, Mirna Carranza, Olive Wahoush, Bruce Newbold, Ameil Joseph

Preface

This chapter explores how system-level drivers, such as immigration related constraints and the existing provincial healthcare infrastructure for mental healthcare services influence decision making related to seeking out mental healthcare services. It includes the perspectives of both service users and service providers in highlighting the gaps and needs among racialized immigrants for improved services and delivery.

The **N**avigational **I**nsights for immi**G**rant mental **H**ealth **A**ccess and **T**reatment (NIGHAT) Framework was intended to spell out my mother's name, Nighat, when transformed into an acronym.

This manuscript was completed between June 2022 and November 2023.

This manuscript will be adapted for publication based on journal guidelines and will be submitted to Social Science and Medicine – Qualitative Research in Health.

Contributions

Zoha Salam conceptualized the study, developed the interview protocols, conducted the interviews, analyzed the data, and wrote the manuscript. Mirna Carranza, Olive Wahoush, Bruce Newbold, and Ameil Joseph (the dissertation committee) provided feedback to the study's materials and also to the manuscript.

Declarations

Funding

The authors have no relevant financial or non-financial interests to disclose.

Conflicts of Interest/Competing Interests

The authors have no conflicts of interest to declare that are relevant to the content of this article.

Abstract

Background: Canada has a publicly funded healthcare system; however, there are notable gaps within services that are covered even across provinces. In Ontario, the mental healthcare system is considered to be a patchwork system, as it is not fully integrated into the healthcare system. Therefore, there are considerable disparities in accessing mental healthcare services for all Ontarians. For racialized immigrants, this process becomes more complicated due to limitations in accessing provincial healthcare services as a consequence of one's legal status. While much of the literature focuses on individual and systemic-level factors, it does not consider how access to care is shaped or impacted by overarching regulations. The aim of this study is to explore how constraints from one's legal status and Ontario's provincial mental healthcare structure interact in producing specific experiences for racialized immigrants when seeking mental healthcare services.

Methods: Using a qualitative descriptive methodology, questions related to identifying issues/critiques of mental healthcare provision were explored. A point of exploration was also to understand potential solutions to these issues based on navigational insights. Interviews were conducted with 16 service users and 10 mental healthcare service providers and analyzed through Braun & Clarke's (2021) approach to reflexive thematic analysis.

Findings: It was understood that racialized immigrants' ability to access mental healthcare services were impacted by restrictions imposed by the immigration system and the patchwork nature of the mental healthcare system. The inclusion of the perspectives of both service users and providers allowed for more meaningful accounts, as there were overlapping issues and solutions identified. Three major themes developed: governing structures, service delivery, and client characteristics. With the first theme, this signaled how the immigration system interplayed with the mental healthcare system. Service delivery as a theme highlighted how services existed in Ontario and how appraisals of care contribute to understanding access. Lastly, client characteristics included how shared identities with a provider and produced vulnerabilities play an important role in access. From the findings, the **N**avigational **I**nsights for immi**G**rant mental **H**ealth **A**ccess and **T**reatment (NIGHAT) Framework was developed. This proposed conceptual framework builds off the scoping review by Salam et al., 2022 and it offers a guide to understand racialized immigrants' challenges and needs when accessing mental healthcare services by emphasizing on more macro-level drivers. This paper consolidates the findings/themes and maps them into three layers. These layers are interactive with one another, as this demonstrates how individual level choices are informed by broader policies.

Conclusion: It can be understood that mental healthcare access for racialized immigrants is a complicated process due to legal status and the patchwork mental healthcare system. The NIGHAT Framework is a conceptual framework which provides a lens of interrogation to this issue by highlighting how structural and systemic issues interact and shape the experiences an individual encounters when seeking services. Improving access to care for this broad population begins with acknowledging how the governing systems set in place need to be addressed adequately to ensure appropriate downstream effects.

Introduction

According to a 2021 report by the Commonwealth Fund analyzing the performances of healthcare systems of 11-high income countries, Canada's healthcare system ranks 10th (2021). Canada also received the lowest rankings for the domains of access to care, equity, and health care outcomes (Commonwealth Fund, 2021). There are considerable gaps in coverage in what is provided for within Canada's public healthcare system (Commonwealth Fund, 2021). One notable gap is a lack of coverage for comprehensive mental healthcare services (McAlister et al., 2018; Mulvale & Hurley, 2008). While this gap exists, mental healthcare services are sometimes available through hospital (e.g., outpatient and inpatient) and community healthcare settings which may be covered through provincial healthcare plans (Beiser et al., 1993; Moroz et al., 2020; Mulvale & Hurley, 2008; Wiktorowicz et al., 2020). Ways of obtaining mental healthcare services, such as counselling, assessment, and psychotherapy can be supplemented through private healthcare insurance plans, personal payment, or through social assistance support programs that are unique to each province (Murray & Knudson, 2023; Vasiliadis et al., 2005; Wiktorowicz et al., 2010). This is generally the case for Canadian citizens or those who hold permanent residency, but for those who have recently arrived or hold precarious forms of legal status, accessing mental healthcare services can become a complicated process (McKenzie, 2019; McKenzie et al., 2014).

Based on a report in 2021, it is estimated that 75% of Canada's population growth comes from immigration, more specifically, those coming within economic categories (IRCC, 2021). Canada's medical inadmissibility immigration policy applies to certain migratory pathways, and filters individuals who are deemed to pose an "excessive demand" on both social and healthcare services (Boychuk, 2015; MacIntosh, 2019). Therefore, this policy limits and shapes who can come to Canada based on certain thresholds (Abu-Laban et al., 2022; Boychuk, 2015). Migration scholars have long critiqued the medical inadmissibility policy in Canada, specifically as it has been considered an instrumental policy tool in producing what is considered to be the ideal "citizen" on the basis on notions of eugenics and biomedical essentialism – and "mental illness" has been a key topic as it fits under the realm of disability (Joseph, 2018; Kanani, 2011; MacIntosh, 2019; Mawani, 2007; Reitmanova et al., 2015). Furthering this argument, what constituted as being "fit" for immigration based on xenophobic ideas, has shifted over time, and racialization has been intertwined with ableism and racism (Joseph, 2018; Kanani, 2011; Mawani, 2007; Reitmanova et al., 2015). Racialized immigrant groups experience unique challenges when arriving and settling into Canada, and this is layered with racism and xenophobia which is sometimes encountered within the healthcare system (Edge & Newbold, 2013; Hyman, 2009; Hynie, 2018). Within Canada's immigration system, there exists a variety of immigration classes that have certain stipulations associated with accessing social services and the healthcare systems in different provinces (Bobadilla et al., 2017; Magalhaes et al., 2010). For example, those with permanent residency status generally experience a significant waiting period when being enrolled into their provincial healthcare system. In Ontario, the waiting period is approximately three months (Bobadilla et al., 2017; Goel et al., 2013; Landolt, 2022). During this time, it has been documented that immigrants sometimes tend to accrue significant debt as they end up paying out of pocket as a consequence of this policy. Additionally, some delay seeking medically urgent care services due to the exorbitant fees they may face due to lack of coverage during this period (Bobadilla et al., 2017; Gagnon et al., 2021; Goel et al., 2013). For racialized immigrant groups, navigating a new country while also learning how to traverse a new healthcare system produces complexity when trying to access services that are necessary based on their needs (Bobadilla et al., 2017; Gagnon et al., 2021; Goel et al., 2013).

Accessing mental healthcare services is a complicated process for many racialized immigrant groups as a consequence of how the Canadian immigration system interacts with the provincial healthcare system (Bobadilla et al., 2017; Gagnon et al., 2021; Goel et al., 2013). Limitations from one's legal status may impact an individual's ability to seek mental healthcare services in a timely matter (Caulford & D'Andrade, 2012; Durbin et al., 2015; Gagnon et al., 2021; McKenzie, 2019; McKenzie et al., 2014). Therefore, it can be understood that the existing gaps within the mental healthcare system and services are associated with specific experiences and interactions for racialized immigrant groups (McKenzie, 2019; McKenzie et al., 2014).

The purpose of this paper is to understand how racialized immigrants' experiences of seeking mental healthcare services are influenced by factors driven by the immigration and healthcare systems, and to identify solutions in overcoming such barriers.

For brevity, the term "migrants" will be used as a catch-all in this paper to encompass individuals of all immigration backgrounds where experiences are similar and encompassing. However, when needed to make specific distinctions relevant to migration status, it will be explicitly identified.

Method

Guiding Framework

The guiding conceptual framework used for this study is Andersen's Behavioural Model of Health Care Utilization (ABMHCU) (Andersen, 1995). This specific model seeks to understand how an individual's healthcare service utilization patterns are influenced by their predisposing characteristics, presence of enabling resources, and contextualized need (Andersen, 1995). The ABHMCU takes into consideration broader factors, such as the healthcare system and external environment influence on the three domains (Andersen, 1995). A key emphasis of this study is to focus on the broader factors, namely the Ontario mental health system and external environment which is driven by the immigration system at the federal and provincial levels (Andersen, 1995). The purpose of this study is to understand the perspectives of both racialized migrants and mental healthcare providers in their perceptions of what some challenges and solutions are for improving access to mental healthcare services for racialized migrants in Ontario. The ABMHCU model allows for a detailed interrogation as it attends to the dynamics of the broader factors influencing individual level resources and characteristics of migrants and providers (Andersen, 1995). The present study aims to situate the challenges and solutions identified by the participants in regard to how the Ontario mental health healthcare system and Canada's migration system coalesce to produce specific outcomes, such as disparities in seeking care that are a consequence of one's legal status.

Methodology

This qualitative study utilizes a constructivist paradigm, as it recognizes that realities are co-constructed by individuals and their own interpretations based on the unique contexts it unfolded within (Braun & Clarke, 2021). Therefore, constructivism takes a subjective approach to understanding individuals' experiences (Braun & Clarke, 2021). In the context of this study, the goal is to explore racialized migrants' experiences of seeking mental healthcare services in Ontario. This will be informed by interviewing both racialized migrants and mental healthcare providers who serve this broad population. The inclusion of both participant groups will lend into providing unique insights from a supply and demand perspective. Their accounts may be overlapping or contradictory in exploring the question at hand, which highlights the importance of both perspectives. The selected methodology for this study is informed by Sandelowski's qualitative descriptive (QD), an approach to understanding individual's experiences aligned with a constructivist notion (Sandelowski, 2000, 2010). It is used commonly within health research, specifically focusing on patient experiences of a health phenomenon. Additionally, as the name suggests, it aims to produce a close-to-data interpretation of accounts shared by individuals. However, QD as a methodology is not inherently atheoretical, as it acknowledges that individuals' experiences exist in a context that is shaped by their environments. For example, Sandelowski (Sandelowski, 2010) argues that quotations should be presented with an interpretation that is aligned with the research study's paradigms. Furthermore, the level of "interpretation" entails that participants should be able to speak for themselves and that the researcher is not making assumptions for them (Sandelowski, 2010). QD for the purpose of this study allows an exploration of both sets of participants' accounts while situating them in broader contextual influences of social and structural determinants that drive and shape these reflections and produce these experiences.

Population of Interest and Recruitment

Participants relevant for this study included two groups: racialized migrants who have accessed mental healthcare services and mental healthcare services providers who work with racialized migrants. The Canadian province of Ontario was selected to recruit both sets of participants due to it having the largest number of racialized migrants in all of Canada. Additionally, constraining to one particular province was important as there are provincial differences in migrant recruitment programs and mental healthcare services and regulations. Therefore, comparisons across provinces would become difficult given the scope of this project. The criterion for selection for racialized migrants included the following: self-identify as a racialized migrant (e.g., economic migrant, dependent migrant, refugee, student), have sought out mental healthcare services in Ontario, and comfortable having a conversation in English. There were no limits posed on years since arrival to allow a wide variety of individuals to participate. Mental healthcare providers needed to be licensed and qualified to practise in Ontario and work with racialized migrants in a professional capacity. It was not required for them to have this broad population as their main clientele group.

Separate digital flyers and emails were distributed across numerous platforms that included research/academic listservs, community health networks in Ontario, and professional networks that targeted both participant groups. Additionally, to recruit mental healthcare providers, emails were sent to private group practices that claimed to serve "diverse," "immigrant," or "racialized" individuals on their websites. These practices were found by Googling keyword variations of "psychotherapy" and "racialized" and then filtered for being in Ontario. A snowball approach was also taken to maximize recruitment, as potential participants who were contacted were also asked if they would feel comfortable sharing the study's materials within their own professional and personal networks.

Data Collection

Interview guides for the two participant groups were developed to include overlapping and complementary questions and were guided by elements from the ABMHCU. The interview guide for the racialized migrants started by asking basic demographic questions, such as their age, landing status in Canada, gender, and ethnoracial identity. Questions relevant to their mental healthcare service use included questions that asked them about their mental healthcare seeking journey such as what challenges they experienced, what were some supportive facilitators involved in receiving care, and what would have made their experience better. Additionally, as part of closing the interview they were asked to describe their ideal mental healthcare system.

With the mental healthcare provider participants, they were asked questions related to their demographics, such as their gender, degree, how long they have been practising, and ethnoracial identity, The main interview questions for this participant group were developed from the Integrated Checklist of Determinants of Practice (PICD) (Flottorp et al., 2013). The PICD seeks to understand the barriers in providing care and encompasses the following seven factors: guideline factors, individual health professional factors, patient factors, professional interactions, incentives and resources, capacity for organizational change, and social, political, and legal factors (Flottorp et al., 2013). Participants were asked questions specific to working with racialized migrants in their practise, including what they personally perceived this clientele group to experience as barriers and facilitators in seeking care, what were some professional challenges they personally experienced in working with said clientele group, and what would help them in providing better care. Similar to the other group, they were also asked to describe the ideal mental healthcare system as a point of departure.

Both interview guides were developed in English and the interviews were conducted in English. The interview guides were developed alongside a dissertation committee that had expertise in the domains being explored within this research project. The ethics for this study were given approval by McMaster's Hamilton Integrated Research Ethics Board (HIREB) (projects #13739 and #13736). Interviews for both sets of participants were conducted starting in November 2021 and ending in April 2022.

Once participants had agreed to participate in the study through e-mail communication, they were emailed the consent form to examine and sign when they became comfortable. Opportunities for asking questions were provided and there was no time limit posed on how long they had to take when determining to participate in the study. Once there was an agreement to participate, then an interview time was scheduled based on their availability. The interviews took place through Zoom, the online videoconferencing platform approved by HIREB, and were approximately an hour to hour and a half long for both participant groups. They were conducted only by the first author (ZS). For the purpose of providing more privacy and comfort, the video feature was turned off and the interviews were audio only. The interviews were recorded through the Zoom platform once participants gave their second consent to do so during the interview. Participants were given breaks through the interview and checked-in on frequently to provide space if the conversation was becoming too “heavy.” This was determined by paying attention to the pauses and silences during the conversation as body language could not be viewed because the video was turned off. Once the interview was over, participants were given a list of free to access online psychosocial resources available in Ontario along with their financial compensation in the desired e-gift card. For service users, they were given $20 and service providers had received $10.

An overview of participants and their demographics are in Table 1 (service users) and Table 2 (service providers). For the purpose of anonymity, the ethnoracial identities of both service users and service providers in this study are not listed in the table below as they become identifiable. It is important to note that all service providers in this study identified as being racialized (i.e., not white) and some also were born overseas. This imparted significant insights, as they were aware what the main population of interest, racialized migrants, in this study experienced.

Table 1

Demographics of Service User Participants

Participant	Gender	Age	Landing Status in Canada	Years Since Arrival
1	Male	26	Government Sponsored Refugee	11 months
2	Male	25	International Student	5
3	Female	26	International Student	5
4	Female	27	Refugee Claimant	24
5	Male	26	International Student	7
6	Female	53	Spouse	20
7	Female	33	Spouse	8
8	Female	27	International Student	10
9	Female	27	International Student	11
10	Male	22	International Student	6
11	Non-binary	21	Child Dependant	10
12	Male	27	International Student	1
13	Female	41	Government Sponsored Refugee	4
14	Male	33	Privately Sponsored Refugee	7
15	Female	27	Refugee Claimant	15
16	Female	26	Refugee Claimant	5

Table 2

Demographics of Mental Healthcare Provider Participants

Participant	Gender	Degree	Years of Practise	Can Provide Service in Language Other Than English?
1	Female	Master of Social Work	2	No
2	Female	Master of Arts in Counselling	2	Yes
3	Male	Diploma in Gestalt Therapy	8	Yes
4	Female	Master of Arts in Counselling	1	No
5	Female	Master of Social Work	11	Yes
6	Female	Master of Arts in Counselling	5	Yes
7	Female	PhD in Clinical Psychology	2	Yes
8	Female	Master of Arts in Counselling	2	Yes
9	Male	Master of Social Work	7	Yes

10	Female	PhD in Clinical Psychology	5	Yes

Analysis

Data analysis for of this study was informed by Braun & Clarke's six step approach to reflexive thematic analysis (RTA) (2006, 2021). The ABMHCU guided analyses of the findings, as the emphasis of this paper was to centre on the broader context only: the healthcare system (i.e., Ontario's existing mental healthcare system) and external environment (i.e., Canada's immigration system). Therefore, attention in the analyses was given to how these two systems interacted in each other in producing certain experiences related to access.

While interviews were being conducted with both set of participants, notes were taken that included personal thoughts in addition to writing down key points and quotes related to the question that was being asked. Once interviews were concluded, summaries were written that included reflections as well as a general overview of what the participant had shared. As part of the six step approach outlined by Braun & Clarke (2006, 2021), these summary notes were used as a source of data. While interviews were not transcribed, the audio records were constantly returned to and listened to for the purpose of refamiliarization. A more detailed iteration of analyses can be found in Chapter 2 of this dissertation as the approach is similar, but for the purpose of this paper, there is brevity. Given that there were two set of participants (service users and service providers), attention was given to how viewpoints overlapped and differed. As noted above, service providers were also all racialized due to coincidence and not intention in recruitment. This happenstance provided unique insights, as this set of participants were intimately familiar with what racialized migrants experience when seeking out mental healthcare services. Themes from analyses were not identified based on the frequency, but their ability to provide further understanding of the complexity that was being explored. RTA does not focus on "counting" or "frequency" of topics as a means to denote significance to deter from "positivism creep" – or reliance on positivistic approaches to understanding experiences (Braun & Clarke, 2021). Rather, RTA acknowledges and encourages highlighting unique experiences as they provide a further layer of understanding (Braun & Clarke, 2021). 6/5/24 11:55:00 AM

Findings

The purpose of this paper was to understand racialized migrants' experiences of seeking mental healthcare services in Ontario in regard to how they are shaped by the province's mental healthcare system along with the immigration system. The perspectives of both service users and mental healthcare providers were solicited to understand the interplay of the two systems. As a point of departure, both sets of participants were also asked to provide suggestions as to how to "fix" or "reimagine" a new system of mental healthcare services. Therefore, the findings (i.e., subthemes) will be presented by the critiques put forth by the participants followed by their suggestions to improve them. Through the analyses, three broad themes were identified with each theme having two corresponding subthemes. See Table 3 for list. This findings section will describe each theme along with its related subthemes, and quotes will be used to illustrate participants' accounts.

