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An Exploration on the Barriers to Accessing Mental Health Services Among South Asian Youth

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Among South Asian Youth

By

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Abstract

Research in Canada and the United States has found that South Asians routinely underutilize mental health services, however research on the barriers experienced by South Asians is limited, especially research regarding the experiences of South Asian youth (Inman et al., 2014; Islam et al., 2017; Karasz et al., 2016). Through a series of semi-structured interviews (N=20) with South Asian youth between the ages 16 to 27 in the Greater Toronto Area, the present study explores South Asian youths' experiences accessing mental health services and the impact of COVID-19 on mental health and service use. Thematic analysis of interview data reveal that South Asian participants experience several barriers preventing effective mental health support. In particular, issues relating to the lack of diversity among service providers and difficulties building and maintaining rapport with service providers were described. Further, participants experienced mental health stigma from family members, the South Asian community, and health professionals which posed additional barriers to accessing services. These issues are further exacerbated by the COVID-19 pandemic as participants reported a worsening of mental health, increased substance use, and additional barriers associated with accessing remote mental health services. Results demonstrate a gap in current mental health services and shed light on individual and programmatic changes that can be implemented to better serve this population.

Keywords: South Asian youth, mental health, COVID-19, service utilization

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Introduction

Canada's South Asian population has been growing rapidly in the past several decades with over a 1.5 million South Asians residing in Canada in 2016 (Bakhshaei & Henderson, 2016). With such a large population of Canadians identifying as South Asian, it is becoming increasingly important to understand the experience of being South Asian Canadian (this includes both South Asians born in Canada and those who immigrated to Canada). One particular area of concern in psychological research is the mental health of South Asian Canadians. Approximately one in five Canadians will experience mental health or substance use problems in any given year, and by the time Canadians reach the age of 40, one in two will have experienced mental health problems (Smetanin et al., 2011). In the last two decades, a number of studies have emerged identifying the unique factors contributing to poor mental health for South Asians living in Canada, including stress from the immigration process and experiences with racism and discrimination (Inman et al., 2014). However, despite increasing concerns of mental health problems, research shows that South Asians routinely underutilize mental health services (Karasz et al., 2016). This may leave many South Asians with unsupported mental health problems as one study found that South Asians have higher level of unmet mental healthcare needs compared to White and other East/Southeast Asian groups (Gadalla, 2010).

A scan of the extant literature suggests that low service utilization can be understood as a result of two overarching issues: 1) barriers in the mental healthcare system and 2) mental health stigma among members of the South Asian community in Canada. Issues with how mental illness and treatment are conceptualized in Western society result in mental health services that are often times incompatible with South Asian conceptions of treatment or healing (Ekanayake, Ahmed, & McKenzie, 2012). Likewise, negative experiences from service providers such as microaggression relating to race and a lack of cultural awareness can deter help-seeking

behaviour (Inman et al., 2014; Li & Browne, 2000). Similarly, mental health stigma and its intersection with race and culture can lead to ineffective mental health support or deter service utilization altogether (Arora, Metz, & Carlson, 2016; Loya, Reddy, & Hinshaw, 2010). Current research in the field has not adequately investigated the in-depth experiences of Canadian South Asians in accessing mental health services and the barriers they may face. Notably, little research exists on the experiences of South Asian youth (16-27 years old), especially Canadian born youth whose experiences may differ from their immigrant counterparts (Inman et al., 2014). The purpose of the present study is to understand the experiences of both Canadian-born and immigrant South Asian youth living in Canada experiencing mental health problems with respect to accessing mental health services. Investigating these experiences and situating them in the context of structural forces of oppression including systemic racism, discrimination, and cultural stigma are the main goals of this project.

Literature Review

A Brief History on The Arrival of South Asians in Canada

South Asian refers to the ethnic group of people who are from the Indian subcontinent including India, Pakistan, Bangladesh, Nepal, and Sri Lanka. While these different countries may often be lumped into a single group, South Asia comprises a diverse number of cultures, religions, and languages (Bakhshaei & Henderson, 2016). Early South Asian settlements began in the late 19th century when Sikhs from Punjab India arrived in British Columbia for work (Government of Canada, n.d.). These South Asians, mainly men, arrived to work in lumber, mining, and railway industries (Government of Canada, n.d.). However, in 1908, the Government of Canada implemented the “continuous journey regulation” as a part of the Immigration Act. This regulation prohibited immigrants from entering Canada unless they came

by continuous journey from their native country, in other words, if a ship made stops prior to arriving to Canada, they were prohibited from docking in Canada (Government of Canada, n.d.). This created barriers to South Asians as the trip from most South Asian regions to Canada required stops (Government of Canada, n.d.). Additionally, the regulation prevented British subjects such as those living in India from entering Canada as immigrants (Government of Canada, n.d.). This prevented many of the men in these early Sikh communities from bringing their families to Canada (Government of Canada, n.d.). The continuous journey regulation remained in effect until 1947 with further racial restrictions being repealed in the following two decades (Government of Canada, n.d.).

During the end of British rule of India in the 1940s, South Asians living in Canada were eligible to apply for Canadian citizenship and given the rights to vote and hold office (Ghosh, 2017). Likewise, Canada's immigration regulations became more relaxed with the hopes of expanding the economy through a larger workforce comprised of new immigrants (Ghosh, 2017). In 1967, Canada shifted to an immigration points system which focused on the personal, social, and occupational characteristics of immigrants in order to accept highly skilled individuals (Ghosh, 2017). Between 1967-1975, over 10 000 South Asians arrived in Canada, most of whom were professionals ranked highly in the points system (Ghosh, 2017). Since then, many South Asians have arrived in Canada, both as immigrants and refugees as a result of the 2010 refugee reforms where Canada resettled refugees from over 140 countries (Ghosh, 2017; Government of Canada, 2021).