Table 3

Themes and Corresponding Subthemes

Theme	Subtheme

Governing structures	Limitations of one's legal status Existing mental health infrastructure
Service delivery	Supportive forms of care Pathways into care
Client characteristics	Produced vulnerabilities Shared identities

Governing Structures

The theme of "governing structures" was identified to highlight the interplaying role of immigration status and the Ontario mental healthcare system. While a key area of exploration within this study, it should not go unacknowledged as its own theme.

Limitations of One's Legal Status

Both sets of participants reflected on how conditions put forth by the immigration system ultimately shape access to mental healthcare services. Additionally, for some service user participants, their legal status affords them specific privileges such as having access to better jobs which in turn provides them healthcare insurance benefits. The attention to one's legal status and conditions imposed on them, either beneficial or detrimental is an important piece in understanding access to services in Ontario.

Critiques

Those participants within the study who held permanent residency status often described how their legal status was important because it allowed them to apply for certain jobs which entitled them with healthcare benefits. As one participant shares below, mental healthcare services were covered and therefore this was a key factor in encouraging them to seek care since it allowed them to afford it more easily.

“I think, also like being a permanent resident have allowed me to get like the job that I’m in that would cover for these, like, the cost of these kinds of things, like, because without a benefit plan work I can 100% certainty, I would not have done this because while I would technically have been able to afford it without the benefit plan that would become a much, much bigger expense. I would have been like nope and I’ll deal with this whatever by myself somehow” - Service User 2

For those who held more precarious visa statuses, such as being international students, their mental health was described to be impacting their ability to continue their studies and remain as full-time students. This particular participant wished that there was more clear messaging because she did not want to be punished for her status and the strict stipulations associated with being a student, such as remaining in what is considered to be “good status” for her program.

“But if I say I have been having the mental health issue, I'm not so sure if I would be able to because … you have to stay as a full-time student. And then, more, like, more strong messaging that I would be able to stay here. So, like, an affirmation from the government that didn't punish me about my status." - Service User 3

Another international student recounted an experience of when he failed to pay tuition on time and therefore was placed in a precarious position. As he was no longer enrolled or had access to health benefits through his university, he ended up relying on receiving care from health clinics that served individuals who were uninsured.

"Like, you can't access the healthcare. I had to pretty much go to, like, in a refugee clinic but even then, there wasn't stated that there were mental facilities was available. Just, like, so this is, like, a basic medical care and, like, at least, like, if things went wrong, like, if I got sick or something, I could go there. But with regards to my mental pain… to have access to anything. And I was just waiting for my status change, like, for me to become a student again so that I could have insurance again and then actually seek professional help." - Service User 5

For refugee clients, some mental healthcare providers stated that a common concern was that the financial coverage and supports provided to them were not adequate. One service provider participant elaborated on how limited services refugees have received over time from the government in terms of resettlement support and also health related expenditures:

"Yes, it's a very time and money limited. They usually come looking for a sliding scale, the most affordable possible, the better. And that's also an imbalance because refugees don't often have access to better insurances, right, while immigrants through work they do.” – Service Provider 3

Suggestions

Participants provided a variety of suggestions that attended to the immigration process. For starters, both mental healthcare providers and services users indicated that there should be a list of resources and a guide on how to access mental healthcare services upon arrival. For those who were settled refugees, especially privately sponsored, this was not a problem as sometimes the sponsor would be well equipped with connections to various social and material resources; however, there was a distinction made for all other arrivals (e.g., temporary, claimant, dependent).

“The ideal thing would have been, like, as an immigrant, like part of our settlement plan,” – Service User 7

“But for immigrants there's not there's not a pamphlet that describes what to do next.” – Service Provider 3

Existing Mental Health Infrastructure

In Ontario, the mental healthcare system exists as a “patchwork”: not all services are entirely funded or fully integrated. This includes a significant lack of coverage for psychotherapy and pharmaceuticals. Services that are currently covered through the provincial healthcare plan are limited, and mainly require referrals which requires access to a primary care physician in the first place. This subtheme highlights how the mental healthcare system is lacking in providing other forms of care (e.g., psychotherapy), which may be inaccessible to many individuals who cannot afford them or cannot legally access them.

Critiques

Some mental healthcare service providers who worked with this client group noted that they often met clients who were on Ontario Works and other workplace disability related services because they were legally entitled to them based on their status. While this helped facilitate receiving care by lessening the financial burden, the number of services a service provider could provide was limited through their coverage and sometimes impacted their ability to provide adequate care.

“If they're sticking Ontario Works, that's another, like, you know we have, like, I feel like barriers. It's limited already.” – Service Provider 5

In relation to those mental healthcare services that were funded entirely by the government, such as outpatient treatment programs, there was a huge waitlist for clients to get onto them. A mental healthcare provider who worked within both the hospital and community health setting lamented that she feared some clients may very well die before they receive treatment from the hospital settings given the severity of their issues. This highlights how burdened the publicly funded healthcare system is to begin with, and how individuals deemed at extreme risk may be deterred from seeking services in a timely manner.

"For example, eating disorder related issues and to get treatment. You could die before you have treatment, as now these waitlists are so long" – Service Provider 6

Mental healthcare providers within this study discussed the cost of services being a factor that shaped care. However, some providers themselves indicated that they did not take on certain forms of insurance or provided a sliding scale for clients because they themselves were not financially able to do so as part of their private practice and the costs associated with it.

"Insurance companies that just provide very, very limited coverage that just don't seem realistic and individuals who are unable to seek psychotherapy for free, basically, and so even you know, especially when you're working on a private practice, like, there are costs of your own." - Service Provider 4

"I don't offer a sliding scale, because my private practice employs all people who are in full time work." - Service Provider 7

These comments highlights how licensure costs, student debt, insurance, and other expenses play a role in determining whether services can become affordable for their clients.

Suggestions

In discussions of the current existing mental healthcare infrastructure, there were shared sentiments about how psychotherapy services along with prescription medications should be covered. Service providers felt that migrants in general would be more likely to access care if mental healthcare services would be fully funded by the province. Relatedly, for many service user participants within the study who were on medication, some described paying out of pocket and encountering exorbitant fees. They shared that they felt that medications should be covered as a way of improving access to care.

"The likelihood that refugees and immigrants would access mental healthcare services, there is one major thing: one is that psychotherapy gets covered by province" – Service Provider 3

"As I think that you should not have to pay for prescription medications when you need them as well." - Service User 5

Some mental healthcare providers discussed how their licensing bodies limited their ability to provide care to clients in other provinces. This was often the case for providers who were being contacted by individuals from another province who were looking for a specific provider who matched their cultural, racial, or linguistic background. This demonstrates the lack of availability of non-white providers in other provinces but also highlights their need as well.

"Restrictions on a therapist... so, let's say as a registered psychotherapist registered in Ontario that I'm only able to provide therapy in Ontario." – Service Provider 4

Service Delivery

This theme reflects the nature of mental healthcare service delivery in Ontario. Namely, how services are made available and individuals' appraisals of them. This theme is broken into two subthemes of "supportive forms of care" and "pathways into care" as an attempt to demonstrate the current state of service provision.

Supportive Forms of Care

Both sets of participants reflected on how mental healthcare services in Ontario were lacking in many domains and how it should encompass other forms of support as well. A more holistic approach to "care" was echoed across participants' accounts, and this included the need for services that would address material conditions. A key emphasis was that mental healthcare services should not be punitive in nature, especially given repercussions that would involve other systems, like the law. Individuals noted that they did not want carceral systems, such as child welfare services or law enforcement, as a consequence of seeking out help. Currently, as it stands in Ontario, the mental health system and related laws involve elements of "threats to public and community safety" which may prevent individuals from seeking services.

Critiques

In discussing hesitations for accessing care, there were a variety of reasons, and some entailed the specific nature of mental healthcare services.

For one service user who was a mother and arrived in Canada as a spousal dependant, she described that when she decided to reach out to her primary care provider, she was reluctant because she did not want to be deemed as an unfit parent due to her mental health concerns. In the quote below, it can be understood that she had to censor herself to an extent to not pose as a risk towards her child when she approached her primary care provider for a referral to services.

“And it's on a priority basis, so if you know if I was, for example, feeling suicidal or like I was going to harm myself or my child or something, then I would get sort of pushed up the list, but then on the flip side, you know that that also involves kind of child services and then was that brings a whole other thing” - Service User 7

Suggestions

In relation to providing suggestions for service level fractures, participants pointed to solutions that generally consisted of more holistic forms of services to help suit their needs and provide a continuity of care. Both service providers and service users indicated that they would benefit from a combination of both psychotherapy and social services (e.g., housing, legal support, employment) in order to meet their needs outside of treatment. Some mental healthcare providers shared that they felt that their client’s basic needs must be met before they started services to help get the most out of their sessions.

“Yeah, I feel like some of these clients, they could really use that assistance and then, and then they will you know, maybe consider accessing services.” – Service Provider 10

Some providers and service users also indicated that they wished services would be “less institutionalized” and not contingent on removing autonomy from them. One provider specifically described treatment that encompassed a family approach within a community living setting and increased resources. She prefaced that she recognizes the colonial nature of the field of social work and how it has been used as tool to subjugate families and cause disruption.

"…like all these kinds of things and now like CAS or CPS, like all these things than like the system like they were created, like, these things were created for like as a tool of colonization… You just like invite the family into a space that is not institutionalized in a way, where it's sterile and gross but, just like a community living situation where everyone is contracting to like work on their stuff and have the resources they need." – Service Provider 8

On a similar note, there were a few service user participants who shared sentiments similar to the participant above. They described that there was a phone number separate from emergency services that was specifically for mental health emergencies. One participant indicated that there should not be the involvement of police. This can be understandable especially for those with more precarious forms of legal status as they do not want to have interactions with law enforcement, as it could get them deported.

"There should be a hotline number we can call for mental health. No police." - Service User 10

Pathways Into Care

Following with the major theme, this subtheme discusses broadly the pathways into how an individual can receive mental healthcare services in Ontario. Currently, mental healthcare services can be accessed through one's primary care provider, they would provide a referral to a psychiatrist or connect an individual to resources available in the community. Another option is for an individual to independently seek out resources which may or may not be covered through the provincial healthcare plan. For some individuals, this pathway of relying on their primary care provider posed a great concern, as they described them as being gatekeepers who limited their ability to seek out services. The solutions posed by both sets of participants highlight the role of peer workers or system navigators to not rely so heavily on the current system which may be perceived as limiting to many individuals. This finding demonstrates the need to provide individuals with more choices that increase accessibility and approachability.

Critiques

Some service user participants elaborated that they experienced difficulty in receiving services after contacting their primary care provider. Some, such as the participant below, described that their provider became a major hurdle in seeking care. Some described that their provider was not aware of counselling services and was unhelpful in that sense.

“I think you know, being able to go directly there because I think It almost feels like the entryway is blocked except through your family doctor” - Service User 7

However, it is important to note that not all experiences with primary care providers were negative and many participants found their interactions with them to be positive and helpful as they were able to be connected with the appropriate services. This does attend to the role of primary care providers and their importance in being a gateway for accessing services as this is how the current system is set up to be.

Suggestions

Within the context of improving accessibility, some service user participants shared that they were able to access services because their colleagues, coworkers, and friends were aware of them and helped them to receive services. The role of social networks is important, especially for those who recently arrived and are trying to re-make their lives in a new country. A handful of participants shared that they wished there was a dedicated set of individuals they could interact with, such as via email, text, or phone call, to help them connect with services.

“So, I wish that if I was able to ask questions to someone who is, like, who knows the system or who knows the mental health issue very well.” - Service User 9

This quote highlights the need for system navigators or peer support workers to help racialized migrants access services. The emphasis on shared identities becomes a key factor as service user participants described that it would help them feel less alone in their help seeking journeys.

Additionally, both mental healthcare providers and service users identified aspects to make services more easily available, such as by loaning out electronic devices fit for videoconferencing to receive services remotely or by meeting elsewhere in different locations that are closer or more appropriate to them.

“Or, if you prefer virtual to either provide a phone or a tablet computer etc. that they could use to receive services… or clients are interested in maybe receiving services, not in a home, not in a building maybe they prefer to go outside for walks etc.” – Service Provider 9

Client Characteristics

This theme attends to how an individual's characteristics, such as personal histories and perceived needs, play a role in accessing mental healthcare services. While the other two major themes attended to more systemic influences, this theme stands alone to provide nuance in how individual level characteristics may interact with them. Two subthemes of "produced vulnerabilities" and "shared identities" were identified as drivers to understanding barriers to seeking care in the context of the immigration and mental healthcare systems.

Produced Vulnerabilities

While racialized migrants are not inherently vulnerable, they are made vulnerable in the current immigration and mental healthcare systems. The interlocking systems place them in conditions or statuses that potentially threaten their ability to stay in Canada, as identified previously in the other findings on how legal conditions limit certain individuals. Their statuses also may make them more vulnerable towards forms of violence, such as domestic abuse. Additionally, such risks or experiences may ultimately impact an individual's desire to seek out services in the future. Overall, this subtheme attends to an individual's autonomy in the process of seeking out mental healthcare services. The related solutions to the critiques posed by participants reflect how practitioners must take active approaches, such as anti-oppressive and reflexive framings, to understand why individuals may be hesitant to seek out services rather than individualizing behaviours.

Critiques

Service user participants who were settled refugees or those with precarious legal statuses (e.g., international students or refugee claimants) were already cautious of mental healthcare services, often times due to previous interactions with mental healthcare services or personal life experiences.

“It was the most unnerving experience of my life because I still have that fear of being deported, like, I’m going to say the wrong thing.” – Service User 4

Other participants who initially arrived at a young age as dependents shared that they felt it was difficult for them to receive services within the school setting:

“Because I lived at home, I couldn’t use those resources. But someone, I don’t know who, reported me to the counsellor’s office and made me sit through school mandated counselling and made it worse because now I have someone else to hide it from.” - Service User 10

This participant shared that they felt extremely upset as the mandated counselling through the school system when they were a minor, was given to them without their choice. This highlights how a lack of agency, specifically choice, made them more hesitant in interactions with school staff in the future and they had to police their behaviours going forward. It is important to note that this service user was closeted and did not want their parents involved, and the intervention posed by the school potentially could have outed them.

Relatedly, service providers themselves within this study indicated how sometimes it was difficult to work with clients due to the implicit involvement of their family. For some, they sought services without their families or spouses knowing to receive help. As one service user participant described in the quote below, she shared that her female clients sometimes must have alternative individuals listed in their emergency contacts.

“A lot of my clients are females, and some of them, like, I have one client who I’m not even sure if her husband knows she's in counseling says, ‘I don't want to put him as an emergency contact, I had a friend’. So again, like, just that stigma around and a lot of them will voice like that, when they do come like they have that hesitation of being disabled, ‘you know how it is in our culture, like if you see someone for mental health and you're crazy’.” – Service Provider 2

This highlights the layered concerns of privacy and confidently within mental healthcare services and why some racialized migrants, specifically those who are female spouses may not want to seek care in the first place. This includes layers of stigma which can be gendered and related to ideas of disability.

“My husband used to scare me with saying he was going to have me kicked out of the country. I was too scared to be called crazy.” – Service User 6

Aligned with this, a service user participant who arrived as a spouse shared her experiences of domestic violence and how her husband would threaten to have her deported and spread rumours that she was “crazy” and “unwell” to her family and therefore she hesitated receiving services. In all of the shared accounts above, issues about confidentiality and information about the services themselves produce specific vulnerabilities.

Suggestions

In helping racialized migrants overcome such challenges that emerged at the individual level, both service users and mental healthcare providers in the study identified a range of solutions. For providers, this included a need to continuously reflect and interrogate themselves in order to "meet the client where they were at" in order to provide care that was appropriate based on cultural and structural needs.

"I like to always you know, think of what's at stake for this client. Whether that's, like, what that culturally or what's at stake morally, you know. Yeah, those are those are just some of the ways I define it and I think like what I do is I look at schemas." – Service Provider 2

Some providers highlighted that they understood that their clients experienced burdens from the "oppressive" systems within their lives that may have been producing their mental health concerns in the first place. For this practitioner, she highlighted how she always took a step back to understand how her own privilege could produce limitations from bias due to her life experiences. She emphasized the role of intersectionality and how it manifested in her clients' lives and interactions.

"They're really burnt out and they just have been burned by oppressive systems. Whether it's been law enforcement, institutional systems, whether it's by their own shelter staff, and on top of that there's, like, you know racial oppression and so many things that play a role into that so whenever I'm working with moms and their families." – Service Provider 1

Shared Identities

A common need for service user participants was the availability of mental healthcare providers who shared similar backgrounds as them. This was often mentioned as being from the same ethnicity. This subtheme highlights the strong need for a "diverse" profession, as the workforce is predominately white; however, slowly changing. Additionally, this subtheme also signaled to service user participants' accounts of the general lack of competency or reflexivity to work with racialized migrant clients. Having shared experiences and identities, either in the context of migration or ethnicity, became a key driver in impacting service usage. A common solution posed by both service users and providers was to increase diversification. It is important to note that this did not solely mean an increase in racial and ethnic diversification, but for other identities as well such as gender identity and sexual orientation. Many mental healthcare providers felt that their identity was an asset in the current market, as this attracted a variety of non-white clients who did not share an ethnic or racial match as them.

Critique

"I was very resistant to help from white people. Like, what do you know about war? trauma?" - Service User 14

The quote above by one participant highlights the need of culturally reflexive service providers. He emphasizes how he was resistant in receiving services from white providers and also those who have never experienced war as they may not fully be able to understand his experiences as a refugee. Later in recounting his experiences of seeking care within the hospital and later through outpatient services, he describes how uncomfortable and resistant he was because he felt as if he was not being understood correctly. Lastly, some service user participants identified that they wished they had access to service providers who held identities similar to them. In recollecting experiences of accessing services, many had described that they found it important to work with providers who would understand them at a deeper level through shared lived experiences.

Suggestions

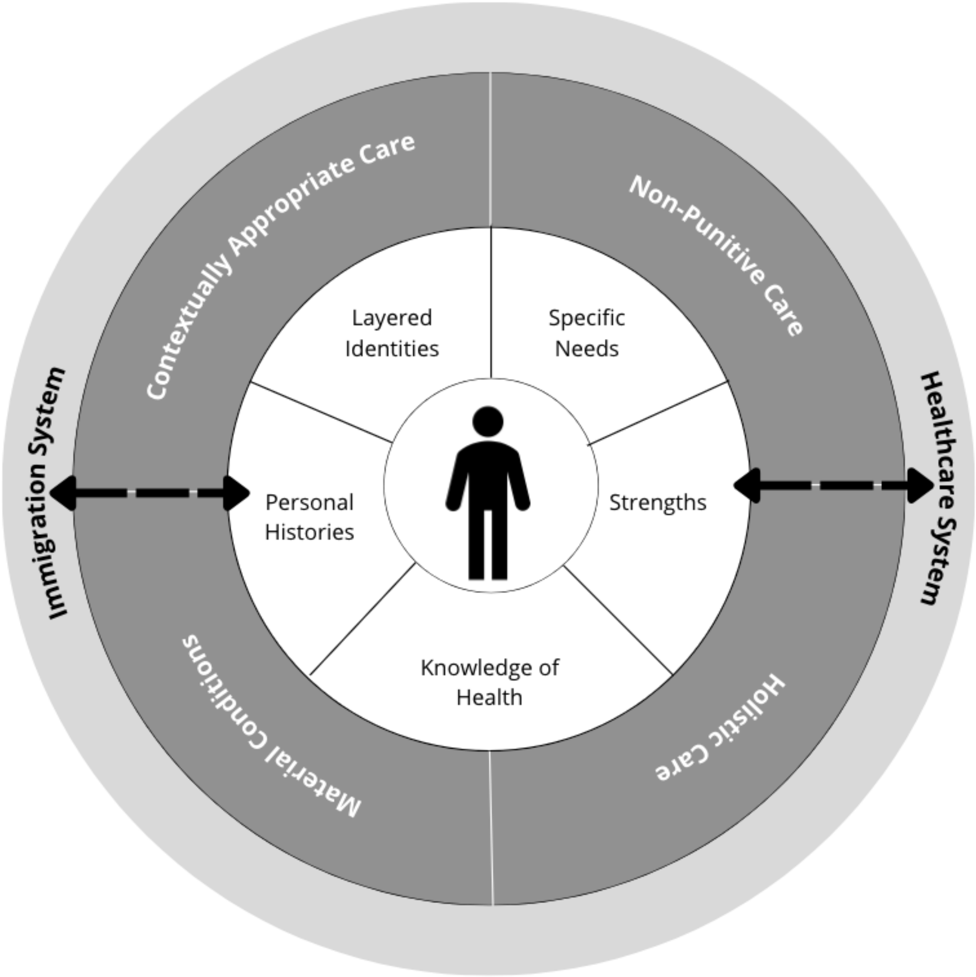
“Every single counselor I’ve seen is a white woman typically. You know, to really have someone who has identities like mine…More representation because, for example, the third peer support person, she was trauma informed, she is a woman of color; however, she was like, ‘oh yeah I don't have any experience with LGBTQ+ folks’, and the one I’ve been seeing the most consistently she's like, ‘yep I worked extensively with people of color’” - Service User 11

Similarly, as all the mental healthcare providers within this study were racialized, they signalled that their non-white identities sometimes made it easier for their clients to approach them and be open to working with them. Some even went as far to say that they were the only individual from their ethnoracial background on websites such as PsychologyToday, and this garnered them a lot of clients. This highlights an important need for the inclusion and equal participation of non-white mental healthcare providers in order to meet the needs of racialized migrant clients who may be seeking out providers based on such criteria.

The findings presented in this present paper are arranged in Figure 1. This diagram represents a proposed conceptual framework for understanding mental healthcare access based on the lived experiences of racialized migrants. The **N**avigational **I**nsights of immi**G**rant mental **H**ealth **A**ccess and **T**reatment (NIGHAT) Framework consists of three layers that are mutually reinforcing and interactive which demonstrates how accessing mental healthcare services is a dynamic and complex process for racialized migrants. The layers will be briefly discussed in relation to framing the findings of the present study, and then the findings section of this paper will go in more detail.

Figure 1

NIGHAT Framework Visual Schematic.



Outer Layer: Governing Structures

The two identified governing structures that shape service delivery and access are the immigration system and also the mental healthcare system of Ontario. With regards to the former, this involved the issue of one's legal status and how it influenced access to care or certain forms of benefits. In the latter, the mental healthcare system was discussed in its patchwork nature, regulations from licensing boards, and the gaps of provision of care that stem from the publicly funded healthcare system.

Middle Layer: Service Delivery

The middle layer represents the mental healthcare services that racialized migrants would like to receive. The middle layer interacts with the outer layer and the centre layer in producing such health service experiences for patients.

Inner Layer: Client Characteristics

The innermost layer specifically highlights the client's needs, layered identities, personal histories, strengths, and knowledge of health. This could include the history of the individual and their previous experiences with the immigration system or also mental healthcare system.

Discussion

The purpose of this study was to examine how aspects stemming from the immigration and mental healthcare system produce barriers and facilitators in accessing care among racialized migrants in Ontario. Through emphasis on the fractures identified in the two systems when seeking care and centering the solutions posed by both service users and mental healthcare providers, it is clear that that accessing mental healthcare is a complex and multifaceted problem due to the patchwork nature of the existing mental healthcare system itself and its interactions with the immigration system. This discussion section will present and describe the different layers of NIGHAT Framework and speak back to what is known in the literature.

From the analysis of the interviews involving both service users and mental healthcare providers, a conceptual framework was developed to understand what should be considered when conceptualizing access to mental healthcare services for racialized migrants when explicitly examining the provincial mental healthcare and federal immigration systems. This conceptual framework integrates findings from a related scoping review conducted (Salam et al., 2022) as part of a broader study (this dissertation) that attends to both systemic and individual level factors that shape access to mental healthcare services for this broad population in Canada. While the scoping review aimed to understand what is currently known as barriers and facilitators to care, this current paper extends the conversation by including potential strategies to improve access as identified by both service users and providers. In the NIGHAT Framework, there are three layers identified in shaping access to care: governing structures, service delivery, and client characteristics. It is worth noting that each layer is not independent, as it is impacted by the others and therefore is reinforcing through a dynamic approach. This conceptual framework does not intend to serve a clinical purpose, but instead offers a perspective to understand racialized migrants' challenges and needs which may inform further research or policies to support improving mental healthcare access.

Within the outer layer, in recognizing that mental healthcare services are not entirely funded or supported under current existing healthcare infrastructure in the province of Ontario and broadly in Canada, this limitation produced certain experiences rooted in systemic barriers. In the scoping review by Salam et al. (2022), structural and systemic factors included accessibility, migration class, and interlocking systems. In the present study, these barriers include financial setbacks due to the sheer cost of services and wait times of underfunded publicly available services (Beiser et al., 1993; Moroz et al., 2020; Mulvale & Hurley, 2008; Wiktorowicz et al., 2020). For those who were able to access care through insurance or resources either provided through work or social assistance programs (e.g., Ontario Works or Ontario Disability Support Program), these resources became a benefit and facilitator. However, it is important to note that such coverage is limited because of legal status (Caulford & D'Andrade, 2012; Hartog, 2020; McKeary & Newbold, 2010). Solutions identified by both sets of participants included emphasizing that mental healthcare services, including psychotherapy, should be covered by the provincial or federal government (Beiser et al., 1993; Moroz et al., 2020; Mulvale & Hurley, 2008; Wiktorowicz et al., 2020). A concern noted by a service provider participant was that specific licensing bodies have them restricted to particular provinces, and a more universal approach may help alleviate this specifically in situations where there are lack of providers in certain areas (Cohen & Peachey, 2014; Johnson, 2014). A national coverage of psychotherapy services, would alleviate the burden of a patchwork mental healthcare system that also calls upon providers to deal with insurance companies who sometimes have arbitrary regulations and coverages (Bradley & Drapeau, 2014; Cohen & Peachey, 2014; Gazzola et al., 2009). In addition, there were suggestions for a comprehensive pharmacare strategy, as some participants themselves stated that they had to pay exorbitant fees for medication due to not having appropriate coverage (Caulford & D'Andrade, 2012; Dewa et al., 2005). A national pharmacare strategy would help support access and improve quality of care (Dewa et al., 2005). In relation to improving access to healthcare coverage for migrants of all statuses, there has been the StatusForAll movement led by the Migrants Rights Network within Canada that supports this. In recognizing that healthcare access is a human right – migrants are being denied access to necessary healthcare services such as mental healthcare services due to restrictions placed upon them from their immigration status that consequently maintains structural constraints from the healthcare system (Beatson, 2016; Caulford & D'Andrade, 2012; Kuile et al., 2007; Magalhaes et al., 2010; Stanbrook, 2014).

The middle layer for service delivery within this paper's findings indicates how accessing care services through one's primary healthcare provider plays is a key resource, but also the need for more holistic services to be explored. For many recently arrived migrants, having access to a primary care physician is a key factor in determining whether their health needs will be met (Asanin & Wilson, 2008; Durbin et al., 2015; McMurray et al., 2014; Muggah et al., 2012). Additionally, the quality of care received influences the health outcomes, and participants did identify that there were both positive and negative experiences (Asanin & Wilson, 2008; Durbin et al., 2015; Muggah et al., 2012). However, it is important to note that some participants felt that they had to voice their concerns of their symptoms to their health care providers in specific ways in order to not call for alarm for further surveillance, such as Children's Aid Society (CAS) being involved or involuntarily institutionalized. This idea calls attention to how assessment of risk is important, but also emphasizes the agency and specific needs of a service user and how that assessment may potentially jeopardize their legal status or expose them to structural harms from surveillance (Asgary & Segar, 2011; Hacker et al., 2015; Salami et al., 2019).

Mental healthcare providers who worked within private practise settings indicated that their ability to provide services was sometimes dependent on their personal financial capabilities which were shaped by student loans, insurance cuts, and paying other practitioners in their practise. This is a consequence of how mental healthcare exists as a patchwork service in Ontario and how insurance company polices and practices complicate things further (Moroz et al., 2020; Mulvale & Hurley, 2008). Understandably, this interacts with the first layer of the framework. The solutions posed within this layer attend to the fractures caused by these critiques, as many mentioned that there should be more emphasis on holistic forms of care that help racialized migrants meet their material needs before seeking mental healthcare services (Hansen & Metzl, 2019; Salami et al., 2018; Thomson et al., 2015). Some newly arrived migrants experience economic precarity, housing instability, and poor employment prospects and this is more common for those who belong to more precarious migration statuses, thus an emphasis on increasing the access of social services (e.g., housing supports) would help improve their mental health status and recognize their contexts (Hansen & Metzl, 2019; Hynie, 2018; Salami et al., 2018; Thomson et al., 2015). Similarly, both service users and providers highlighted a need for "less institutionalized" forms of care that removed the presence of law enforcement and other tools of policing through social welfare services, such as CAS (Gagnon et al., 2021; Jack et al., 2022; O'Mahony et al., 2012). Historically, racialized migrants, specifically those who are racialized as Black, have been disproportionately and negatively targeted by law enforcement due to Canada's colonial roots that perpetuate systemic racism (Hyman, 2009; Penney et al., 2020; Waldron, 2020). Interactions with law enforcement can become deadly and put those with precarious legal status at risk of deportation (Gagnon et al., 2021). This was identified in the scoping review by Salam et al. (2022), as the interlocking systems of the medical and legal system were highlighted as both barriers and facilitators to care. Furthermore, some participants highlighted the need for system navigators or peer support workers in helping them access care which signals how individuals would want to "enter" the pathway of accessing care differently rather than immediately going to a primary care provider which they may or may not have access to (Grant et al., 2018; O'Mahony & Clark, 2018; Shommu et al., 2016). The solutions posed by the participants within this layer attend to both community level and structural needs, which highlights the complexity of the issue at hand.

The inner layer in this framework from this study's findings centres the individual's characteristics and needs. This includes aspects related to layered identities, personal histories, and knowledge of health. Through the findings elaborated previously on this layer, it can be evident that this layer interacts with the other two layers and has produced specific experiences and expectations of mental healthcare services for service users. In discussing layered identities, service users in this study who described being hesitant of services and highlighted their reluctance of working with white providers who also did not have histories of migration themselves, this posed a certain form of hesitancy as they believed their migration related experiences would not be understood. Service user participants within this study noted cultural and racial insensitivities from providers who were white, such as racist or xenophobic comments made towards them. A solution posed by both sets of participants was to increase the representation of service providers who are similar to them based on certain identities (McGuire & Miranda, 2008; Meyer & Zane, 2013). The scoping review (Salam et al., 2022) highlighted how experiences related to service providers, such as discrimination, shared identity, and professionalism were key aspects shaping access to care for racialized migrants.

In considering personal histories, complex family arrangements and dynamics for some, prevented seeking care, such as in circumstances where the service user was a minor, their caregivers had to consent (Ahn et al., 2014; Gopalan et al., 2010). However, not all participants indicated negative experiences with family members, as some were extremely supportive and beneficial in helping their loved ones seek care (Tulli et al., 2020). This draws on the complexity, but also importance of family systems that exist within racialized migrant communities broadly and how they can be a key resource or barrier when seeking services (Salam et al., 2022; Thomson et al., 2015). For addressing specific needs as part of this framework, service providers in the present study indicated the need to work directly with clients to meet their needs and tailor treatment to be more appropriate and mindful of both cultural and structural aspects (Hansen & Metzl, 2019; Kirmayer et al., 2011). Meeting their needs included referrals to other services, such as housing, legal, and employment, when required (Hansen & Metzl, 2019; Pottie &

Magwood, 2019). When considering knowledge of health as part of understanding access to care in this broad population, many individuals come from similar healthcare systems and are familiar with services that exist in related regions (McKenzie et al., 2014; Pottie et al., 2011). However, concepts of mental health are nebulous and are shared by one's understandings, therefore, some individuals may not see their issues to be remedied through a "medical" system (Kirmayer & Jarvis, 2019; Kleinman, 1980). This highlights how migrants are not a monolith in their understandings of health, and may perceive their health needs differently from each other (Kleinman, 1980). Social and individual level factors, such as family and community assets and cultural conceptualizations of mental health were highlighted by the scoping review (Salam et al., 2022).

Lastly, focusing on strengths is crucial in interrogating the experiences of mental healthcare access among this broad population. There exists broader discourses within immigration of how refugees are seen as perpetually "traumatized" by their experiences and this does not recognize their strengths and dignity and constructs them as objects of rescue even within clinical settings (Beatson, 2016; Bhatia, 2018). Many service user participants within this study drew upon a variety of resources, both internal and external, when trying to access services which must be acknowledged when understanding their experiences. Framing their experiences from a strengths-based perspective emphasizes the need to move away from a deficit framing of the issue – as this perpetuates harmful narratives and further stigmatizes them (Beatson, 2016; Bhatia, 2018).

The findings from this paper and the development of the NIGHAT framework highlights how barriers to accessing mental healthcare services along with their solutions are a consequence of existing policies and healthcare infrastructure (Beatson, 2016; McKenzie, 2019; McKenzie et al., 2014; Pottie et al., 2011). More specifically, disparities in accessing care from the perspective of this framework could be thought of as what I articulate as where "individuals meet the policies where they are at" rather than meeting the needs of racialized migrants and where they are at. The policies stemming from the immigration and patchwork mental healthcare systems in Ontario produce disparities by failing individuals who need them the most (Beatson, 2016; Bhatia, 2018). While some individual level factors, such as cultural assumptions or knowledge of mental health may be a barrier in seeking and receiving care, a behavioural or cultural approach to understanding access is limiting (Kleinman, 1980). It imposes an individualized understanding of mental health and access and reinforces a form of cultural racism (Lin, 2022; Viruell-Fuentes et al., 2012). A plethora of research within this context points to assumed "cultural differences" in driving disparities of access; however, this framing is problematic (Lin, 2022; Lo & Sasaki, 2023; Viruell-Fuentes et al., 2012). Consequently, other behavioural modes of interpretation within the context of migrant health research, such as the "healthy immigrant effect" truly do not capture how migrants of various statuses delay seeking care due to the precarity imposed on them due to their legal status or lack of resources (Castañeda et al., 2015; Viruell-Fuentes et al., 2012). As such, I argue that their health status may become depleted by the time they finally feel comfortable in receiving or accessing care either by having the financial means to do so, know how to navigate the health or social system well enough, or when they have finally have a "safer" legal status (Castañeda et al., 2015; Viruell-Fuentes et al., 2012). This was the case with one participant, as she finally sought out services when she had citizenship because she feared she may be deported as she arrived as a refugee claimant.

Through the findings presented within this paper, it is highlighted that a structural and social determinants of health approach can interrogate these issues, especially when emphasizing migration as a structural determinant of health as well. As argued by Castañeda et al. (2015) and (Hynie, 2018), migration status itself needs to be recognized as a social stratifier as it shapes the distribution of determinants of health one is entitled to based on social and legal stipulations. It can be understood that through the immigration system, migrants as a broad group are not made equal as their access to services is dependent on their legal status. Furthermore, migrants are pushed into precarious statuses and poorer health outcomes because of such limitations imposed on them (Ng & Zhang, 2020, 2021). This reframing of centring a policy and systemic analysis in exploring mental healthcare access helps to extrapolate beyond behavioural or cultural levels of understanding and appropriately contextualize such disparities that exist (Lin, 2022; Lo & Sasaki, 2023; Viruell-Fuentes et al., 2012).