Mental Health Problems Among the South Asian Diaspora

Mental health has become an increasing concern for South Asians in North America and the United Kingdom. A study conducted by Lee, Martin, & Lee (2014) found that South Asians

living in the United States had a 24.5% lifetime rate of any diagnosed mood, anxiety, and substance use disorder compared to East and Southeast Asians who had a lifetime rate of 22.5% and 34.6% respectively. Likewise, an analysis of the Canadian Community Health Survey from 2011 found that approximately 11.5% of Canadian South Asians reported being diagnosed with a mood or anxiety disorder (Islam, Khanlou, & Tamim, 2014). In comparison, 10.1% of Canadians reported mental or substance use disorders in 2012 (Statistics Canada, 2013). There are several factors that can contribute to poor mental health, however a particularly important factor that is often cited in research is the migration process. Several aspects of the migration process in Canada can create mental health problems for both first- and second-generation South Asians. Firstly, negative circumstances leading to migration may contribute to later mental health problems, for example traumatic events experienced by refugees of South Asian countries (Islam, Khanlou, & Tamim, 2014). Next, post-migration issues such as the loss of social status and support, separation from family, lack of employment, and difficulty integrating into Canadian culture can contribute to poor mental health. Experiences of racism and discrimination may further complicate matters and also negatively impact mental health (Samuel, 2009). Furthermore, intergenerational conflict that may arise between first- and second-generation Canadian South Asians has been reported as a risk factor for mental health problems including stress, anxiety, depression, and identity loss (Islam, Khanlou, & Tamim, 2014; Samuel, 2009).

Mental Health Problems Among South Asian Women. While the issue of migration may affect anyone in the community, research indicates clear gender differences in mental health problems. In particular, Canadian South Asian women often report more mental health problems than South Asian men due to stressors in social life, economic challenges, and navigating between South Asian and Western cultures (Ahmed et al., 2005). Ahmed et al. (2005) conducted

focus groups with immigrant and newcomer South Asian women in the Greater Toronto Area and described mental health problems which arose from a loss of social support, economic uncertainty, downward social mobility, and a mechanistic lifestyle. A mechanistic lifestyle was defined as busyness and lack of leisure time which led to women not completing expected daily activities such as housework (Ahmed et al., 2005). Overall, the loss of social networks and change in lifestyle negatively impacted the participant's mental health (Ahmed et al., 2005). Similar qualitative research conducted by Ekanayake, Ahmed, & McKenzie (2012) with South Asian women experiencing depression in Toronto indicated that women explain their mental health problems as a result of problems in their family or relationship, culture and migration, and socioeconomics. Likewise, self-harm and suicide rates are greater among South Asian women than men in Canada and the United Kingdom (Karasz et al., 2016). Younger women in particular are at an increased risk of self-harm (Waheed & Husain, 2006). One literature review by Waheed, & Husain (2006) found that South Asian women in the United Kingdom aged 16-24 were 1.5 times more likely to self-harm than White women.

Mental Health Problems Among South Asian Youth. Another area of concern is the mental health of South Asian youth. Research regarding the mental health of South Asians have typically focused on first generation, immigrant South Asian adults, however the limited research on South Asian youth show that both first- and second-generation youth face unique challenges which can lead to mental health problems. A meta-analysis by Sharma, Shaligram, & Yoon (2020) identified challenges for second generation Canadian and American South Asian youth in the family sphere, as well as within and outside the South Asian community contributing to poor mental health.

Parent-child conflict is often cited as an area of concern for South Asian youth (Sharma, Shaligram, & Yoon, 2020). As Sharma, Shaligram, & Yoon (2020) explain, expressions of autonomy in sexuality, religious practices, and career choices during the adolescent stage in development may be considered normal by Western standards; however, within the South Asian context, they may also be perceived as disrespectful or disobedient to cultural values. Likewise, differences in communication, rules, and values may further create stress within the family (Sharma, Shaligram, & Yoon, 2020). Islam et al. (2017) identified similar areas of concern for South Asian youth, in particular issues with ethnic identity, academic pressures, and family difficulties have commonly been reported by participants. Issues with their ethnic identity arose as parents and youth had to balance Western and South Asian cultures within one household which often led to disagreement in navigating the two cultures. Additionally, pressures for academic and career success often lead to stress in the household and lead to youth often comparing their experiences in a strict household to their peers' home environment.

Beyond the household, youth also experience acculturative stress when integrating to both Western and South Asian cultures (Sharma, Shaligram, & Yoon, 2020). Here again we see that women face increased burdens as the gender based cultural expectations to be modest, limit dating or abstain from premarital sex conflict with Western expectations leading to increased stress among South Asian women (Sharma, Shaligram, & Yoon, 2020). Similarly, a study by Patel & Gaw (1996) found that immigrant South Asian young women had a higher risk of suicide compared to South Asian men and older South Asian women in Canada. Likewise, Canadian South Asian young women had a higher risk of suicide than young women in the Indian subcontinent, reinforcing the idea that the conflict between South Asian and Canadian

expectations greatly contribute to mental health problems among South Asian women living in Canada (Patel & Gaw, 1996).

Finally, both first and second-generation Canadian and American South Asian youth may face a myriad of micro and macro-aggressions from outside of the South Asian community. For example, harmful associations with terrorism because of one's brown skin or wearing a turban or hijab can contribute to mental health problems (Sharma, Shaligram, & Yoon, 2020). Perceived discrimination is significantly correlated with psychological stress among both first-and second-generation South Asians (Sharma, Shaligram, & Yoon, 2020). Similarly, Samuel & Burney (2003) interviewed second generation South Asian university students in Ontario and found all 22 of the participants had perceived experiences of racism from faculty and students on campus. In particular, stereotypes such as the model minority myth created negative impacts on students' well-being (Samuel & Burney, 2003).

Substance Use Among South Asians. Research on the experiences of substance use among South Asian youth is limited, however there is a growing concern around the issue. A recent review by Fraser Health Authority (2020) indicated that the number of overdoses has increased by 255% among South Asians between 2015 and 2018 compared to an 138% increase for non-South Asians in this region of Southern British Columbia. In contrast to research highlighting greater prevalence of mental health problems among South Asian women, South Asians who experienced overdose events were disproportionately young men. Stressors reported by Canadian South Asian men included interpersonal conflict, suicidal ideation, and a history of traumatic brain injury or motor vehicle accident (Fraser Health Authority, 2020). The report highlights the need to address substance use and mental health problems within this community.