Implications for Researchers

The NIGHAT framework offers a conceptual understanding of mental healthcare services for racialized migrants in being driven by system-level influences. Based on the findings of this study, there are implications for policy makers and organizations. It is important to note that there are opportunities for both upstream and downstream changes, given how accessing mental healthcare services is complex.

For policy makers, the findings from the present study emphasize how the medical system intertwines with the legal system in different dimensions, such as immigration, public safety, and social welfare (Joseph & Double, 2020; Joseph, 2018). There needs to be increased protections for individuals who are systemically vulnerable, such as international students, family dependents, and refugee claimants (Kaga et al., 2021). All are at increased risk of exploitation, neglect, and deprivation of services through conditions that they are subjected to

(Kaga et al., 2021). For example, domestic violence and intimate partner violence is an issue that female family dependents may experience (Bhuyan & Bragg, 2021; Jayasuriya-Illesinghe, 2018; Okeke-Ihejirika et al., 2020). Many feel obligated to stay with their partners who sponsored them, and they are at risk due to the nature of financial dependance created (Bhuyan & Bragg, 2021; Jayasuriya-Illesinghe, 2018; Okeke-Ihejirika et al., 2020). While there are existing legal and support mechanisms put in place to help them, there needs to be increased training, policies, and supports for women upon their arrival (Bhuyan & Bragg, 2021; Jayasuriya-Illesinghe, 2018; Okeke-Ihejirika et al., 2020). Additionally, policy makers should work closely with consulting community organizations when considering new initiatives related to mental health and population-specific issues to develop targeted and representative programs (Healey et al., 2017; Minas, 2007). Given that mental healthcare professionals were involved in this study to understand their perspectives, there are opportunities at the policy-level, specifically in the form of increased training and education. While "cultural competency" is included as a key aspect in many accredited educational backgrounds that lead into licensure of becoming a mental health provider, there needs to be training that centre on "structural competency" and also competency on working with those with immigration backgrounds of any kind (Hansen & Metzl, 2019; Kohn-Wood & Hooper, 2014). Additionally, there needs to be a departure from "competency" as a training model and the inclusion of practices such as "humility" and "reflexivity" instead. This framing acknowledges how concepts of "culture" should not be reduced to simple checklists, as this iterates harm and further promotes homogenization of this broad population (Cénat, 2020; Menezes et al., 2022; Vasquez & Jones, 2006; Williams et al., 2022). Diversity of the profession is currently a topical issue, the collection of sociodemographic data, specifically race-based data by licensing boards of registered members would be a start in locating if there are any disparities

(Cénat, 2020; Menezes et al., 2022; Williams et al., 2022). The collection of this data would lend into targeted approaches for recruitment and training (Cénat, 2020; Menezes et al., 2022; Vasquez & Jones, 2006; Williams et al., 2022). Lastly, the need for an integration of mental healthcare services within the provincial system is a key component of increasing accessibility of services (Moroz et al., 2020; Mulvale et al., 2007; Mulvale & Hurley, 2008; Steele et al., 2006). While this may be an obvious solution, it cannot be understated. There should be an agreed upon set of core services (e.g., medication, psychotherapy, counselling) that are available to anyone in Ontario, regardless of status (McKenzie, 2019; McKenzie et al., 2014). Insurance companies have variability in the services and amount that is covered, and this presents unequal access for even those with insurance (Lee et al., 2021). Consistent and increased funding to community-health centres is also important, specifically those that provide services to individuals without provincial insurance, as they act as a lifeline for many racialized migrants who are at risk of losing their status (Bunn et al., 2013; Campbell et al., 2014; Caulford & D'Andrade, 2012; Rousseau et al., 2013).

There are many opportunities for increasing access to services by capitalizing on community organizations (e.g., religious centres, ethnoracial community centres, faith-based organizations) and the relationships and reach they have with their communities and other organizations. Through a community-driven approach, mental healthcare services can be advertised in these locations to increase awareness of them. An example of how this can be implemented could be through the inclusion of peer support workers, which is what one participant highlighted as a solution (Grant et al., 2018). This would depart from a standard pathway of accessing care within the existing healthcare system which rely on having a family physician (Grant et al., 2018; Salami et al., 2019). It also is an alternative to more medicalized forms of care, which reinforces that community-level supports are important (Joseph & Double, 2020). From the findings of this study, religious centres (e.g, churches), were involved in providing material supports for participants. Black churches in Ontario have been a source of community and support for racialized claimants who are unable to receive services from government funded programs due to waitlists or unavailability (Balintec, 2023). This highlights the need for increased funding to community organizations as they provide a plethora of services beyond material and tangible resources. Similarly, non-medical centres, such as settlement organizations, play a vital role in alleviating blocked access to services both medical and social (Ratnayake et al., 2022).

Limitations and Future Directions

The limitations within this paper should be addressed as they influence the interpretation of the results. For starters, the sample size in this paper is geographically constrained to Ontario and the participants mainly came from metropolitan cities with large amounts of migrants and racialized populations. This may have shaped their experiences in seeking care considering their experiences may have been different if they were living in locations where there are lower amounts of migrant and racialized groups or in remote or rural geographical areas with fewer services and resoueces. While the participants included in the present study come from a variety of backgrounds (e.g., sexual orientation and gender identity, ethnicity and race, migration class, professional background), the inclusion of other migrant classes (e.g., temporary workers) and providers (e.g., psychiatrists and nurse practitioners) could have provided more complexity in the information gathered. The goal of qualitative research utilizing critical thematic analysis is not to be generalizable, to achieve saturation, or to focus on large sample sizes, but to be transferrable to related contexts and theories. While the interviews were conducted online through a videoconferencing platform, this may have been an unfavourable approach for those who did not have access to device or those migrants who are rightfully critical of surveillance regimes.

Some future directions for research include the active addition of those who are disabled, LGBTQ+, and belong to more structurally precarious legal statuses. Their experiences with the immigration and the mental healthcare system may provide interesting insights based on their identities. Further research is required to validate the NIGAHT Framework, as it was developed solely based on the local context - it being situated within Canada and in the province of Ontario. This conceptual framework is not exhaustive, as it aims to serve as a starting point for explorations related to understanding how local mental healthcare systems interact with immigration systems and produce experiences for racialized migrant service users. A key strength to this study is that the mental health providers were racialized and migrants themselves, therefore, the accounts posed by service users were validated given shared identities. However, future studies involving the NIGHAT Framework should include mental healthcare providers from other backgrounds to understand how their relationship to the existing healthcare infrastructure plays a role in either limiting or expanding the services they can provide.

Conclusion

Accessing mental healthcare services in Ontario is a complex process for racialized migrants of all backgrounds. The findings of this study highlight how access to care is driven by broader immigration processes, such as legal and material consequences imposed by one’s immigration status (Caulford & D’Andrade, 2012; McKenzie, 2019; McKenzie et al., 2014). It brings attention the importance of understanding access by analyzing how both the immigration and mental healthcare system work together in producing specific experiences, but also recognizing how these may disparately impact those who are systemically placed at risk. (Castañeda et al., 2015; Hynie, 2018) The NIGHAT Framework creates a conceptual understanding in opportunities for future researchers to take a system-driven approach in exploring disparities in access to mental healthcare services. To increase accessibility of mental healthcare services, there needs to be consideration of how overarching systems and policies are limitations, or potential enablers, for both service users and service providers.

References

Abu-Laban, Y., Tungohan, E., & Gabriel, C. (2022). *Containing diversity: Canada and the politics of immigration in the 21st century*. University of Toronto Press.

Ahn, Y., Miller, M. M., Wang, L., & Laszloffy, T. (2014). "I didn't understand their system, and I didn't know what to do": Migrant Parents' Experiences of Mandated Therapy for Their Children. *Contemporary Family Therapy*, *36*(1), 25–40.

Andersen, R. M. (1995). Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? *Journal of Health and Social Behavior*, *36*(1), 1–10. https://doi.org/10.2307/2137284

Asanin, J., & Wilson, K. (2008). "I spent nine years looking for a doctor": Exploring access to health care among immigrants in Mississauga, Ontario, Canada. *Social Science & Medicine*, *66*(6), 1271–1283. https://doi.org/10.1016/j.socscimed.2007.11.043

Asgary, R., & Segar, N. (2011). Barriers to health care access among refugee asylum seekers. *Journal of Health Care for the Poor and Underserved*, *22*(2), 506–522.

Balintec, V. (2023, December 30). 'We need help': Toronto churches close their doors to asylum seekers due to dwindling resources. *CBC*. https://www.cbc.ca/news/canada/toronto/toronto-churches-refugee-claimant-closures-1.7071709

Beatson, J. (2016). The stories we tell about refugee claimants: Contested frames of the health-care access question in Canada. *Refuge*, *32*, 125.

Beiser, M., Gill, K., & Edwards, R. G. (1993). Mental health care in Canada: Is it accessible and equal? *Canada's Mental Health*.

Bhatia, V. (2018). *Anger, Compassion and Identity: Constructing Refugee Citizenship Through Health Care Policy*.

Bhuyan, R., & Bragg, B. (2021). Epistemologies of bordering: Domestic violence advocacy with marriage migrants in the shadow of deportation. *Migration Studies*, *9*(2), 159–178.

Bobadilla, A., Orchard, T., Magalhaes, L., & Fitzsimmons, D. (2017). Ontario healthcare coverage eligibility among new permanent residents: A scoping review. *Journal of Immigrant & Refugee Studies*, *15*(4), 384–405.

Boychuk, C. K. (2015). *Choosing Citizens: Canada's Obligations to Migrants with Disabilities*.

Bradley, S., & Drapeau, M. (2014). Increasing access to mental health care through government-funded psychotherapy: The perspectives of clinicians. *Canadian Psychology/Psychologie Canadienne*, *55*(2), 80.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021). *Thematic Analysis: A Practical Guide*. SAGE Publications. https://books.google.ca/books?id=eMArEAAAQBAJ

Bunn, S., Fleming, P., Rzeznikiewiz, D., & Leung, F.-H. (2013). Understanding the demographic characteristics and health of medically uninsured patients. *Canadian Family Physician*, *59*(6), e276–e281.

Campbell, R. M., Klei, A. G., Hodges, B. D., Fisman, D., & Kitto, S. (2014). A Comparison of Health Access Between Permanent Residents, Undocumented Immigrants and Refugee Claimants in Toronto, Canada. *Journal of Immigrant and Minority Health*, *16*(1), 165–176. https://doi.org/10.1007/s10903-012-9740-1

Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M.-E. D., Beyeler, N., & Quesada, J. (2015). Immigration as a Social Determinant of Health. *Annual Review of Public Health*, *36*(1), 375–392. https://doi.org/10.1146/annurev-publhealth-032013-182419

Caulford, P., & D'Andrade, J. (2012). Health care for Canada's medically uninsured immigrants and refugees: Whose problem is it? *Canadian Family Physician*, *58*(7), 725–727.

Cénat, J. M. (2020). How to provide anti-racist mental health care. *The Lancet Psychiatry*, *7*(11), 929–931.

Cohen, K. R., & Peachey, D. (2014). Access to psychological services for Canadians: Getting what works to work for Canada's mental and behavioural health. *Canadian Psychology/Psychologie Canadienne*, *55*(2), 126.

Commonwealth Fund. (2021). *Mirror, Mirror 2021: Reflecting Poorly Health Care in the U.S. Compared to Other High-Income Countries*.

Dewa, C. S., Hoch, J. S., & Steele, L. (2005). Prescription drug benefits and Canada's uninsured. *International Journal of Law and Psychiatry*, *28*(5), 496–513.

Durbin, A., Moineddin, R., Lin, E., Steele, L. S., & Glazier, R. H. (2015). Mental health service use by recent immigrants from different world regions and by non-immigrants in Ontario, Canada: A cross-sectional study. *BMC Health Services Research*, *15*(1), 1–15.

Edge, S., & Newbold, B. (2013). Discrimination and the health of immigrants and refugees: Exploring Canada's evidence base and directions for future research in newcomer receiving countries. *Journal of Immigrant and Minority Health*, *15*(1), 141–148. https://dx.doi.org/10.1007/s10903-012-9640-4

Flottorp, S. A., Oxman, A. D., Krause, J., Musila, N. R., Wensing, M., Godycki-Cwirko, M., Baker, R., & Eccles, M. P. (2013). A checklist for identifying determinants of practice: A systematic review and synthesis of frameworks and taxonomies of factors that prevent or enable improvements in healthcare professional practice. *Implementation Science : IS*, *8*, 35. https://doi.org/10.1186/1748-5908-8-35

Gagnon, M., Kansal, N., Goel, R., & Gastaldo, D. (2021). Immigration Status as the Foundational Determinant of Health for People Without Status in Canada: A Scoping Review. *Journal of Immigrant and Minority Health*, 1–16.

Gazzola, N., Drapeau, M., Synard, J., Horvath, A., Page, L., & Toukmanian, S. (2009). The psychotherapeutic professions in Canada. *Annual Meeting of the Society for Psychotherapy Research, Barcelona, Spain*.

Goel, R., Bloch, G., & Caulford, P. (2013). Waiting for care: Effects of Ontario’s 3-month waiting period for OHIP on landed immigrants. *Canadian Family Physician*, *59*(6), e269–e275.

Gopalan, G., Goldstein, L., Klingenstein, K., Sicher, C., Blake, C., & McKay, M. M. (2010). Engaging families into child mental health treatment: Updates and special considerations. *Journal of the Canadian Academy of Child and Adolescent Psychiatry/Journal de l’Académie Canadienne de Psychiatrie de l’enfant et de l’adolescent*.

Grant, K. L., Simmons, M. B., & Davey, C. G. (2018). Three nontraditional approaches to improving the capacity, accessibility, and quality of mental health services: An overview. *Psychiatric Services*, *69*(5), 508–516.

Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: A literature review. *Risk Management and Healthcare Policy*, 175–183.

Hansen, H., & Metzl, J. M. (2019). *Structural competency in mental health and medicine: A case-based approach to treating the social determinants of health*. Springer.

Hartog, J. (2020). Immigrants and Refugees in Toronto and Their Encounters with Healthcare: New Research Paths. In *Multilingual Healthcare* (pp. 191–208). Springer.

Healey, P., Stager, M. L., Woodmass, K., Dettlaff, A. J., Vergara, A., Janke, R., & Wells, S. J. (2017). Cultural adaptations to augment health and mental health services: A systematic review. *BMC Health Services Research*, *17*(1), 1–26.

Hyman, I. (2009). *Racism as a determinant of immigrant health*.

Hynie, M. (2018). The social determinants of refugee mental health in the post-migration context: A critical review. *The Canadian Journal of Psychiatry*, *63*(5), 297–303.

IRCC. (2021). *Canada welcomes the most immigrants in a single year in its history*.

Jack, S. M., Duku, E., Whitty, H., Van Lieshout, R. J., Niccols, A., Georgiades, K., & Lipman, E. L. (2022). Young mothers' use of and experiences with mental health care services in Ontario, Canada: A qualitative descriptive study. *BMC Women's Health*, *22*(1), 1–16.

Jayasuriya-Illesinghe, V. (2018). Immigration policies and immigrant women's vulnerability to intimate partner violence in Canada. *Journal of International Migration and Integration*, *19*, 339–348.

Johnson, G. R. (2014). Toward uniform competency standards in telepsychology: A proposed framework for Canadian psychologists. *Canadian Psychology/Psychologie Canadienne*, *55*(4), 291.

Joseph, A., & Double, D. (2020). *Critical perspectives in mental health*.

Joseph, A. J. (2018). Traditions of colonial and eugenic violence: Immigration detention in Canada. *Containing Madness: Gender and 'Psy'in Institutional Contexts*, 41–65.

Kaga, M., Nakache, D., Anderson, M., Crépeau, F., Delisle, A., Fraser, N., Frenyó, E., Purkey, A., Soennecken, D., & Tanotra, R. (2021). Vulnerability in the Canadian protection regime: Research report on the policy framework. *Zenodo.[Google Scholar]*.

Kanani, N. (2011). Race and madness: Locating the experiences of racialized people with psychiatric histories in Canada and the United States. *Critical Disability Discourses*.

Kirmayer, L. J., & Jarvis, G. E. (2019). Culturally Responsive Services as a Path to Equity in Mental Healthcare. *HealthcarePapers*, *18*(2), 11–23. https://dx.doi.org/10.12927/hcpap.2019.25925

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., Pottie, K., & (CCIRH), C. C. for I. and R. H. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *183*(12), E959–E967. https://doi.org/10.1503/cmaj.090292

Kleinman, A. (1980). *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry*. University of California Press. https://books.google.ca/books?id=ZRVbw6-UyucC

Kohn-Wood, L., & Hooper, L. (2014). Cultural competency, culturally tailored care, and the primary care setting: Possible solutions to reduce racial/ethnic disparities in mental health care. *Journal of Mental Health Counseling*, *36*(2), 173–188.

Kuile, S., Rousseau, C., Munoz, M., Nadeau, L., & Ouimet, M. (2007). The universality of the Canadian health care system in question: Barriers to services for immigrants and refugees. *International Journal of Migration, Health and Social Care*, *3*(1), 15–26.

Landolt, P. (2022). Assembling the local politics of noncitizenship: Contesting access to healthcare in Toronto-sanctuary city. *Social Problems*, *69*(1), 74–90.

Lee, S. K., Rowe, B. H., & Mahl, S. K. (2021). Increased private healthcare for canada: Is that the right solution? *Healthcare Policy*, *16*(3), 30.

Lin, S. (Lamson). (2022). Access to health care among racialised immigrants to Canada in later life: A theoretical and empirical synthesis. *Ageing and Society*, *42*(8), 1735–1759. https://doi.org/DOI: 10.1017/S0144686X20001841

Lo, R. F., & Sasaki, J. Y. (2023). Lay Misperceptions of Culture as "Biological" and Suggestions for Reducing Them. *Perspectives on Psychological Science*, 17456916231181139.

MacIntosh, C. (2019). Medical inadmissibility, and physically and mentally disabled would-be immigrants: Canada's story continues. *Dalhousie LJ*, *42*, 125.

Magalhaes, L., Carrasco, C., & Gastaldo, D. (2010). Undocumented migrants in Canada: A scope literature review on health, access to services, and working conditions. *Journal of Immigrant and Minority Health*, *12*(1), 132–151.