Other studies on the topic suggest that substance use is associated with 1) coping with mental health problems and 2) integrating into Western culture. Research by Rastogi & Wadhwa (2009) and Bhattacharya (1998) found that substance use among South Asian adolescents in the United States is linked to coping with mental health problems including stress, depression, and anxiety that arise from intergenerational conflict and destabilized family dynamics. Bhattacharya (1998) further indicated that second generation South Asian American youth may use more alcohol and drugs to help integrate into Western society, for example drinking or smoking at parties. Finally, Islam et al. (2017) found that Canadian South Asian youth used substances to cope with family problems and rebel against South Asian traditions. These findings suggest that substance use among South Asian youth is linked to mental health problems which arise from some of the issues previously mentioned, such as intergenerational conflict and integrating into Western culture. Further investigation is needed to build on previous findings and consider how the barriers to accessing mental health services may be related to substance use.

Mental Health & Substance Use During COVID-19

Impact on Mental Health. It is necessary to situate the issue of the increased prevalence of mental health problems among members of the South Asian community in the context of the current COVID-19 pandemic. Coronavirus disease (COVID-19) has disrupted the lives of everyone as it bears consequences beyond physical health with impacts on personal and social life, employment, school, and more. It is not surprising then that the pandemic has greatly impacted the mental health of Canadians as many indicate that their mental health has worsened since the start of the pandemic (Craig et al., 2022). The impact on mental health can be associated with isolation, anxiety around the pandemic, and increased conflict at home (Craig et al., 2022). A survey conducted with one thousand adults by the Centre of Addiction and Mental

Health (CAMH) (2021) revealed that one in five respondents reported moderate to severe anxiety levels, feeling depressed, or feelings of loneliness during the pandemic. In comparison, in 2019, the Canadian Community Health Survey found approximately 14% of Canadians aged 12 or older reported a mood or anxiety disorder suggesting an increase in mental health problems among Canadians (Statistics Canada, 2020). Additionally, gender differences have been exhibited such that 24% of women report feelings of loneliness compared to 18% of men (CAMH, 2021). Findlay, Arim, & Kohen (2020) and Miconi et al. (2021) report similarly; those most at risk of reporting poor mental health due to the pandemic include women and youth, even after considering socioeconomic and health factors.

Narrowing in on the South Asian diaspora, one survey indicates that this community is especially at risk of poor mental health during and post-pandemic (Moyser, 2020). Moyser (2020) found that among other visible minorities, Canadian South Asians reported the highest prevalence of self-rated poor mental health and increased anxiety since the start of the pandemic. One reason for the negative impact on mental health may be the increased exposure associated with COVID-19. Miconi et al. (2021) conducted an online survey measuring mental health outcomes as well as COVID-19 discrimination and stigma in Quebec. The authors found that, of the 3231 participants, Black (38.7%), Arab (33.5%), and South Asian (28.7%) participants reported higher exposure to the virus compared to White and Asian participants (Miconi et al., 2021). Higher exposure to the virus may be the result of overrepresentation of Canadian South Asians in low wage, essential work such as grocery stores, public transportation, and factories (Thobani & Butt, 2022). These work environments may not be able to adequately implement public health measures such as social distancing and thus, those working in these frontline jobs are at an increased risk of contracting the virus (Thobani & Butt, 2022). Similarly, South Asians

are at a greater risk of becoming seriously ill from the virus as pre-existing conditions such as cardiovascular disease and diabetes are more common among South Asians compared to White Canadians (Thobani & Butt, 2022).

Exposure to COVID-19 may also be associated with increased discrimination as Miconi et al. (2021) found that East and South Asians in Canada reported the highest prevalence of experiencing COVID-19 discrimination (31.4% and 30.1% respectively), that is the perceived discrimination experienced for COVID-19 status (Miconi et al., 2021). Similarly, Jaspal & Lopes (2021) conducted a survey with 226 Black and South Asian participants in the United Kingdom and found that South Asian participants reported significantly more religious discrimination than Black participants, presumably due to growing Islamophobia. The authors found that discrimination was directly associated with fear of contracting COVID-19 which in turn was associated with a decreased life satisfaction, increased depression and generalized anxiety (Jaspal & Lopes, 2021). Overall, both exposure to the virus and associated discrimination contributed to poorer mental health (Miconi et al., 2021).

Impact on Substance Use. Worsening mental health as a consequence of the pandemic may also lead to increased substance use, especially for individuals with pre-existing mental health problems (Vigo et al., 2020). A survey by Rotermann (2020) found that substance use was higher among Canadians who reported lower mental health status since the beginning of the pandemic compared to those who did not report lower mental health. In addition to the mental health findings, CAMH (2021) also revealed that 26% of respondents report binge drinking in the previous week, with men significantly more likely to report binge drinking compared to women though the authors do not indicate how many of those who reported binge drinking also reported worsening mental health. MacMilan et al. (2021) conducted an online survey with 1405

participants across Canada and the United States measuring concerns around the pandemic and alcohol and substance use and found that one third of participants reported using alcohol or substances to cope during the pandemic. In particular, higher alcohol and substance use was associated with those more personally affected by COVID-19 (e.g., contracting the virus or knowing someone else who contracted the virus), more likely to experience childcare challenges during the pandemic, and less associated with a religious community (MacMillan et al., 2021).

Another study by Craig et al. (2022) examined youth (12-18 years old) mental health and substance use during the pandemic through an online survey with 809 participants across Canada. In addition to finding that women and trans and non-binary youth experience more pandemic related stress compared to men, the authors found that over 50% of youth used substances in the last three months and about 20% reported regularly using substances at least once a week. However, without information on substance use prior to the pandemic, it is unclear if current consumption is associated with the pandemic or poor mental health. Nonetheless, it is clear that the pandemic is causing great strains on the mental health of Canadian South Asians and moreover, some links have begun to emerge between poor mental health and increased alcohol and substance use especially among youth, however there is currently a gap in our understandings of how South Asian youth specifically are coping with the pandemic.

The Underutilization of Mental Health Services Among the South Asian Diaspora

Despite the prevalence of mental health problems among the South Asian community in Canada, research shows that South Asians underutilize mental health services. A study by Tiwari & Wang (2006) found that compared to White participants, immigrant Asians who received a diagnosis of major depressive disorder were less likely to use mental health services in Canada. Likewise, a study by Chui et al. (2018) reported that compared to White participants, Asian

participants living in Canada were less likely to seek out mental health support and consequently, had lower rates of mental health diagnoses. Similarly, Li & Browne (2000) conducted interviews with 60 Asian Canadian adults about their mental health and barriers to accessing mental health services and found that participants often perceived mental health problems as serious and untreatable (Li & Browne, 2000). Additionally, the authors found that immigrant Asians report language barriers (i.e., lack of proficiency in English) and health practitioners discounting Asian culture as the two most common types of barriers impeding mental health service use (Li & Browne, 2000).

Looking at the experiences of racialized communities in the United Kingdom, where they may have similar experiences to racialized communities in Canada navigating in a Euro-centric mental health service system, a qualitative study by Memon et al. (2016) indicated two major themes that affected access to mental health services among Black and Asian communities in Southeast England. Firstly, personal and environmental factors such as public stigma, reluctance to speak about psychological distress among men, cultural identity, and financial factors commonly affected help seeking behaviour (Memon et al., 2016). Second, the relationship between the service user and mental health service provider, which may be affected by long waitlists, language barriers, power imbalances, and inadequate recognition of mental health needs also affected participants' ability to access mental health services (Memon et al., 2016).

Looking more closely at the relationship between service providers and service users, waitlists result in leaving mental health problems unaddressed and at times, leads to a worsening of mental health problems (Memon et al., 2016). On the other hand, language barriers and communication problems reflect the service user's inability to adequately express mental health problems and service provider's failure to listen to the concerns and needs of the service user

respectively. Likewise, participants state that healthcare providers did not adequately respond to service user's needs and express the lack of flexibility to supporting people's preferences including individual or cultural preferences (Memon et al., 2016). For example, participants discussed the overemphasis of medication to treat mental health problems and feeling discouraged to explore other therapy modalities that would have allowed them to discuss their concerns more creatively (Memon et al., 2016). Participants also discussed a general feeling of powerlessness as mental health service users (Memon et al., 2016). Participants felt that service providers often talked down to them and did not allow for input from service users creating a sense of helplessness and passivity (Memon et al., 2016). Lastly, participants report cultural insensitivity and discrimination from White service providers including an inability to discuss issues of racism and receiving different types of treatment compared to White counterparts (Memon et al., 2016). For example, one participant explained that they did not receive a referral to a specialist from their general practitioner while their White friend who expressed similar mental health concerns did (Memon et al., 2016).

The majority of the existing literature on the issue of service utilization focuses on the Asian community as a whole and given the heterogeneity of this population, the studies do not provide in-depth information on the experiences of South Asians especially South Asian youth as current research typically focuses on adults. Research on the specific experiences of South Asians accessing mental health services is far more limited. The following studies examine the experiences of South Asians accessing mental health services. The findings highlight several problems with mental health services that create barriers to effective treatment for South Asians.

A content analysis conducted by Inman et al. (2014) on the psychological research conducted in the last three decades with the South Asian community in the United States found

that South Asian Americans identified experiences with racial discrimination, internalized stereotypes, and health professionals' lack of cultural knowledge as the primary barriers they faced when accessing mental health services. Islam et al. (2017) conducted semi-structured interviews with South Asian youth in the Peel Region. Interviews covered various topics including mental health stressors and barriers to accessing mental health services. Regarding barriers to mental health services, participants noted mental health stigma, lack of South Asian representation among mental health professionals, fees for services not covered by the Ontario Health Insurance Plan (OHIP), long wait times, and a lack of specialization on youth issues as primary barriers (Islam et al., 2017). Furthermore, youth noted that conceptions of mental health treatment were highly westernized and overemphasized medication (Islam et al., 2017).

A literature review of 15 studies conducted by Prajapati & Liebling (2022) investigated the experiences of adult South Asian mental health service users in the United Kingdom and found three themes in line with other existing literature. Firstly, service users were "distanced" from services (Prajapati & Liebling, 2022). This distance was due to services being outside participants' awareness or outside participants' cultural norms and practices which discouraged help seeking behaviour such as cultural stigma and difficulties disclosing private information (Prajapati & Liebling, 2022). Second, participants described difficulties trusting service providers (Prajapati & Liebling, 2022). Participants reported being wary of trusting White mental health professionals as they lacked cultural awareness and did not acknowledge the complexities of their mental health problems (Prajapati & Liebling, 2022). On the other hand, issues such as stigma and confidentiality made it difficult for participants to trust South Asian mental health professionals (Prajapati & Liebling, 2022). Thirdly, the participants described services as a threat

to their cultural identity referring to a lack of cultural sensitivity and collaborative care between the service provider and user (Prajapati & Liebling, 2022).

A study by Bowl (2007) provides another perspective to understand the issue of mental health service utilization among the South Asian community. Conducting focus groups with South Asian mental health service users in the United Kingdom, the author highlights three dimensions of exclusion that contribute to barriers to accessing effective mental health support: cultural, institutional, and socioeconomic exclusion (Bowl, 2007). Cultural exclusion refers to the inability of mental health service providers to understand service users who are not from White populations (Bowl, 2007). This goes beyond a lack of understanding due to language barriers and includes difficulties in understanding what service users want and issues with standard psychiatric assessments (Bowl, 2007). Participants who were in-patients at hospitals discussed service providers not taking into account cultural practices, for example not providing space for prayer (Bowl, 2007). Institutional exclusion refers to mental health services not acknowledging racial and cultural differences of service users which may contribute to poor mental health, for example a lack of focus on how family and community related issues impact mental health (Bowl, 2007). Finally, socioeconomic exclusion refers to how lower socioeconomic status and stressors associated with it can contribute to poor mental health. For example, employment and financial issues were reported as stressors that contributed to poor mental health for South Asian men (Bowl, 2007). These issues were exacerbated by race as language barriers and racism can further affect socioeconomic status (Bowl, 2007). These dimensions of exclusion speak to difficulties South Asians in the United Kingdom have in participating in standard mental health services which do not integrate an understanding of cultural and social factors that contribute to poor mental health (Bowl, 2007).

The current literature points to a number of reasons why South Asians across Canada, the United States, and United Kingdom are experiencing barriers to effective mental health services. To explore these barriers further and understand why they arise, we can organize them into three (inter-related) major factors: mental health stigma, poor provider-client experiences, and systems level issues with mental health services. Exploring these factors will shed light on how they result in low service utilization among Canadian South Asians.