Mawani, R. (2007). Screening out Diseased Bodies: Immigration, Mandatory HIV Testing, and the Making of a Healthy Canada. In *Medicine at the Border: Disease, Globalization and Security, 1850 to the Present* (pp. 136–158). Springer.

McAlister, F. A., Cram, P., & Bell, C. M. (2018). Comparing Canadian health care to that in other countries: Looking beyond the headlines. *CMAJ*, *190*(8), E207–E208.

McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: Policy implications. *Health Affairs*, *27*(2), 393–403.

McKeary, M., & Newbold, B. (2010). Barriers to Care: The Challenges for Canadian Refugees and their Health Care Providers. *Journal of Refugee Studies*, *23*(4), 523–545. https://doi.org/10.1093/jrs/feq038

McKenzie, K. (2019). Improving Mental Health Services for Immigrant, Racialized, Ethno-Cultural and Refugee Groups. *HealthcarePapers*, *18*(2), 4–9. https://dx.doi.org/10.12927/hcpap.2019.25926

McKenzie, K. J., Tuck, A., & Agic, B. (2014). Mental healthcare policy for refugees in Canada. *Refuge and Resilience: Promoting Resilience and Mental Health among Resettled Refugees and Forced Migrants.*, 181–194. http://dx.doi.org/10.1007/978-94-007-7923-5_12

McMurray, J., Breward, K., Breward, M., Alder, R., & Arya, N. (2014). Integrated primary care improves access to healthcare for newly arrived refugees in Canada. *Journal of Immigrant and Minority Health*, *16*, 576–585.

Menezes, A., Henry, S., & Agarwal, G. (2022). It's high time Canada started collecting race-based performance data on medical training and careers. *The Lancet Regional Health–Americas*, *14*.

Meyer, O. L., & Zane, N. (2013). The influence of race and ethnicity in CLIENTS'EXPERIENCES of mental health treatment. *Journal of Community Psychology*, *41*(7), 884–901.

Minas, H. (2007). Developing mental-health services for multicultural societies. *Cultural Psychiatry*, 389–401.

Moroz, N., Moroz, I., & D'Angelo, M. S. (2020). Mental health services in Canada: Barriers and cost-effective solutions to increase access. *Healthcare Management Forum*, *33*(6), 282–287.

Muggah, E., Dahrouge, S., & Hogg, W. (2012). Access to primary health care for immigrants: Results of a patient survey conducted in 137 primary care practices in Ontario, Canada. *BMC Family Practice*, *13*(1), 1–7.

Mulvale, G., Abelson, J., & Goering, P. (2007). Mental health service delivery in Ontario, Canada: How do policy legacies shape prospects for reform? *Health Economics, Policy and Law*, *2*(4), 363–389.

Mulvale, G., & Hurley, J. (2008). Insurance coverage and the treatment of mental illness: Effect on medication and provider use. *Journal of Mental Health Policy and Economics*, *11*(4), 177.

Murray, J. K., & Knudson, S. (2023). Mental health treatment and access for emerging adults in Canada: A systematic review. *Frontiers in Public Health*, *11*.

Ng, E., & Zhang, H. (2020). The mental health of immigrants and refugees: Canadian evidence from a nationally linked database. *Health Reports*, *31*(8), 3–12. https://dx.doi.org/10.25318/82-003-x202000800001-eng

Ng, E., & Zhang, H. (2021). *Access to mental health consultations by immigrants and refugees in Canada*.

Okeke-Ihejirika, P., Yohani, S., Muster, J., Ndem, A., Chambers, T., & Pow, V. (2020). A scoping review on intimate partner violence in Canada's immigrant communities. *Trauma, Violence, & Abuse*, *21*(4), 788–810.

O'Mahony, Donnelly, T. T., Bouchal, S. R., & Este, D. (2012). Barriers and facilitators of social supports for immigrant and refugee women coping with postpartum depression. *Advances in Nursing Science*, *35*(3), E42–E56. https://dx.doi.org/10.1097/ANS.0b013e3182626137

O'Mahony, J., & Clark, N. (2018). Immigrant women and mental health care: Findings from an environmental scan. *Issues in Mental Health Nursing*, *39*(11), 924–934.

Penney, S. R., Prosser, A., Grimbos, T., Egag, E., & Simpson, A. I. F. (2020). Voluntary and forced migrants in forensic mental health care. *The International Journal of Forensic Mental Health*, No-Specified. http://dx.doi.org/10.1080/14999013.2020.1812772

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., Narasiah, L., Kirmayer, L. J., Ueffing, E., MacDonald, N. E., Hassan, G., McNally, M., Khan, K., Buhrmann, R., Dunn, S., Dominic, A., McCarthy, A. E., Gagnon, A. J., Rousseau, C., & Tugwell Laurence J.; ORCID: http://orcid.org/0000-0002-6228-1739, P. A. I.-O. http://orcid.org/Kirmayer. (2011). Evidence-based clinical guidelines for immigrants and refugees. *Canadian Medical Association Journal*, *183*(12), e824–e925. http://dx.doi.org/10.1503/cmaj.090313

Pottie, K., & Magwood, O. (2019). Community-based mental healthcare for marginalized or excluded populations. *HealthcarePapers*, *18*(2).

Ratnayake, A., Sayfi, S., Veronis, L., Torres, S., Baek, S., & Pottie, K. (2022). How are non-medical settlement service organizations supporting access to healthcare and mental health services for immigrants: A scoping review. *International Journal of Environmental Research and Public Health*, *19*(6), 3616.

Reitmanova, S., Gustafson, D. L., & Ahmed, R. (2015). “Immigrants can be deadly”: Critical discourse analysis of racialization of immigrant health in the Canadian press and public health policies. *Canadian Journal of Communication*, *40*(3), 471–487.

Rousseau, C., Laurin-Lamothe, A., Rummens, J. A., Meloni, F., Steinmetz, N., & Alvarez, F. (2013). Uninsured immigrant and refugee children presenting to Canadian paediatric emergency departments: Disparities in help-seeking and service delivery. *Paediatrics & Child Health*, *18*(9), 465–469.

Salam, Z., Odenigbo, O., Newbold, B., Wahoush, O., & Schwartz, L. (2022). Systemic and Individual Factors That Shape Mental Health Service Usage Among Visible Minority Immigrants and Refugees in Canada: A Scoping Review. *Administration and Policy in Mental Health and Mental Health Services Research*, 1–23.

Salami, B., Hegadoren, K., Kirova, A., Meherali, S., Nsaliwa, C., & Chiu, Y. (2018). ‘And when a certain health issue happen, they try to cover it’: Stakeholder perspectives on the health of temporary foreign workers and their families. *Social Work in Health Care*, *57*(1), 13–26. http://dx.doi.org/10.1080/00981389.2017.1379458

Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *International Journal of Mental Health Nursing*, *28*(1), 152–161. http://dx.doi.org/10.1111/inm.12512

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*(4), 334–340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Sandelowski, M. (2010). What’s in a name? Qualitative description revisited. *Research in Nursing & Health*, *33*(1), 77–84. https://doi.org/10.1002/nur.20362

Shommu, N. S., Ahmed, S., Rumana, N., Barron, G. R. S., McBrien, K. A., & Turin, T. C. (2016). What is the scope of improving immigrant and ethnic minority healthcare using community navigators: A systematic scoping review. *International Journal for Equity in Health*, *15*(1), 1–12.

Stanbrook, M. B. (2014). Canada owes refugees adequate health coverage. *CMAJ*, *186*(2), 91–91.

Steele, L. S., Glazier, R. H., & Lin, E. (2006). Inequity in mental health care under Canadian universal health coverage. *Psychiatric Services*, *57*(3), 317–324.

Thomson, M. S., Chaze, F., George, U., & Guruge, S. (2015). Improving Immigrant Populations' Access to Mental Health Services in Canada: A Review of Barriers and Recommendations. *Journal of Immigrant and Minority Health*, *17*(6), 1895–1905. https://doi.org/10.1007/s10903-015-0175-3

Tulli, M., Salami, B., Begashaw, L., Meherali, S., Yohani, S., & Hegadoren, K. (2020). Immigrant mothers' perspectives of barriers and facilitators in accessing mental health care for their children. *Journal of Transcultural Nursing*, *31*(6), 598–605.

Vasiliadis, H.-M., Lesage, A., Adair, C., & Boyer, R. (2005). Service use for mental health reasons: Cross-provincial differences in rates, determinants, and equity of access. *The Canadian Journal of Psychiatry*, *50*(10), 614–619.

Vasquez, M. J., & Jones, J. M. (2006). Increasing the number of psychologists of color: Public policy issues for affirmative diversity. *American Psychologist*, *61*(2), 132.

Viruell-Fuentes, E. A., Miranda, P. Y., & Abdulrahim, S. (2012). More than culture: Structural racism, intersectionality theory, and immigrant health. *Social Science & Medicine*, *75*(12), 2099–2106.

Waldron, I. R. G. (2020). The wounds that do not heal: Black expendability and the traumatizing aftereffects of anti-Black police violence. *Equality, Diversity and Inclusion: An International Journal*.

Wiktorowicz, M. E., Di Pierdomenico, K., Buckley, N. J., Lurie, S., & Czukar, G. (2020). Governance of mental healthcare: Fragmented accountability. *Social Science & Medicine*, *256*, 113007.

Wiktorowicz, M. E., Fleury, M.-J., Adair, C. E., Lesage, A., Goldner, E., & Peters, S. (2010). Mental health network governance: Comparative analysis across Canadian regions. *International Journal of Integrated Care*, *10*.

Williams, M. T., Faber, S. C., & Duniya, C. (2022). Being an anti-racist clinician. *The Cognitive Behaviour Therapist*, *15*.

Chapter 6: Conclusion

Overview of Findings

The three research chapters within this dissertation aim to further expand the literature surrounding the influence of individual and systemic factors among racialized immigrant groups when seeking mental healthcare services in Ontario, Canada. This conclusion chapter will provide a summary of the key findings, their contributions to the literature, and potential implications. It will also detail a synthesis of the three chapters and discuss the limitations and future areas for research.

Regarding the contributions and perceived novelty of this dissertation, I would like to begin framing my response with this quote by Michel Foucault (1971): “I don't write a book so that it will be the final word; I write a book so that other books are possible, not necessarily written by me" (translated by O’Farrell, 2005). The subject of my dissertation itself is not novel, as these issues have been long studied by individuals from various disciplines and even beyond the academic sphere as communities have raised similar concerns and strived toward improving the issues explored in this dissertation. My research is only “novel” when it is out of context. Additionally, as part of RTA, the goal of research is not to close any gaps but create dialogue with existing research (Braun & Clarke, 2006, 2021). Furthermore, the use of the word “novel” when focusing on racial health inequities is problematic and implies an extractive nature that is driven by academia’s pursuit of inquiry rooted in neoliberal beliefs (Lett et al., 2022). This dogma of “novel inquiry” is also entrenched within the field of Global Health due to its colonial, white supremacist, and racist genesis (Abimbola & Pai, 2020; Hirsch, 2021). The issues interrogated within this dissertation have been known to exist as truths within many racialized migrant communities here in Ontario and beyond or elsewhere. My dissertation builds on the said tapestry of truths within my communities and the existing published research. Aligned with this statement by Zora Neale Hurston (1984), "research is formalized curiosity. It is poking and prying with a purpose." I only seek to add to the literature and recognize my own limited and constrained contributions to the broader corpus of knowledge surrounding this issue.

Key findings

Chapter 3 is a scoping review utilizing Arksey and O'Malley's (2005) approach to understand what the barriers and facilitators experienced by racialized immigrant groups are when seeking mental healthcare services in Canada. A key finding from this review centered on the broader ideas of how systemic and individual factors work in tandem to produce specific experiences, such as systemic racism. A critical finding which presented as a subtheme was the notion of trust towards the "system" which entailed both the legal and healthcare systems. This finding highlights the strong influence of policies and legislations in shaping mental healthcare access broadly. Ultimately, the contribution of this scoping review to the broader literature rests in the notion that this review attends to how racism plays a role along with citizenship in producing inequities to receiving care.

Chapter 4 focuses on drawing from 16 interviews with racialized migrants and inquiring about their experiences of seeking mental healthcare services in Ontario. This paper uses Andersen's Model of Behavioural Model of Health Care Utilization (Andersen, 1995) and Kleinman's Explanatory Model (Kleinman, 1980, 1987) as conceptual frameworks for the interview guide and analysis of the findings. The findings included the following themes: structural constraints, individual factors, and appraisal of services which reiterate how access to mental healthcare services is a complex process. A key contribution to the broader literature from this paper is that accessing mental healthcare services is dependent on the individual's past experiences and familiarity of mental healthcare services. Findings signal how racialized immigrants are not homogenous in their experiences of seeking such services and there exists variability within and even among groups.

Chapter 5 centers on understanding the interplay of the federal immigration system and provincial mental healthcare system in producing experiences for racialized migrants when seeking mental healthcare services. This chapter includes interviews conducted with 16 racialized migrants who have used mental health services in Ontario and interviews conducted with 10 mental healthcare providers in Ontario who provide services to racialized migrants. The analysis uses Andersen's Model of Behavioural Model of Health Care Utilization (Andersen, 1995) as a conceptual framework to explore participants' perceived barriers related to accessing mental healthcare services and as a point of departure, to reimagine the ideal mental healthcare system. Through analysis of the interviews, attention was given to how regulations and policies shape access to mental healthcare services. The findings were arranged to produce a conceptual framework, NIGHAT, to understand mental healthcare access utilization among racialized migrants in Ontario. This conceptual framework builds on the findings from the scoping review in chapter two (Salam et al., 2022). This framework embeds the critiques of the immigration and Ontario healthcare system put forth by participants and potential solutions on how to overcome them to improve access to mental healthcare services for this broad population. The findings from this paper provide a conceptual contribution supporting a new conceptual framework to examine this issue. This framework provides a critique of existing theories in understanding healthcare inequities among immigrant groups, such as the "healthy immigrant effect" as it was found that individuals from more precarious immigration categories may not want to receive care until they feel they are "safe" to do so. While this paper and conceptual framework attends to the more macro-level factors, it provides another substantial theoretical critique to behavioural or "cultural" explanations for healthcare utilization among racialized migrant groups as they are arguably myopic and racist approaches that center on individualizing individuals' decisions which detracts from how their choices are ultimately shaped by structural issues, such as their legal status and the confines of the Ontario healthcare system.

Synthesizing findings

In synthesizing the findings from the research chapters, this dissertation highlights tensions and considerations for researchers when exploring the issue of racialized migrants' access to care broadly.

First, framing it simply as an "access" issue at an individual level detracts from how broader overarching systems are influencing choices and decision making for racialized migrants when seeking care services (Kahn, 2013; Kleinman, 1980, 1987; May, 2007). This framing also assumes that services are there, and individuals are just not receiving them and assumes that these are the appropriate services that are needed by this broad population. Mental healthcare service providers in the present study were limited in the quality of services they could provide due to the overarching rules set by insurance companies, social benefit programs, and organizational policies. The "patchwork" nature of existing mental healthcare services does harm to racialized migrants (Caulford & D'Andrade, 2012; Kuile et al., 2007; McKenzie, 2019; McKenzie et al., 2014). Rather than emphasizing individual and behavioural-level factors in exploring this issue, it is important to consider how racialized migrants are made structurally vulnerable due to immigration policies and how those policies undermine their access to care

(Castañeda et al., 2015; Hynie, 2018; McKenzie et al., 2014). It can be understood that immigration status along with racism is reified as a social determinant of health across all three research chapters, as it profoundly shapes one's access to mental healthcare services (Castañeda et al., 2015). The NIGHAT Framework highlights how racialized migrants' access to care in Ontario is shaped by overarching policies and practices that exist because of limitations enacted by one's immigration status and the existing mental healthcare system.

Second, this dissertation focused on two identities as sites of interrogation: being a migrant and being racialized. Regarding the first identity, it was understood that one's legal status produced certain experiences of accessing care due to consequences of legal restrictions imposed on them from their status (Campbell et al., 2014; Hacker et al., 2015; McKenzie et al., 2014). It was also identified that there are material conditions associated with one's legal status that led into unique stressors which produced mental distress at varying levels (Castañeda et al., 2015; Hynie, 2018). With the latter site of interrogation, being racialized came with encountering racism in different domains (Jones, 2000). Many participants' racial identities created experiences where they often wanted an individual who was racialized - which signals how there is an inherent understanding that the current system or modalities of services/training in place lacks racial awareness or competence to begin with. Thus, a racialized provider would somehow circumvent this issue as there is a perception that these individuals would be able to provide care that is relevant to their world views and needs. This highlights how cultural forms of racism exist within the mental healthcare system and the training within this broad profession excludes non-white individuals and non-Western realities, knowledge systems, and conceptualizations (Bedi et al., 2020; Joseph & Double, 2020; McKenzie, 2019; Viruell-Fuentes et al., 2012). In turn, it can be argued it is a form of medical racism (Jones, 2000; Lo & Sasaki, 2023). Other forms of discrimination, such as interpersonal, were reported in this dissertation. However, there is the recognition that when individuals wanted a "racial" or "cultural" match, these needs may arise from the inherent fact that the current existing system/training does not fit the needs of racialized individuals (Abdel-Baki et al., 2020; Bedi et al., 2020; Cénat, 2020; Kirmayer, 2012; Williams et al., 2022). While "diversifying" the profession is an easy call to solve this problem, it is not enough - as many of the providers themselves are faced with burdens that are a consequence of systemic racism in educational systems (e.g., higher proportion of student loans, challenges in navigating academia, etc.). There is the broader issue of acknowledging and interrogating racism as a key aspect within the mental health profession itself (Abdel-Baki et al., 2020; Cénat, 2020; Williams et al., 2022).