Mental Health Stigma. A critical barrier to receiving mental health support cited in the mentioned research is mental health stigma. Gary (2005) defines *mental health stigma* as the "collection of negative attitudes, beliefs, thoughts, and behaviours that influences [an] individual, or the general public, to fear, reject, avoid, be prejudiced and discriminate against people with mental disorders." (p. 980) Stigma manifests in many ways, including verbally through language and physically through behaviour (Gary, 2005). Two common forms of mental health stigma that are often studied are public/perceived stigma and personal/self-stigma. *Public stigma* refers to the discrimination towards individuals with mental health problems because they are perceived as socially unacceptable (Arora, Metz, & Carlson, 2016). On the other hand, *personal stigma* refers to an individual's own stigmatizing views (Arora, Metz, & Carlson, 2016). Personal stigma is associated with lower self-esteem and self-efficacy and creates a sense of helplessness regarding accessing mental health support (Gary, 2005). Related to the concept of stigma is prejudice and discrimination which reflect stereotypes of minority groups including racialized groups and individuals with mental health problems (Gary, 2005). Both prejudice and discrimination can perpetuate and deepen personal and public stigma experienced by those experiencing mental health problems.

Stigma is often discussed in the field of mental health because it can be a barrier to accessing mental health services. While public stigma is often thought to be linked to low mental health service use, research has found that, for members of the South Asian community, personal stigma is negatively associated with help seeking attitudes (Loya, Reddy, & Hinsaw, 2010). Studies by Loya, Reddy, & Hinsaw (2010) and Arora, Metz, & Carlson (2016) found that South Asian American college students with poor attitudes towards mental health services also showed increased levels of personal stigma compared to those with better attitudes about mental health. Increased personal stigma may be the result of traditional cultural values for some South Asian students, including social conformity, emotional restraint, and discomfort with self-disclosure (Arora, Metz, & Carlson, 2016). These values may encourage individuals to conceal their mental health problems and deter help seeking behaviour. Moreover, Arora, Metz, & Carlson (2016) found gender differences in stigma such that South Asian American women were more willing to seek mental health services than men. This likely reflects gender expectations for men to be strong and in control (Arora, Metz, & Carlson, 2016). Thus, personal stigma towards mental illness can act as a strong barrier to accessing mental health services among this population.

Poor Service Provider-Client Relationships. Beyond personal stigma, South Asians may also be stigmatized or discriminated against by healthcare providers which may further prevent help seeking behaviour. Gary (2005) suggests that Black, Indigenous, and People of Colour (BIPOC) experiencing mental health problems face double stigma as they are both part of a minority group and experience mental health problems. The term “double stigma” refers to how “minority group members with mental illnesses endure discriminatory practices from numerous segments of society, including politicians, researchers, and clinicians” (Gary, 2005, p. 981). Racialized minorities with mental health problems show significantly lower levels of

access to mental health services and poorer mental health outcomes when compared to White counterparts (Gary, 2005). In this case, a lack of cultural competency, racist stereotypes and discrimination interact and promote power imbalances between the service provider and client which may deter help seeking behaviour. South Asians may be more likely to be discriminated against, mistreated, and misdiagnosed by mental health providers and as a result, build distrust towards the mental health system which ultimately leads to underutilization of services (Gary, 2005).

Incompatible Mental Health Services. A final piece regarding low mental health service utilization within the South Asian community revolves around the differences in conceptions of mental health treatment. The dominant forms of mental health services in Canada reflect a biomedical and individualized conception of mental illness (Ekanyake, Ahmed, & McKenzie, 2012). For example, mental illness may be seen as a result of genetics or irregular neurochemical production in the brain (Ekanyake, Ahmed, & McKenzie, 2012). This contrasts with South Asian conceptions of mental illness which are largely situational and social in nature (Ekanyake, Ahmed, & McKenzie, 2012). For example, South Asian women in Canada report their depressive symptoms to result from problems with family and relationships, culture and migration, and socioeconomics (Ekanyake, Ahmed, & McKenzie, 2012). Differences in the conceptions of mental illness may lead to different ideas of what treatment and healing look like. This is highlighted by the success of the modified mental health programs developed by Karasz et al. (2015) and Naeem et al. (2015). These programs are modified mental health services that better suit different populations of South Asian women.

Karasz et al. (2015) started the Action to Improve Self-Esteem and Health (ASHA) project, a mental health intervention targeting Bengali Immigrant women with depression in the

Bronx. This project was based on participants' conceptions of distress that focused heavily on social isolation and financial dependence and thus, in addition to providing mental health treatment, the program helped increase asset building (Karasz et al., 2015). Asset building involved matched savings accounts funded by the U.S. Department of Health and Human Services where women deposited $10 a week in addition to receiving financial literacy training. Participants showed a reduction in depressive symptoms and saved an average of $10 per week which was put towards starting a small business and enrolling in community college (Karasz et al., 2015).

Similarly, Naeem et al. (2015) adjusted a cognitive behavioral therapy (CBT) program for South Asian Muslims in the United Kingdom. This program was modified to better suit collectivists cultures by increasing awareness of culture and religion, creating different forms of assessment, reducing barriers between the service providers and clients, and adjusting therapy technique tools to improve accessibility (Naeem et al., 2015). These projects highlight the potential for improved mental health services for South Asians, however they are far from commonly employed within the mental health field. Moreover, the Naeem et al. (2015) and Karasz et al. (2015) studies are targeted towards South Asian adults, thus more work is needed to adjust mental health services for different South Asian groups including youth. Regardless, these two studies demonstrate that mental health services as they currently are delivered are insufficient in improving the mental health of South Asians, hence leading to underutilization of these services.

The current research on mental health service utilization among Canadian South Asians cannot be understood as simply identifying a failure on the part of the individual to seek out help for their mental health. There are many problems with the mental healthcare system that create

barriers for individuals to access services. However, more research is needed on the experiences of South Asian youth and how stigma, provider-client experiences, and different kinds of mental health support affect their experiences with accessing services.

Research Gaps

Based on the background research provided, there are several gaps in the literature. First, qualitative research on the experiences and barriers to accessing mental health services is limited. Current research heavily focuses on quantitative data, such as surveys. As a result, qualitative research that provides participants with the space to express their experiences with mental health services is lacking and is much-needed.

Next, the majority of research regarding mental health among the South Asian community typically focuses on immigrant adults with less investigation on youth (Inman et al., 2014). In particular, youth who are second generation South Asian-Canadians may experience racialization differently than immigrant counterparts. For example, Sundar (2008) describes how second generation South Asian youth are flexible in their identity as a South Asian and Canadian and will bring aspects of either identity to the forefront when advantageous. This malleable nature of their identity can lead to youth being racialized as more “Canadian” than South Asian immigrants and newcomers. Likewise, attitudes towards mental health services may differ between first generation South Asians adults and second generation South Asian youth as research show that youth are more willing to discuss their mental health problems whereas youth describe their parents as more likely to exhibit stigma and conceal mental health problems from the community (Islam et al., 2017).

Relatedly, issues of substance use, which are often related to mental health problems, may be particularly relevant for youth, as existing studies suggest that substance use is one way to cope with mental health problems (Rastogi & Wadhwa, 2009; Bhattacharya, 1998). More in-depth research on the experiences of South Asian youth using substances is required to identify how youth perceive their own substance use and how the pandemic may have impacted consumption.

Asian Critical Theory & Mental Health Services

Understanding the underutilization of mental health services among members of this community involves looking beyond individual reasons and investigating the larger structures that affect the experiences of being South Asian in Canada. To bridge the previous background research to these structures, I will be using the Asian Critical Theory (AsianCrit) by Iftikar & Museus (2014). AsianCrit is a branch of Critical Race Theory (CRT), a theory originally developed in the field of legal scholarship. Under this theory, the inequities of society are understood to be a result of racial hierarchies and the normalization of racism (Riemer et al., 2020). The AsianCrit theory utilizes these core principles of CRT to understand issues specific to the Asian community. Western society often racializes Asians into a single group resulting in similar experiences of oppression, thus despite the heterogeneity of this community, the AsianCrit theory is suitable for all Asians, including the South Asian community. Iftikar & Museus (2018) describe seven tenets of AsianCrit which can be used to understand how White supremacy shapes the experiences of Asians: asianization; transnational context; (re)constructive history; strategic (anti)essentialism; intersectionality; story, theory, and praxis; and commitment to social justice. These seven tenets can also be used to guide community mental health research as well as understand barriers to accessing mental health services.

Asianization. Asianization refers to the racialization process of Asians in North America and the way in which White supremacy is intrinsically woven into this process (Iftikar & Museus, 2018). In particular, Asians are often racialized as foreigners, model or deviant minorities, or sexual deviants (Iftikar & Museus, 2018). The model minority myth refers to the ways in which Asians are expected to succeed in work and school settings in North American (Iftikar & Museus, 2014). This racialization process ensures that Asians are always perceived as the "other" in North America. This in turn informs laws, policies, and programs that systematically exclude Asians, such as the Chinese Immigration Act in 1923 (Iftikar & Museus, 2018).

To develop the asianization tenet further, we need to understand what Harpalani (2013) coins as *racial ambiguity*. Harpalani's (2013) DesiCrit is a branch of CRT tailored towards the South Asian community. While it was developed in the area of legal scholarship, the theory's emphasis on the concept of racial ambiguity is relevant to understanding the specific racialization process of South Asians in North America. Harpalani (2013) describes racial ambiguity as "the changing racial characterization of a person or group, depending on the local and historical context." (p. 83). When South Asians began to arrive in Canada, their place in the country's racial hierarchy was uncertain (Ghosh, 2017). Unlike Black, White, or Indigenous peoples, South Asians arrived in Canada fairly recently and moved around the racial hierarchy throughout history where their status in Canada shifted from being equal to or inferior to White people at different time points (Ghosh, 2017).

Moreover, the diverse physical features and cultural and religious practices among members of the South Asian community further contribute to racial ambiguity; for example, Christian South Asians may be privileged in ways that Muslim South Asians are not (Harpalani,

2013). Consequently, South Asians are racialized in diverse ways against different racial groups. For example, in comparison to White people, South Asians may be perceived as foreigners, thus upholding ideas of White supremacy. On the other hand, in comparison to Black people, South Asians may be racialized as model minorities who have successfully integrated into Western society and act as a model for other minority groups, suggesting that Asians are better or more successful than the Black community and perpetuating anti-Blackness in Canada. In summary, this racialization process is fluid and changes depending on the context.

These varying forms of racialization can contribute to both the development of mental health problems and the underutilization of mental health services. Problems that arise from navigating between Western and South Asian cultures can be understood as a product of South Asians being racialized as the "other". By constantly being perceived as a foreigner or excluded from dominant racial groups, South Asians may feel that they need to conceal their South Asian heritage in order to integrate into Western society (Sundar, 2008). Attempts to conceal South Asian heritage may cause distress for both the individual and their family leading to intergenerational conflict (Sundar, 2008). Likewise, being perceived as a foreigner may affect the extent to which South Asians are willing to access mental health services as they may feel that these services are not compatible for members of their community (Inman et al., 2014; Karasz et al., 2016). Similarly, the model minority stereotype promotes personal stigma of mental illness as it reinforces the minimization or concealment of mental health concerns as the stereotype suggests that Asians are always successful (Inman et al., 2014).

Transnational Context. Transnational context refers to the importance of situating the experiences of Asians and the effects of White supremacy within both individual and larger networks of global economic, political, and social processes (Iftikar & Museus, 2018).

Understanding both the past and present global processes shape conditions for Asians in Canada, including experiences of racism (Iftikar & Museus, 2018). Consequently, these processes can have a negative impact on the mental health of Asians in Canada. For example, the current COVID-19 pandemic has fueled anti-Asian racism around the world which may in turn affect the mental health of Asians living in Canada as well as their ability to access services for their mental health (Misra & PhuongThao, 2020)

(Re)constructive History. (Re)constructive history refers to how Asians are typically invisible in North American history and speaks to the need to break this silence and create a collective Asian historical narrative (Iftikar & Museus, 2018). As already stated, the history of South Asians in Canada is a short one as the majority of South Asians arrived in Canada within the last 80 years. In the context of the current study, attention needs to be paid to how recent events can contribute to mental health problems and barriers to accessing mental health services for South Asians. For example, the increase in Islamophobia following 9/11 and Muslim Ban in 2017 in the United States are events in recent history that have negatively impacted the wellbeing of South Asian Muslims and even South Asians who are not Muslim but are none the less perceived as such (Smari, Alcala, & Sharif, 2018).