Third, broadening the scope of what constitutes as "mental healthcare services" to fully respond to the needs of racialized migrants (Wren-Lewis & Alexandrova, 2021). Both sets of participants highlighted how material needs must be fulfilled in order to alleviate certain stressors which ultimately exacerbate mental health issues (Hynie, 2018; Kirmayer et al., 2011). Said stressors are often driven by immigration related conditions, such as lack of social support and connection to adequate resources (Castañeda et al., 2015; Hynie, 2018; Pottie et al., 2011; Robert & Gilkinson, 2012). The medicalization of distress that arises from social and structural issues is inherently harmful as it leads to an overemphasis on providing mental healthcare services as a first realm of supports to alleviate said distress and stressors (Albarracin et al., 2015; Ameil, 2017; Kronick, 2018; Miller, 2017; Thangadurai & Jacob, 2014). Therefore, the medicalization of "mental health" can ultimately overlook the root causes and potentially worsen symptoms (Albarracin et al., 2015; Ameil, 2017; Miller, 2017; Thangadurai & Jacob, 2014). In aligning with the KEM, an individual may locate their solution outside of the medical system

(Kleinman, 1980, 1987). Reiterating how an individual-level focus must not be taken in understanding the needs of this population, the shift from "mental health" to "mental wellbeing" in framing these issues yields more holistic forms of responses which would include social and material supports (Agteren & Iasiello, 2020; Wren-Lewis & Alexandrova, 2021).

Fourth, in consideration of documenting facilitators in the context of individual strengths among participants, there is conflation of understanding these as resilience or protective factors in public health paradigms (Rumala & Beard, 2022; Sims-Schouten & Gilbert, 2022; Suslovic & Lett, 2023). While resilience itself is a useful concept which underscores a positive framing of individuals experiences, this approach is problematic especially given that racialized individuals are navigating a system that is complicated through different functions of systemic racism (Kanani, 2011; Rumala & Beard, 2022; Sims-Schouten & Gilbert, 2022; Suslovic & Lett, 2023). Arguably, no amount of building resilience is enough when the mere function of racism is to erode equitable access to life (Rumala & Beard, 2022; Sims-Schouten & Gilbert, 2022; Suslovic & Lett, 2023). Therefore, there needs to be explicit attention to how racism, and not race, is a key barrier when accessing mental healthcare services (Castañeda et al., 2015; Ford & Airhihenbuwa, 2010, 2010). Additionally, how migration itself is intertwined with concepts of racialization which produces another layer of systematic othering and vulnerabalization (Abu-Laban et al., 2022; Joseph, 2018; Kanani, 2011; Moffette, 2021). This framing allows for a more fulsome understanding of racialized migrants' experiences in similar and related contexts.

Lastly, within most research centering on this topic and broad population there is often an overemphasis on increasing mental health literacy as a means to improve access to mental healthcare services (Abel & Benkert, 2022). While psychoeducation is useful as it helps individuals to identify potential health challenges and communicate their needs with providers, this is still an individual-centric approach (Hansen & Metzl, 2019; Kirmayer, 2014). This solution, while tangible, averts attention from the complexities produced by the system itself (Kirmayer, 2012, 2014; Sukhera et al., 2022). Arguably, it is a difficult system to navigate as a consequence of the patchwork nature of the mental healthcare structure in Ontario (Moroz et al., 2020; Mulvale et al., 2007; Mulvale & Hurley, 2008). Researchers should depart from focusing solely on building "awareness" as this assumes that this broad population with unique needs, histories, and challenges is not aware in the first place (Sukhera et al., 2022; Taylor, 2003). This is also a deficit-based understanding and does not acknowledge how this broad population is not a monolith (Lin, 2022). Similarly, there is the assumption that "mental health" is "more" stigmatized within this broad population compared to white Canadians, and therefore increasing awareness and literacy can improve access to care among this population (Kirmayer, 2014; Schomerus & Angermeyer, 2021; Shannon et al., 2015). This assumption is erroneous as stigma is not just unique to this broad population given that stigma is structurally enforced within Canada and renders individuals vulnerable through various practices (Bhatia, 2018; Joseph & Double, 2020; Joseph, 2018; Sukhera et al., 2022). Activists, community organizers, and academics have argued that existing mental health laws and practices in Canada can further harm individuals, especially given the involvement of various legal systems (e.g., law enforcement, child welfare, and immigration enforcement) (Bhatia, 2018; Joseph & Double, 2020; Joseph, 2018; Sukhera et al., 2022). For example, one female participant who was a spousal dependent noted that she was cautious with wording her mental health symptoms to her primary care provider as to not risk child welfare involvement and be deemed a "threat" to her child, which highlights how mothering as a racialized immigrant becomes further criminalized when "mental health" intersects.

Limitations and Future Areas for Exploration

This dissertation has obvious limitations that texture its findings and their applicability. The first limitation that must be stated is related to my identity – I am not a mental healthcare service provider and my own limited knowledge of the profession and its technicalities may have impacted my ability to fully understand or appreciate the perspectives put forth by my service provider participants. However, I did deliberately select someone for my committee who is a mental healthcare provider to help circumvent that and their feedback is pivotal. While I am a racialized immigrant that accesses mental healthcare services in Ontario, my experiences themselves are limiting. However, I believe my perspective offers a unique position in understanding some of my participants' struggles more deeply.

The second limitation stems from the methodological aspects, and this involves the specific contours of qualitative research. While a dissertation that includes the sample sizes of 16 immigrants and 10 service providers, this can be seen as constraints by those uninitiated in terms of qualitative research. Given that this dissertation used reflexive thematic analysis as the analysis tool for all the papers, issues of "small" sample size and "data saturation" do not exist within Braun and Clarke's (2006, 2021) method for thematic analysis. The data collection for the studies was done virtually through Zoom which is a videoconferencing platform approved by Hamilton integrated Research Ethics Board. This is due to the fact of the COVID-19 pandemic and as an attempt to mitigate spread and keep participants safe. This obviously discounts the participation of those who did not have access to adequate internet or a personal device. While it was not known where the interviews were taking place from the participants' locations, some were at home. This could have limited their ability to share certain details in confidence if they felt as if they could potentially be listened to. Therefore, issues of privacy while conducting research via Zoom become apparent. This also signals to broader issues of data surveillance, as there have been threats posed by Zoom and some journalists have been contacted by law authorities for their work with marginalized populations. For settled refugees, refugee claimants, and those escaping domestic violence, the use of an online platform poses concerns for safety. The use of Zoom does have obvious advantages, as participants do not have to travel, and a wider audience can be reached across the province. Additionally, another methodological limitation was that the interviews were conducted in English only due to a lack of funding. While the language requirement was posed as “comfortable having a conversation in English” to depart from stigmatizing and xenophobic English as Second Language criteria, this obviously limits participants who do not feel comfortable speaking English.

The third limitation is the demographics of the participants. The participants from both groups included a wide variety of individuals from various sociodemographic backgrounds which became an asset in terms of exploring issues related to gender, sexuality, religion and ethnoracial identity. The three immigrant groups represented within this study were international students, family dependents, and refugees (both settled and claimants) which provided a unique perspective on legal barriers to accessing mental healthcare services in the findings outlined in this dissertation. Arguably, by focusing on improving access to care for some of the most systemically vulnerbalized, such as international students and refugee claimants, there can be upward benefits for those with other statuses that are less systemically disadvantaged. The presence of these three categories can be attributed to the recruitment methods which relied on professional (e.g., listserv for a university and an academic research institution) and personal (e.g., communities I belong to where there is an overrepresentation of refugees and dependents) networks. While the goal was not to have an entirely representative sample of the Canadian immigrant population, there were no individuals who belonged to certain immigration classes, such as economic or temporary seasonal workers. Additionally, all the international students within the study were students at universities, and their experiences may be distinct from those at colleges. The inclusion of such individuals may have produced specific findings related to the structurally precarious nature of their status and sometimes their reliance on their sponsor or employer. Future studies should examine the experiences of those under such immigration classes but also those without status. On the other hand, there were no psychiatrists, physicians, occupational therapists, nurse practitioners or other forms of culturally relevant healers for “mental health” among the participants, which would have provided a wide variety of information that goes beyond a biomedical scope and approach to health. The participants within this study lived in more dense metropolitan cities and therefore may have access to more resources compared to those in smaller or rural locations. The inclusion of such geographically distinct regions may lend to revealing how health care services and even mental healthcare services play out in under resourced areas. There have been more immigration settlement efforts to help populate smaller and rural regions and this raises a concern related to health services access.

Conclusion

From the findings of the three research papers included within this dissertation, it can be understood that mental healthcare access among racialized immigrant groups within Ontario, and broadly Canada, is a complicated and complex issue. This dissertation included both service users and providers in order to interrogate this issue in-depth. This dissertation takes approaches to understand this issue at both the individual and structural levels. On the individual level, there is a paper centred explicitly on understanding how cultural conceptualizations of wellbeing and mental health influence attitudes towards mental healthcare treatment. By taking a deeper dive on this end of the spectrum of the issue, there exists the unique perspectives and life experiences that individuals bring into informing their care (Kirmayer et al., 2011; Kirmayer & Jarvis, 2019; Lane & Vatanparast, 2022). Conversely, there is a chapter in this dissertation that seeks to emphasize structural aspects such as the immigration and Ontario mental healthcare systems interlock in producing and amplifying these inequities. More specifically, it also highlighted how these limitations impact mental healthcare providers and their ability to provide adequate care to racialized immigrant groups (Caulford & D'Andrade, 2012; McKenzie, 2019; McKenzie et al., 2014; Mulvale et al., 2007). Overall, it can be understood that racialized immigrant groups are not a monolith in their abilities and attitudes towards seeking mental healthcare services; however, they are made more structurally vulnerable in this process which further disadvantages some more than others (Abu-Laban et al., 2022; Joseph, 2018; Kanani, 2011; Moffette, 2021). There exist numerous opportunities for action in order to help improve access for all. Healthcare is a human right, and no one should be denied and delayed in seeking care based on their status (Abu-Laban et al., 2022; Joseph, 2018; Kanani, 2011; Moffette, 2021).

References

Abdel-Baki, R., Collaton, J., Courtice, E. L., Gayfer, B., Lee, S., Linares, N. F. N., Mukunzi, J., Muyingo, L., Sanchez, T. A., & Sharif, N. (2020). *Toward Anti-Racism in Canadian Psychology: A Call to Action from the Future of the Field*.

Abel, T., & Benkert, R. (2022). Critical health literacy: Reflection and action for health. *Health Promotion International*, *37*(4), daac114.

Abimbola, S., & Pai, M. (2020). Will global health survive its decolonisation? *Lancet*, *396 North*(10263), 1627–1628. https://doi.org/10.1016/S0140-6736(20)32417-X

Abu-Laban, Y., Tungohan, E., & Gabriel, C. (2022). *Containing diversity: Canada and the politics of immigration in the 21st century*. University of Toronto Press.

Agteren, J., & Iasiello, M. (2020). Advancing our understanding of mental wellbeing and mental health: The call to embrace complexity over simplification. *Australian Psychologist*, *55*(4), 307–316.

Albarracin, D., Ducousso-Lacaze, A., Cohen, D., Gonon, F., Keller, P.-H., & Minard, M. (2015). There is no cure for existence: On the medicalization of psychological distress. *Ethical Human Psychology and Psychiatry*, *17*(3), 149–158.

Ameil, J. (2017). Pathologizing Distress: The Colonial Master's Tools and Mental Health Services for "Newcomers/Immigrants"'. *Doing Anti-Oppressive Practice: Social Justice Social Work*, 233–251.

Andersen, R. M. (1995). Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? *Journal of Health and Social Behavior*, *36*(1), 1–10. https://doi.org/10.2307/2137284

Arksey, H., & O’Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Bedi, R. P., Domene, J. F., Kassan, A., & Wada, K. (2020). Advocating for Ourselves, Advocating for Our Communities: Canadian Counselling Psychology Into the Next Decade and Beyond. *Canadian Journal of Counselling & Psychotherapy/Revue Canadienne de Counseling et de Psychothérapie*, *54*(4).

Bhatia, V. (2018). *Anger, Compassion and Identity: Constructing Refugee Citizenship Through Health Care Policy*.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021). *Thematic Analysis: A Practical Guide*. SAGE Publications. https://books.google.ca/books?id=eMArEAAAQBAJ

Campbell, R. M., Klei, A. G., Hodges, B. D., Fisman, D., & Kitto, S. (2014). A Comparison of Health Access Between Permanent Residents, Undocumented Immigrants and Refugee Claimants in Toronto, Canada. *Journal of Immigrant and Minority Health*, *16*(1), 165–176. https://doi.org/10.1007/s10903-012-9740-1

Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M.-E. D., Beyeler, N., & Quesada, J. (2015). Immigration as a Social Determinant of Health. *Annual Review of Public Health*, *36*(1), 375–392. https://doi.org/10.1146/annurev-publhealth-032013-182419

Caulford, P., & D’Andrade, J. (2012). Health care for Canada’s medically uninsured immigrants and refugees: Whose problem is it? *Canadian Family Physician*, *58*(7), 725–727.

Cénat, J. M. (2020). How to provide anti-racist mental health care. *The Lancet Psychiatry*, *7*(11), 929–931.

Ford, C., & Airhihenbuwa, C. (2010). *Critical Race Theory, race equity, and public health: Toward antiracism praxis.* https://doi.org/10.2105/AJPH.2009.171058

Foucault, M. (1971). *Entretien avec Michel Foucault* (Vol. 2). Gallimard París.

Hacker, K., Anies, M., Folb, B. L., & Zallman, L. (2015). Barriers to health care for undocumented immigrants: A literature review. *Risk Management and Healthcare Policy*, 175–183.

Hansen, H., & Metzl, J. M. (2019). *Structural competency in mental health and medicine: A case-based approach to treating the social determinants of health*. Springer.

Hirsch, L. A. (2021). Is it possible to decolonise global health institutions? *Lancet*, *397 North*(10270), 189–190. https://doi.org/10.1016/S0140-6736(20)32763-X

Hurston, Z. N. (1984). *Dust Tracks on a Road: An Autobiography*. University of Illinois Press. https://books.google.ca/books?id=t2ViAAAAMAAJ

Hynie, M. (2018). The social determinants of refugee mental health in the post-migration context: A critical review. *The Canadian Journal of Psychiatry*, *63*(5), 297–303.

Jones, C. (2000). *Levels of racism: A theoretic framework and a gardener's tale.* https://doi.org/10.2105/AJPH.90.8.1212

Joseph, A., & Double, D. (2020). *Critical perspectives in mental health*.

Joseph, A. J. (2018). Traditions of colonial and eugenic violence: Immigration detention in Canada. *Containing Madness: Gender and 'Psy'in Institutional Contexts*, 41–65.

Kahn, J. (2013). The politics of framing health disparities. *Mapping "Race": Critical Approaches to Health Disparities Research*, 25–38.

Kanani, N. (2011). Race and madness: Locating the experiences of racialized people with psychiatric histories in Canada and the United States. *Critical Disability Discourses*.

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149–164.

Kirmayer, L. J. (2014). Critical psychiatry in Canada. *Critical Psychiatry and Mental Health: Exploring the Work of Suman Fernando in Clinical Practice.*, 170–181.

Kirmayer, L. J., & Jarvis, G. E. (2019). Culturally Responsive Services as a Path to Equity in Mental Healthcare. *HealthcarePapers*, *18*(2), 11–23. https://dx.doi.org/10.12927/hcpap.2019.25925

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., Pottie, K., & (CCIRH), C. C. for I. and R. H. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *183*(12), E959–E967. https://doi.org/10.1503/cmaj.090292

Kleinman, A. (1980). *Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry*. University of California Press. https://books.google.ca/books?id=ZRVbw6-UyucC

Kleinman, A. (1987). Anthropology and Psychiatry: The Role of Culture in Cross-Cultural Research on Illness. *British Journal of Psychiatry*, *151*(4), 447–454. https://doi.org/DOI: 10.1192/bjp.151.4.447

Kronick, R. (2018). Mental health of refugees and asylum seekers: Assessment and intervention. *The Canadian Journal of Psychiatry*, *63*(5), 290–296.

Kuile, S., Rousseau, C., Munoz, M., Nadeau, L., & Ouimet, M. (2007). The universality of the Canadian health care system in question: Barriers to services for immigrants and refugees. *International Journal of Migration, Health and Social Care*, *3*(1), 15–26.

Lane, G., & Vatanparast, H. (2022). Adjusting the Canadian healthcare system to meet newcomer needs. *International Journal of Environmental Research and Public Health*, *19*(7), 3752.

Lett, E., Adekunle, D., McMurray, P., Asabor, E. N., Irie, W., Simon, M. A., Hardeman, R., & McLemore, M. R. (2022). Health Equity Tourism: Ravaging the Justice Landscape. *Journal of Medical Systems*, *46*(3), 17. https://doi.org/10.1007/s10916-022-01803-5

Lin, S. (Lamson). (2022). Access to health care among racialised immigrants to Canada in later life: A theoretical and empirical synthesis. *Ageing and Society*, *42*(8), 1735–1759. https://doi.org/DOI: 10.1017/S0144686X20001841

Lo, R. F., & Sasaki, J. Y. (2023). Lay Misperceptions of Culture as “Biological” and Suggestions for Reducing Them. *Perspectives on Psychological Science*, 17456916231181139.

May, C. (2007). The clinical encounter and the problem of context. *Sociology*, *41*(1), 29–45.

McKenzie, K. (2019). Improving Mental Health Services for Immigrant, Racialized, Ethno-Cultural and Refugee Groups. *HealthcarePapers*, *18*(2), 4–9. https://dx.doi.org/10.12927/hcpap.2019.25926

McKenzie, K. J., Tuck, A., & Agic, B. (2014). Mental healthcare policy for refugees in Canada. *Refuge and Resilience: Promoting Resilience and Mental Health among Resettled Refugees and Forced Migrants.*, 181–194. http://dx.doi.org/10.1007/978-94-007-7923-5_12

Miller, G. (2017). Reflecting on the Medicalization of Distress. *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health*, 93–108.

Moffette, D. (2021). Immigration status and policing in Canada: Current problems, activist strategies and abolitionist visions. *Citizenship Studies*, *25*(2), 273–291. https://doi.org/10.1080/13621025.2020.1859194

Moroz, N., Moroz, I., & D'Angelo, M. S. (2020). Mental health services in Canada: Barriers and cost-effective solutions to increase access. *Healthcare Management Forum*, *33*(6), 282–287.

Mulvale, G., Abelson, J., & Goering, P. (2007). Mental health service delivery in Ontario, Canada: How do policy legacies shape prospects for reform? *Health Economics, Policy and Law*, *2*(4), 363–389.

Mulvale, G., & Hurley, J. (2008). Insurance coverage and the treatment of mental illness: Effect on medication and provider use. *Journal of Mental Health Policy and Economics*, *11*(4), 177.

O'Farrell, C. (2005). *O'Farrell: Michel Foucault*. Sage.