Strategic (Anti)essentialism. Strategic (anti)essentialism refutes ideas of essentialism that understand social identities independently of each other. In other words, essentialist philosophy asserts that there is an essence to an experience (Grillo, 1995). For example, under essentialism, there is an essential experience for all women regardless of other identities, such as race or sexual orientation. Similarly, the ways in which South Asians may be racialized as foreigners and model minorities essentialize their identity and experiences. Strategic anti-essentialism opposes such ways of thinking and instead, understands the experiences of Asians

as an integrated identity. In the context of mental health, Western society's proclivity to view mental health experiences as a matter of biological processes suggest that mental illness has an essential experience, thus aligning with ideas of essentialism. In reality, the social world can vastly influence mental health experiences. Socioeconomic status, racism, stigma, and discrimination can affect mental health experiences, especially for South Asians who have overwhelmingly stated social factors as contributors for mental health problems (Karasz et al., 2016). This discrepancy in how the West views mental illness and diverse ways in which South Asians experience mental health problems can result in dominant mental health treatments to be ineffective for South Asians, thus reducing the willingness of members of this community to seek out care.

Intersectionality. Intersectionality in AsianCrit theory refers to how White supremacy and other systems of oppression intersect, exploit, and shape the experiences of Asians (Iftikar & Museus, 2018). Taking an intersectional lens on this issue highlights how South Asian women are not only more likely to experience mental health problems as already mentioned but reveal the increased need for culturally appropriate mental health support for South Asians. Cultural expectations and traditions put an increased burden on South Asian women thus, mental health services need to be tailored to address such issues. Likewise, other intersections that may not be explored extensively in the current study but remain important to note include disability, sexual orientation, and religious affiliations that may increase vulnerability to mental health problems and require further specialized care.

Story, Theory, and Praxis and a Commitment to Social Justice. The final two tenets: story, theory, and praxis and commitment to social justice speak to the research process by ensuring that the research undertaken creates meaningful change in the community. Story,

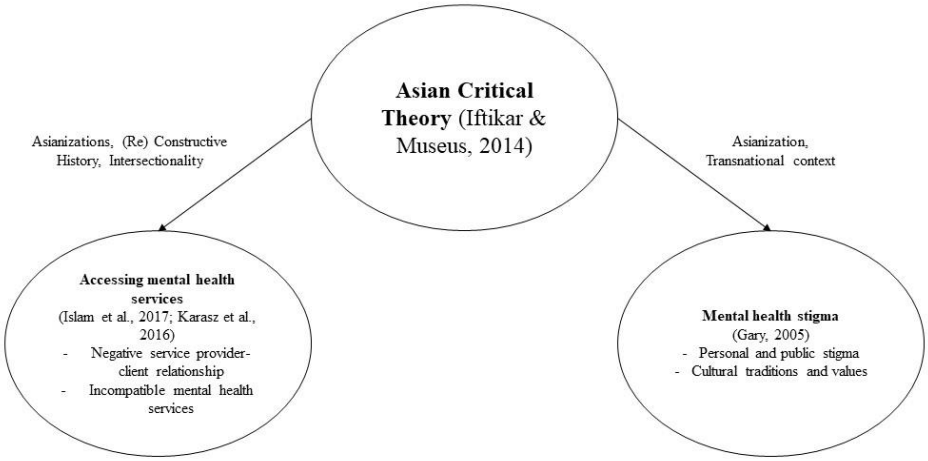
theory, and praxis refers to how the experiential knowledge of Asians can challenge the dominant narratives constructed by White supremacy and shift focus on the realities of Asians (Iftikar & Museus, 2018). Finally, a commitment to social justice refers to how the utilization of this theory is part of a larger process to ultimately end forms of oppression and exploitation (Iftikar & Museus, 2018). These tenets are foundational to Community Psychology research and guide the entire research project. The barriers South Asians face when accessing mental health services can result in mental health problems being unaddressed and ultimately creating a greater burden. Identifying these barriers is the first step in finding solutions to improve access to services to improving the wellbeing of members of this community.

Theoretical Framework: An Adapted AsianCrit Framework for Mental Health Service Utilization

To better understand Canadian South Asians experiencing mental health problems and any experiences they have with mental health services, this study is using an adapted AsianCrit framework (Figure 1) that utilizes the relevant tenets of the theory and brings together other important concepts of mental health based on background literature.

Figure 1

An Adapted AsianCrit Framework for Mental Health Service Utilization



The underutilization of mental health services among the South Asian community can be understood as a result of two overarching factors: 1) problems with the mental health system which include poor service provider-client relationships and incompatible mental health services and 2) mental health stigma. Firstly, Canada's mental health system currently does not meet the needs of the South Asian community. As mentioned earlier, issues with the mental health system arise from poor provider-client experiences and ineffective services. This aspect of the model can be tied to the AsianCrit tenets, asianization, intersectionality, and (re)constructive history.

Understanding the ways in which South Asians are racialized into Canadian society illustrates not only why mental health problems may occur, but also why South Asians may be receiving inadequate mental health services. Being racialized as a foreigner in Canada because of the ways in which White supremacy dominates North American society can lead to discriminatory behaviour from service providers who are not South Asian. Stereotypes, unconscious biases, and a lack of cultural awareness stemming from the racialization process can result in misdiagnoses, limited access to treatment, and poor communication, ultimately leading to health inequities (Arora, Metz, & Carlson, 2016). Likewise, mental health services are not

being developed with the needs of South Asians in mind, but rather they reflect Western understandings of mental illness (Islam et al., 2017). This in turn may lead South Asians to find mental health services incompatible with their own values. Further, an intersectional lens is important as South Asians can experience further marginalization due to intersections with gender and sexuality, for example. These intersections can create unique experiences in the ways in which South Asians are accessing mental health services. Finally, there is a need to reconstruct the current narratives of South Asians, particularly to dispel the model minority myth and engage more in-depth with South Asians on their experiences accessing mental health services.