Pottie, K., Greenaway, C., Feightner, J., Welch, V., Swinkels, H., Rashid, M., Narasiah, L., Kirmayer, L. J., Ueffing, E., MacDonald, N. E., Hassan, G., McNally, M., Khan, K., Buhrmann, R., Dunn, S., Dominic, A., McCarthy, A. E., Gagnon, A. J., Rousseau, C., & Tugwell Laurence J.; ORCID: http://orcid.org/0000-0002-6228-1739, P. A. I.-O. http://orcid.org/Kirmayer. (2011). Evidence-based clinical guidelines for immigrants and refugees. *Canadian Medical Association Journal*, *183*(12), e824–e925. http://dx.doi.org/10.1503/cmaj.090313

Robert, A., & Gilkinson, T. (2012). Mental health and well-being of recent immigrants in Canada: Evidence from the longitudinal survey of immigrants to Canada. *Immigrant Integration: Research Implications for Future Policy*, 191–210.

Rumala, B. B., & Beard, K. V. (2022). Resilience Will Not Erase Structural Racism. *AJN The American Journal of Nursing*, *122*(2), 11.

Salam, Z., Odenigbo, O., Newbold, B., Wahoush, O., & Schwartz, L. (2022). Systemic and Individual Factors That Shape Mental Health Service Usage Among Visible Minority Immigrants and Refugees in Canada: A Scoping Review. *Administration and Policy in Mental Health and Mental Health Services Research*, 1–23.

Schomerus, G., & Angermeyer, M. C. (2021). Blind spots in stigma research? Broadening our perspective on mental illness stigma by exploring ‘what matters most’in modern Western societies. *Epidemiology and Psychiatric Sciences*, *30*, e26.

Shannon, P. J., Wieling, E., Simmelink-McCleary, J., & Becher, E. (2015). Beyond stigma: Barriers to discussing mental health in refugee populations. *Journal of Loss and Trauma*, *20*(3), 281–296.

Sims-Schouten, W., & Gilbert, P. (2022). Revisiting ‘resilience’in light of racism,‘othering’and resistance. *Race & Class*, *64*(1), 84–94.

Sukhera, J., Knaak, S., Ungar, T., & Rehman, M. (2022). Dismantling structural stigma related to mental health and substance use: An educational framework. *Academic Medicine*, *97*(2), 175–181.

Suslovic, B., & Lett, E. (2023). Resilience is an Adverse Event: A Critical Discussion of Resilience Theory in Health Services Research and Public Health. *Community Health Equity Research & Policy*, 2752535X231159721.

Taylor, J. S. (2003). Confronting “culture” in medicine’s “culture of no culture”. *Academic Medicine*, *78*(6), 555–559.

Thangadurai, P., & Jacob, K. (2014). Medicalizing distress, ignoring public health strategies. *Indian Journal of Psychological Medicine*, *36*(4), 351–354.

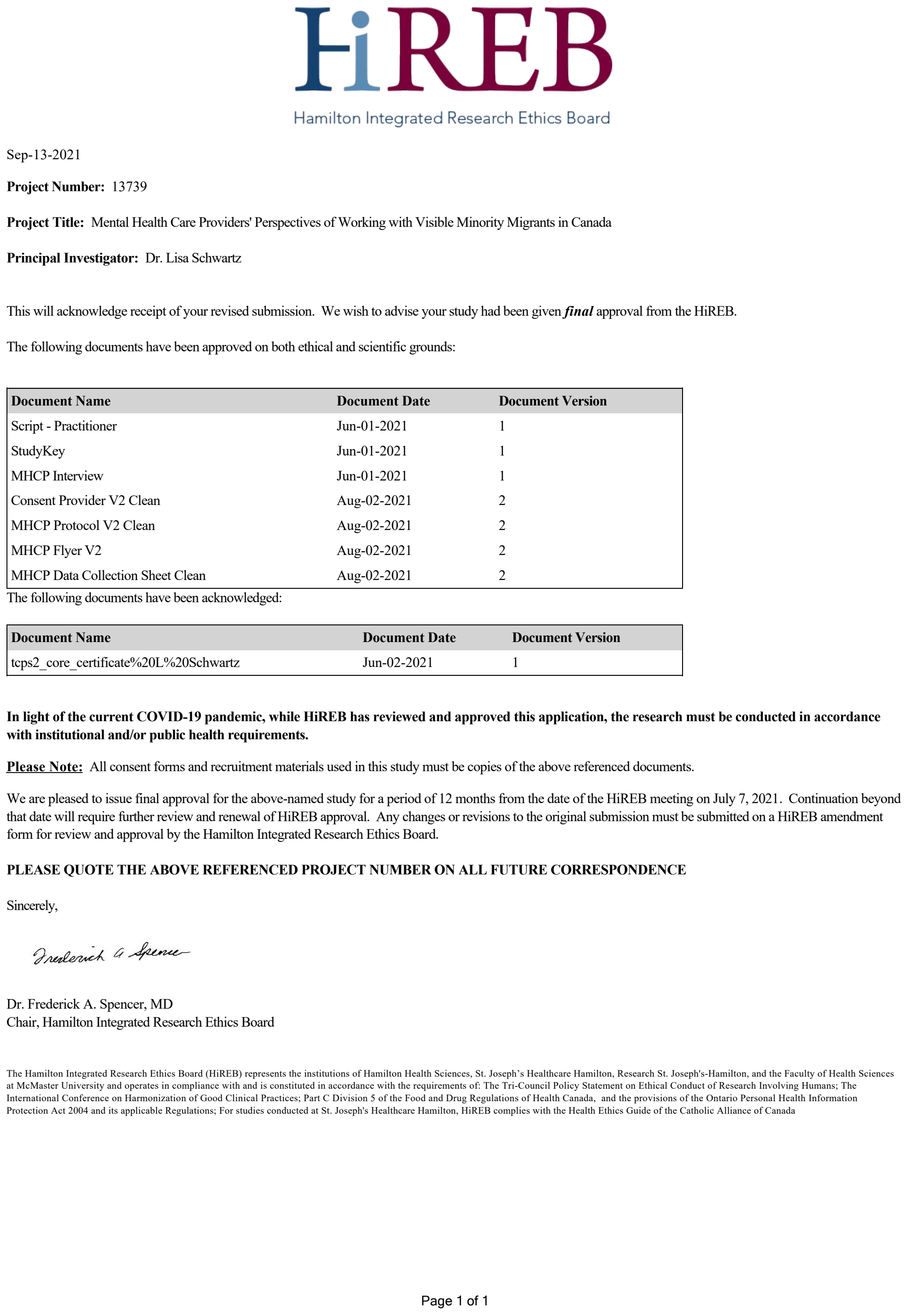
Viruell-Fuentes, E. A., Miranda, P. Y., & Abdulrahim, S. (2012). More than culture: Structural racism, intersectionality theory, and immigrant health. *Social Science & Medicine*, *75*(12), 2099–2106.

Williams, M. T., Faber, S. C., & Duniya, C. (2022). Being an anti-racist clinician. *The Cognitive Behaviour Therapist*, *15*.

Wren-Lewis, S., & Alexandrova, A. (2021). *Mental health without well-being*. *46*(6), 684–703.

Appendix A

HiREB Approval Letter for Study on Racialized Migrant Service Users



HiREB
Hamilton Integrated Research Ethics Board

Sep-13-2021

Project Number: 13739

Project Title: Mental Health Care Providers' Perspectives of Working with Visible Minority Migrants in Canada

Principal Investigator: Dr. Lisa Schwartz

This will acknowledge receipt of your revised submission. We wish to advise your study had been given ***final*** approval from the HiREB.

The following documents have been approved on both ethical and scientific grounds:

Document Name	Document Date	Document Version
Script - Practitioner	Jun-01-2021	1
StudyKey	Jun-01-2021	1
MHCP Interview	Jun-01-2021	1
Consent Provider V2 Clean	Aug-02-2021	2
MHCP Protocol V2 Clean	Aug-02-2021	2
MHCP Flyer V2	Aug-02-2021	2
MHCP Data Collection Sheet Clean	Aug-02-2021	2

The following documents have been acknowledged:

Document Name	Document Date	Document Version
tcps2_core_certificate%20L%20Schwartz	Jun-02-2021	1

In light of the current COVID-19 pandemic, while HiREB has reviewed and approved this application, the research must be conducted in accordance with institutional and/or public health requirements.

Please Note: All consent forms and recruitment materials used in this study must be copies of the above referenced documents.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of the HiREB meeting on July 7, 2021. Continuation beyond that date will require further review and renewal of HiREB approval. Any changes or revisions to the original submission must be submitted on a HiREB amendment form for review and approval by the Hamilton Integrated Research Ethics Board.

PLEASE QUOTE THE ABOVE REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Sincerely,

Frederick A Spencer

Dr. Frederick A. Spencer, MD
Chair, Hamilton Integrated Research Ethics Board

The Hamilton Integrated Research Ethics Board (HiREB) represents the institutions of Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, Research St. Joseph's-Hamilton, and the Faculty of Health Sciences at McMaster University and operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada, and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations; For studies conducted at St. Joseph's Healthcare Hamilton, HiREB complies with the Health Ethics Guide of the Catholic Alliance of Canada

Page 1 of 1

Appendix B

Consent Form for Racialized Service User Participants

LETTER OF INFORMATION / CONSENT

Title: The Experiences of Accessing Mental Health Care Services Among Visible Minority Refugees and Immigrants in Canada

Investigators:

Local Principal Investigator:	**Student Investigator:**
Dr. Lisa Schwartz	Salam Zoha
Department of	Department of
McMaster University	McMaster University
Hamilton, ON, Canada	Hamilton, ON, Canada
(905) 525-9140 ext. 22987	Phone: 226-250-5568
E-mail: schwar@mcmaster.ca	E-mail: zohas@mcmaster.ca

Purpose of the Study

You are invited to take part in this study that aims to understand the experiences of visible minority (e.g., person of colour, non-white) immigrants and refugees when seeking care for their mental health. I am focusing on those who are 18 and above, self-identify as a visible minority, currently live in Ontario, are comfortable having a conversation in English, and either landed as a refugee or immigrant (e.g., student, worker, spousal). I want to learn about your journey when you decided that you needed help for your mental health. I also hope to find out what made it easy or difficult for you in this process. I am doing this research for my doctoral dissertation.

Procedures involved in the Research

If you are interested in this study and would like to participate, you will be interviewed one-on-one by me and through Zoom for an hour to two hours and 30 minutes. You will be allowed to pick any time for this interview that is convenient for you based on your personal schedule. With your permission, the interview will be digitally recorded (audio only).

In the interview, I will be asking you questions about your experiences related to your mental health help-seeking journey. I will also ask you for some demographic/background information like your age, what you identify as ethnoracially, and what your landing status is. Some questions include: “What does not ‘being well and doing well’ look or feel like to you?”, “What are the main problems this has caused for you?”, and “What were the difficulties that you experienced when you were seeking out help?”.

Potential Harms, Risks or Discomforts:

The risks involved in participating in this study are minimal. You may feel uncomfortable with reflecting on past experiences related to your mental health. 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. You can withdraw (stop taking part) at any time. I describe below the steps I am taking to protect your privacy.

Potential Benefits

The research will not benefit you directly. I hope to learn more about visible minority immigrants' and refugees' experiences with accessing mental health care services in Canada. I hope that what is learned as a result of this study will help us to better understand how to improve access for visible minority immigrants and refugees. This could help to improve training for mental health care providers and provide suggestions for local community health centres.

Payment or Reimbursement

As a token of appreciation, you will receive a $20.00 CAD e-gift card to any place you wish. This is a self-funded study.

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 will know whether you participated unless you choose to tell them. Every effort will be made to protect your confidentiality and privacy. I will not use your name or any information that would allow you to be identified. However, we are often identifiable through the stories we tell. If you choose to disclose the name of a person during your interview, I will remove the name to keep their privacy. Similarly, if I am using quotes from your interview in the study's results, I will not use your name.

The audio interview files will be kept on a computer will be protected by a password and only I will have access to it. The interview will be transcribed by me, and the recordings will be kept only for referencing. Also, the transcript of your audio file will be kept on a computer that is protected by a password. Once the study is complete, an archive of the data, without identifying information, will be kept for 10 years. You are also allowed to participate if you are enrolled in other research during the time of this study.

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. You will also not be able to make any unauthorized recordings of the interview.

For the purposes of ensuring the proper monitoring of the research study, it is possible that a member of the Hamilton Integrated Research Ethics Board may consult your research data. However, no records which identify you by name or initials will be allowed to leave the institution. By signing this consent form, you authorize such access.

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

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 or suicidality). Please note that I have an obligation to report this as a researcher.

Participation and Withdrawal

Your participation in this study is voluntary and confidential. 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 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. If you want to remove your interview data that has been already collected, you can contact Salam Zoha at the email and phone number provided above before May 31, 2022.

Information about the Study Results

I expect to have this study completed by approximately June 2022. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study

If you have questions or need more information about the study itself, please contact Salam Zoha at: 226-260-5584 or zohas@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 Salam Zoha 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 by:

____________________	____________________	____________
Name and Role (Printed)	Signature	Date

Appendix C

Recruitment Flyer for Racialized Migrant Service User Participants

Are you a visible minority migrant in Ontario who has accessed mental health care services?

IF YES

I want to learn about *your* experiences as a migrant (permanent resident, student, landed refugee etc.) accessing mental health care services in Ontario. I hope to learn what made it easy or difficult for you.

- Must be 18 or older
- Live in Ontario
- Be a permanent resident, international student, worker, visitor, landed refugee, refugee claimant, etc.
- Comfortable having a conversation in English
- Interviews via Zoom will last to one hour and 30 mins
- You'll get a $20 e-gift card as a 'thank you'

Contact Zoha at zohas@mcmaster.ca

Version 1. June 1st, 2021

This study has been reviewed by the Hamilton Integrated Research Ethics Board under Project # 13736

Appendix D

Recruitment Email Script for Racialized Migrant Service User Participants

E-mail response:

Hello!

Thank you so much for showing interest in my study and reaching out to me. I am a Ph.D. student in the Global Health program at McMaster University.

The study I am leading is on understanding the experiences of visible minority immigrants and refugees when seeking care for their mental health. I am focusing on those who are 18 and above, self-identify as a visible minority, currently live in Ontario, are comfortable having a conversation in English, and either landed as a refugee or immigrant (e.g., student, worker, spousal).

Interviews will be conducted by myself, and it can last up to one hour and 30 minutes. The interviews will be conducted online through Zoom with audio only to provide you with more privacy and prevent any connection issues. I will digitally record these to analyze them for key patterns and points over the following months. The results of this study will be available online if you are interested.

Do you think you might be interested in participating in this study? If you think you might be interested, please let me know and we can set up a time to call so I can answer any questions or concerns you may have. There is a consent form for participants to sign, and if you are still comfortable at that point, we can do the interview. You will be given a $20.00 CAD e-gift card to any place you would like as a thank you.

Thank you so much for your interest!

You can contact me again through my e-mail.

Appendix E

Interview Script for Racialized Migrant Service User Participants

Participant ID:

Introduction

Hello! Thank you so much for taking time out of your day to participate in this study and talk to me about your experiences of accessing mental health services.

My name is Zoha. I'm currently a Ph.D. student in the Global Health program at McMaster University. My work focuses on understanding why there are mental health disparities within visible minority migrant communities in Canada.

To let you know a little more about me, I was born in Pakistan and migrated with my parents to Canada when I was 3. We first arrived in Toronto and then moved to Montreal, but later settled in Windsor.

Our conversation in this interview is broken down into three main parts: 1) exploring your views of well-being, 2) describing what you decided to get help for, and then 3) your actual help-seeking journey. Please remember that whatever you share with me stays with me and no one else will know. You do not need to answer any questions that you do not want to. You can also end the study whenever you want.

First, to get to know you a little better, let me ask some questions about you and your heritage…

Demographics

- How old are you?
  Response
- What gender do you identify as?
  Response
- How do you self-identify as ethno-racially?
- What was your landing status or are you a citizen?
  - Prompt: Refugee, international student...?
  - Prompt: How many years has it been since you've arrived?

  Response
- What languages do you speak at home?
  Response
- What does your cultural heritage mean to you?
  Response
- Are there parts of your background or heritage, such as beliefs and values, which you grew up with that are important to you?
  Response
- How do these shape your understanding of mental health?
  Response
- How important is it to you that these parts of your heritage, beliefs and values, are maintained within your life?
- *Response*
- Do your beliefs differ from those of your parents?

Response

Thank you for sharing with me. Do you want to take a little break before I ask you about the next set of questions exploring your views of well-being? Do you want to continue participating with the study?

If participant does not wish to proceed with study: I understand. Thank you for telling me this. I will end the interview. I will also make sure to send your compensation.

If participant wishes to take a break before continuing: Take your time! I will be right here. Let me know when you're ready.

If participant wishes to continue with the study without a break: Thank you! Let us move onto the other questions.

Part 1

- When I say the phrase, "being well and doing well", what does that look or feel like for you?
  Response
- What does not "being well and doing well" look or feel like to you?
  Response
- When did you realize that you weren't "doing well" based on your standards, and decided that you needed help for your mental health?
  Response

Thank you for sharing with me. Do you want to take a little break before I ask you about the next set of questions describing what you decided to get help for? Do you want to continue participating with the study?

If participant does not wish to proceed with study: I understand. Thank you for telling me this. I will end the interview. I will also make sure to send your compensation.

If participant wishes to take a break before continuing: Take your time! I will be right here. Let me know when you're ready.

If participant wishes to continue with the study without a break: Thank you! Let us move onto the other questions.

Part 2

Before I ask you to share your journey, can we discuss about what was it that you felt like you needed help for?

Original/base questions	Prompts

1. How would you define [INSERT DESCRIPTION OF WHATEVER THEY PROVIDED]?	• Did you hear about this before?
2. What do you think caused this?	• Is there something happening in your family, at work or in your social life that could explain this?
3. Why do you think it started when it did?	• When did it start?
4. What does your [INSERT DESCRIPTION OF WHATEVER THEY PROVIDED] do to you?	• How does it affect your body, spirit, soul, or mind?
5. How severe do you think it is for you?	• When do you think this won't be an issue for you anymore?
6. Is there anything about it that concerns you?	
7. What are the main difficulties this has caused for you?	

Response

Now, I'll only be listening and may ask you some questions at the end. Please take as much time as you need to share your journey and I won't you interrupt at all. You can get into as much detail as you'd like.

- So, can you describe how you went about seeking help and what happened? Like, how do you remember it all happening from start to finish?

Response

Thank you for sharing with me. Do you want to take a little break before I ask you about the last set of questions about your actual help-seeking journey? Do you want to continue participating with the study?

If participant does not wish to proceed with study: I understand. Thank you for telling me this. I will end the interview. I will also make sure to send your compensation.

If participant wishes to take a break before continuing: Take your time! I will be right here. Let me know when you're ready.

If participant wishes to continue with the study without a break: Thank you! Let us move onto the other questions.

Part 3

Thank you for sharing your journey with me. I have some questions I would like to ask you about it.

- Were you satisfied with the help that you received that day?
    - What type of care do you believe would help you? Is there anyone else who can help you?
    - What are the most important results you hope to receive from it?

Response

- What were the difficulties that you experienced when you were seeking out help?
  Response
- What were the factors that made it the most difficult for you?
    - Prompt: How has your status as a [insert whatever status they have] shape your experience?

  Response
- What were some things that made it easy for you?
  Response
- Looking back on this experience, what could have helped in your situation?
  Response
- What would the ideal access to mental health care services look like to you?
    - Prompt: Ways of accessing, services available..

  Response
- What are three things that you would like someone to know about your story?
  Response

We are now at the end of the interview. However, is there is anything else you would like to share in order to help me understand your journey better?

Thank you for participating in this study. I value the time that we spent together today and also sharing your experiences about your journey. I will follow up with your compensation. Again, thank you so much!

Appendix F

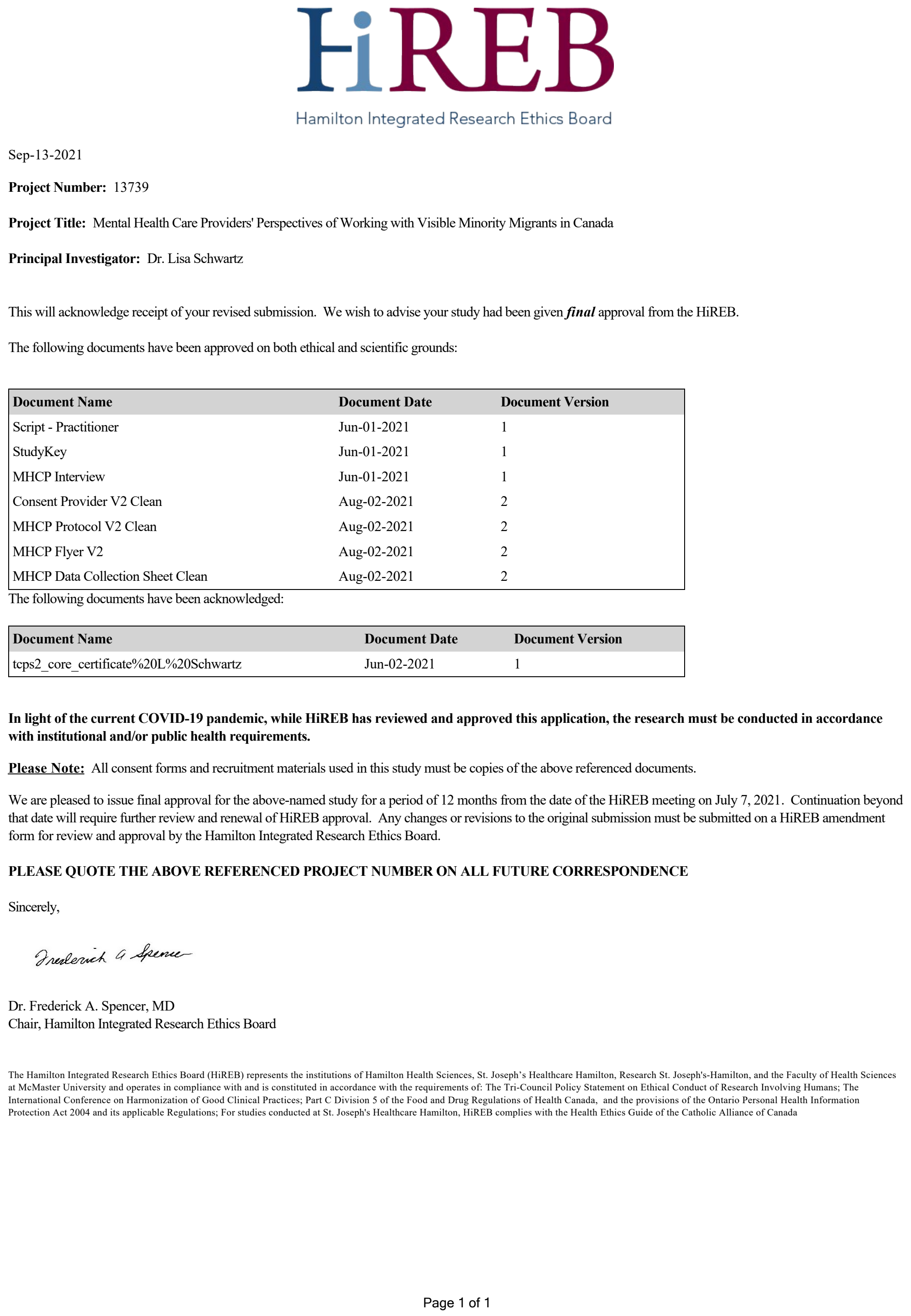
Resource Sheet for Racialized Migrant Service User Participants

If you are in crisis, please call 911 or visit your nearest emergency room at the hospital.

Organization	Details	Method of contact
Telehealth Ontario	Provides professional and confidential advice for mental and physical health issues from a Registered Nurse.	Tel: 1-866-797-0000
Connex Ontario Mental Health Helpline	This service provides confidential support for basic mental health issues, helps people find information about mental health, and can help you find mental health services in Ontario.	Tel: 1-866-531-2600 Website: connexontario.ca (chat and email currently available)
Crisis Services Canada	National network of existing distress, crisis and suicide prevention line services.	Tel: 1-833-456-4566 or you can also text "Start" to 45645 for support.
Good2Talk Helpline	Ontario's 24/7 helpline for postsecondary students.	Tel: 1-866-925-5454 or text GOOD2TALKON to 686868
LGBT Youthline Ontario	Ontario-wide peer-support for lesbian, gay bisexual, transgender, transsexual, two-spirited, queer and questioning young people.	Tel: 647-694-4275 Website: www.youthline.ca (chat, text and email currently available)
Assaulted Women's Helpline	24-hour telephone and TTY crisis line for all women in Ontario who have experienced any form of abuse.	Tel: 1-866-863-0511 or #SAFE (#7233) on your Bell, Rogers, Fido or Telus Mobile
ShelterSafe	Online resource for women and their children seeking safety from violence and abuse. The clickable map serves as a quick resource to connect women with the nearest shelter that can offer safety, hope, and support.	sheltersafe.ca
eMentalHealth	Thorough database of mental health programs available across Canada, for Canadians of all ages.	ementalhealth.ca

Appendix G

HiREB Approval Letter for Study on Mental Healthcare Service Provider Participants



HiREB
Hamilton Integrated Research Ethics Board

Sep-13-2021

Project Number: 13739

Project Title: Mental Health Care Providers' Perspectives of Working with Visible Minority Migrants in Canada

Principal Investigator: Dr. Lisa Schwartz

This will acknowledge receipt of your revised submission. We wish to advise your study had been given ***final*** approval from the HiREB.

The following documents have been approved on both ethical and scientific grounds:

Document Name	Document Date	Document Version
Script - Practitioner	Jun-01-2021	1
StudyKey	Jun-01-2021	1
MHCP Interview	Jun-01-2021	1
Consent Provider V2 Clean	Aug-02-2021	2
MHCP Protocol V2 Clean	Aug-02-2021	2
MHCP Flyer V2	Aug-02-2021	2
MHCP Data Collection Sheet Clean	Aug-02-2021	2

The following documents have been acknowledged:

Document Name	Document Date	Document Version
tcps2_core_certificate%20L%20Schwartz	Jun-02-2021	1

In light of the current COVID-19 pandemic, while HiREB has reviewed and approved this application, the research must be conducted in accordance with institutional and/or public health requirements.

<u>Please Note:</u> All consent forms and recruitment materials used in this study must be copies of the above referenced documents.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of the HiREB meeting on July 7, 2021. Continuation beyond that date will require further review and renewal of HiREB approval. Any changes or revisions to the original submission must be submitted on a HiREB amendment form for review and approval by the Hamilton Integrated Research Ethics Board.

PLEASE QUOTE THE ABOVE REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Sincerely,

Frederick A Spencer

Dr. Frederick A. Spencer, MD
Chair, Hamilton Integrated Research Ethics Board

The Hamilton Integrated Research Ethics Board (HiREB) represents the institutions of Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, Research St. Joseph's-Hamilton, and the Faculty of Health Sciences at McMaster University and operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada, and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations; For studies conducted at St. Joseph's Healthcare Hamilton, HiREB complies with the Health Ethics Guide of the Catholic Alliance of Canada

Page 1 of 1

Appendix H

Consent Form for Mental Healthcare Service Provider Participants

LETTER OF INFORMATION / CONSENT

Title: Mental Health Care Providers' Perspectives of Working with Visible Minority Migrants in Canada

Investigators:

Local Principal Investigator:	**Student Investigator:**
Dr. Lisa Schwartz	Name: Salam Zoha
Department of Health Research Methods, Evidence, and Impact	Department of Global Health
McMaster University	McMaster University
Hamilton, ON, Canada	Hamilton, ON, Canada
(905) 525-9140 ext. 22987	Phone: 226-260-5584
E-mail: schwar@mcmaster.ca	E-mail: zohas@mcmaster.ca

Purpose of the Study

You are invited to take part in this study that aims to understand the experiences mental health care providers who work with visible minority (e.g. people of colour, non-white), immigrants and refugees in Ontario. I am focusing on those who are licensed and registered to a professional organization in Ontario, are practising in Ontario, and currently live in Ontario. I am doing this research for my doctoral dissertation.

Procedures involved in the Research

If you are interested in this study and would like to participate, you will be interviewed one-on-one by me and through Zoom for an hour. You will be allowed to pick any time for this interview that is convenient for you based on your personal schedule. With your permission, the interview will be digitally recorded (audio only).

In the interview, I will be asking you questions about your experiences related to working with visible minority immigrants and refugees as a mental health care provider. I will also ask you for some demographic/background information, like your professional credentials and how you identify as ethnoracially. Some questions include: "What reasons do you see these clients for?", "What barriers do you believe that your clients experience in getting help?", and "What would make your work easier when working with this population?".

Potential Harms, Risks or Discomforts:

It is not likely that there will be any harms or discomforts from the nature of the content that will be discussed. 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. You can withdraw (stop taking part) at any time. I describe below the steps I am taking to protect your privacy.

Potential Benefits

The research will not benefit you directly. I hope to learn more about the experiences of mental health care providers who work with visible minority immigrants and refugees. I hope that what is learned as a result of this study will help us to better understand how to better support mental health care providers and also improve access for visible minority immigrants and refugees. This could help to improve training for mental health care providers and provide suggestions for local community health centres.

Payment or Reimbursement

As a token of appreciation, you will receive a $10.00 CAD e-gift card to Tim Hortons. This is a self-funded study.

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 will know whether you participated unless you choose to tell them. Every effort will be made to protect your confidentiality and privacy. I will not use your name or any information that would allow you to be identified. However, we are often identifiable through the stories we tell. If you choose to disclose the name of a person during your interview, I will remove the name to keep their privacy. Similarly, if I am using quotes from your interview in the study's results, I will not use your name. Participation in the study will not affect employment status or performance review, as the employer would not be told about the participant's involvement.

The audio interview files will be kept on a computer will be protected by a password and only I will have access to it. The interview will be transcribed by me, and the recordings will be kept only for referencing. Also, the transcript of your audio file will be kept on a computer that is protected by a password. Once the study is complete, an archive of the data, without identifying information, will be kept for 10 years. You are also allowed to participate if you are enrolled in other research during the time of this study.

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. You will also not be able to make any unauthorized recordings of the interview.

For the purposes of ensuring the proper monitoring of the research study, it is possible that a member of the Hamilton Integrated Research Ethics Board may consult your research data. However, no records which identify you by name or initials will be allowed to leave the institution. By signing this consent form, you authorize such access.

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

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 or suicidality). Please note that I have an obligation to report this as a researcher.

Participation and Withdrawal

Your participation in this study is voluntary and confidential. 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 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.

If you want to remove your interview data that has been already collected, you can contact Salam Zoha at the email and phone number provided above before May 31, 2022.

Information about the Study Results

I expect to have this study completed by approximately June 2022. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study

If you have questions or need more information about the study itself, please contact Salam Zoha at: 226-260-5584 or zohas@mcmaster.ca. or Dr. Lisa Schwartz at schwar@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 Salam Zoha 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 by:

____________________	____________________	____________
Name and Role (Printed)	Signature	Date

Appendix I

Recruitment Flyer for Mental Healthcare Service Provider Participants

Are you a mental health care provider in Ontario who works with visible minority immigrants and refugees?

You're invited to participate in a study that aims to discuss *your* experiences of working with visible minority immigrants and refugees.

- Must be licensed and registered to practice in Ontario
- Interviews via Zoom will last 1 hr.
- As a token of appreciation, you'll get a $10 gift card to Tim Hortons
- This is part of my Ph.D. dissertation

Contact Zoha at zohas@mcmaster.ca

This study has been reviewed by the Hamilton Integrated Research Ethics Board under Project #13739

Appendix J

Recruitment Email Script for Mental Healthcare Service Provider Participants

E-mail response:

Hello!

Thank you so much for showing interest in my research study and reaching out to me. I am a Ph.D. student in the Global Health program at McMaster University.

The study I am leading aims to understand the experiences mental health care providers who work with visible minority immigrants and refugees. I am focusing on those who are licensed and registered to a professional organization in Ontario, are practising in Ontario, and currently live in Ontario. This is for my doctoral dissertation.

Interviews will be conducted by myself and will last approximately one hour. The interviews will be conducted online through Zoom with audio only. I will digitally record these to analyze them for key patterns and points over the following months. The results of this study will be available online if you are interested.

Do you think you might be interested in participating in this study? If you think you might be interested, please let me know and we can set up a time to call so I can answer any questions or concerns you may have. There is a consent form for participants to sign, and if you are still comfortable at that point, we can do the interview. You will be given a $10.00 CAD e-gift card to Tim Hortons as a thank you.

Thank you so much for your interest!

You can contact me again through my e-mail.

Appendix K

Interview Script for Mental Healthcare Service Provider Participants

Participant ID:

Introduction

Hello! Thank you so much for taking time out of your day to participate in this study and talk to me about your experiences of working with visible minority immigrants and refugees.

My name is Zoha. I'm currently a Ph.D. student in the Global Health program at McMaster University. My work focuses on understanding why there are mental health disparities within visible minority migrant communities in Canada.

Our conversation today is broken down into four parts: 1) your background, 2) your work experience, 3) the barriers and facilitators you come across in your work, and 4) questions related to your profession. Please remember that whatever you share with me stays with me and no one else will know. You do not need to answer any questions that you do not want to. You can also end the study whenever you want.

First, to get to know you a little better, let me ask some questions about your background…

Demographic

- How long have you been practising for?
  Response:
- What are your credentials?
  Response:
- What would you describe your ethnic/racial background as?
  Response:
- Do you provide service in another language asides from English?
  Response:

Thank you for sharing with me. Do you want to take a break before I ask you about the next set of questions? Do you want to continue participating with the study?

If participant does not wish to proceed with study: I understand. Thank you for telling me this. I will end the interview. I will also make sure to send your compensation.

If participant wishes to take a break before continuing: Take your time! I will be right here. Let me know when you're ready.

If participant wishes to continue with the study without a break: Thank you! Let us move onto the other questions.

Practice

- Do you specifically focus on working with refugees and immigrants?
  Response:
- What reasons do you normally see these clients for?

    - Prompt: refugees? Immigrants?
      Response:
- How do they usually end up coming to you?
    - Prompt: refugees? Immigrants?
      Response:
- Do they have a specific pattern of service utilization?
  Response:
- What differences have you noticed among genders?
  Response:
- What differences have you seen within ethnocultural communities?
  Response:

Thank you for sharing with me. Do you want to take a break before I ask you about the next set of questions? Do you want to continue participating with the study?

If participant does not wish to proceed with study: I understand. Thank you for telling me this. I will end the interview. I will also make sure to send your compensation.

If participant wishes to take a break before continuing: Take your time! I will be right here. Let me know when you're ready.

If participant wishes to continue with the study without a break: Thank you! Let us move onto the other questions.

Barriers & Facilitators

- What barriers do you believe that your clients face in getting help?
    - Prompt: refugee vs immigrant
      Response:
- What are some things that makes it easy for them to get help?
  Response:
- What are challenges you experience as a practitioner when you work with them?
    - Prompt: refugees? Immigrants?
      Response:
- Which one would you say is the most difficult?
  Response:
- What do you think that could make it easier for them to get help?
  Response:
- Do you think that aspects of your identity influence your work with these clients?
  Response:

Thank you for sharing with me. Do you want to take a break before I ask you about the last set of questions? Do you want to continue participating with the study?

If participant does not wish to proceed with study: I understand. Thank you for telling me this. I will end the interview. I will also make sure to send your compensation.

If participant wishes to take a break before continuing: Take your time! I will be right here. Let me know when you're ready.

If participant wishes to continue with the study without a break: Thank you! Let us move onto the other questions.

Organizational

- Do you think that your education/schooling provided you with the knowledge that you needed to work with visible minority migrant clients?
    Response:
- Do you work with any partnering organizations to help support their needs outside of your office? (e.g., resettlement agencies, religious..)
    Response:
- What would make YOUR work easier when working with this population?
    Response:
- What would an ideal mental health system look like to you?
    Response:
- Where do you see yourself in it?
    Response:

We are now at the end of the interview. However, is there is anything else you would like to share in order to help me understand your experiences better?

Thank you for participating in this study. I value the time that we spent together today and also sharing your experiences about working with refugee and immigrant clients. I will follow up with your compensation. Again, thank you so much!