Another key reason why South Asians may not seek out mental health services is mental health stigma. As mentioned earlier, stigma may be fueled by cultural values and complicated with its intersection to race and ethnicity as South Asians experiencing mental health problems likely experience double stigma which ultimately affect mental health outcomes (Gary, 2005). This aspect of the framework connects to the AsianCrit tenets, asianization and transnational context. Regarding the asianization tenet, the model minority myth may promote the concealment of mental health symptoms and increase stigma experienced by South Asians ultimately leading to reduced service utilization (Inman et al., 2014). Regarding the transnational context tenet, stigma and related cultural factors that create barriers to accessing services must be understood within larger social processes. For example, increases in Islamophobia, and Asian hate during the COVID-19 pandemic can further stigmatize South Asians experiencing mental health problems (Lee & Jang, 2021). Understanding this context can also inform useful interventions to reduce stigma and promote mental health services that align better with South Asian experiences and values.

Research Objectives

The above literature review suggests that South Asian youth experience cultural barriers such as stigma that prevent help seeking behaviour. Additionally, South Asian youth have unique mental health needs and experiences navigating White supremacy that often lead to negative experiences accessing mental health services (Islam et al., 2017; Inman et al., 2014; Rastogi & Wadhwa, 2009). Using the AsianCrit Theory, the present study attempts to understand and explore these experiences in depth especially in the context of the COVID-19 pandemic in order to identify how to improve access to mental health services for South Asian youth moving forward.

Research Questions

In order to address the gaps mentioned, this project seeks to answer the following questions: what are the experiences of South Asian youth with mental health problems of accessing mental health services in the Greater Toronto Area (GTA)? What are facilitators or barriers that have affected how South Asian youth are accessing mental health services? Additional secondary questions include: How do present mental health problems and the barriers to accessing mental health services contribute to substance use for South Asian youth?; and, How has COVID-19 changed how South Asians are accessing mental health services?

Significance of Research

The current project will increase knowledge in the field of community mental health research. Faulkner's (2017) examination of the power of experiential knowledge highlights the significance this project can have for the community of South Asian youth living in Canada. Understanding their experiences of mental health problems and how they navigate mental health

services can serve as a way to critique the current mental health system and empower members of the community by giving them a voice in a conversation from which they have often times been excluded. Moreover, this experiential knowledge is situated in other knowledge surrounding discrimination and stigma both in the context of mental health and race. This research can further knowledge in the field of community mental health by continuing to address the mental health concerns of marginalized communities and decentering White voices in conversations of mental health.

Further, this project is especially important right now as the COVID-19 pandemic continues to affect the mental health of the entire population. As noted, South Asians are reporting lower mental health and increased anxiety as a result of the pandemic (Moyser, 2020). Failure to recognize and address the unique barriers faced by members of the South Asian community will result in mental health problems that remain unsupported and further marginalize members who may already face racial and gender-based oppression. By bringing South Asian voices to the forefront, further work can be done to address the barriers South Asians experience when accessing adequate mental health services whether it is to tailor mental health services to better meet the needs of this community or create strategies to reduce mental health stigma.

Methods

Research Paradigm

This research project is guided by a constructivist paradigm. Constructivism denies the idea of objectivity and instead, it is founded on the assumption that reality is constructed by the observer (Allen, 1994). What is considered fact, under this paradigm, is the result of the values,

meanings, and attitudes of both the researcher and participant (Allen, 1994). Thus, constructivism situates participant responses in their cultural, societal, and historical context (Allen, 1994). A constructivist paradigm aligns well with the current theoretical framework as constructivism, like the AsianCrit theory, emphasizes the context in which participants are sharing their experiences. For the present study, situating participant's experiences within systems of oppression such as racism, discrimination, and stigma, as identified through the theoretical framework, can demonstrate how the issue of service utilization is systemic in nature rather than the result of individual decisions.

The use of a constructivist paradigm also encourages participants to make meaning of their experiences with the researcher during the interview process and during member check in. For example, participants have the space to reflect on their experiences with mental health service utilization and consider why they may have had certain positive or negative experiences. This reflective process is essential to the study as there is no objective experience for mental health service utilization. Instead, we can only gauge at how South Asian youth feel about their experiences and let that guide future research and action. Similarly, as a researcher, my own worldview, including my experiences as a South Asian women and Community Psychology masters student, shape how I understand the experiences shared by participants and formulate the findings for this project.

Research Design

The current research questions and objectives are appropriately addressed with semi-structured interviews. As mentioned, one of the objectives of the research explores the experiences around mental health and mental health services. As these experiences are nuanced, they require open ended questions and flexibility to explore a number of different topics related

to mental health as well as how participants' mental health, culture, socioeconomic status, and social networks and identities such as gender, sexuality, or even age shape their experiences accessing mental health services (Wilig, 2008).

Further, as indicated in the literature review, research on the utilization of mental health services among members of the South Asian community have thus far relied heavily on quantitative measures (see, e.g., Tiwari & Wang, 2008; Karasz et al., 2016; Chui et al., 2018). These studies do not adequately describe the barriers South Asians face when accessing services. The existing qualitative studies tend to focus broadly on South Asian mental health including the factors contributing to mental health problems. In general, there is limited emphasis on the experience of service utilization and how the barriers South Asians experience relate to systemic problems. The current study places a greater emphasis on the issue of service utilization by investigating the experiences of both individuals who have sought out mental health services and those who experience mental health problems but have not sought out mental health services and further, connecting these experiences in the context of the COVID-19 pandemic. Thus, there is a clear gap in qualitative research for this topic and while some studies have begun to fill this gap, there is more work needed to fully address the problem.

Participants

Participant recruitment. I employed a number of recruitment strategies. I collaborated with Access Alliance to aid in participant recruitment and knowledge dissemination. Access Alliance is a multicultural community organization that focuses on improving the health outcomes of Torontonians (Access Alliance, n.d.). This organization works with various partners to address health inequalities with those most vulnerable including refugees and immigrant communities (Access Alliance, n.d.). In collaborating with this organization, Access Alliance

shared the study poster (Appendix A) internally with other researchers who shared the posters within their own networks. Due to the province wide lockdown that occurred during the study recruitment period, Access Alliance was unable to promote the study in person within their building as originally planned. This overall limited the extent to which Access Alliance was able to assist in participant recruitment.

In addition to connecting with Access Alliance, a number of South Asian university clubs were contacted over email requesting club leaders to forward an email advertising the study to their club members. Some of the clubs that were contacted include South Asian Alliance (including members from Toronto Metropolitan University, York University, and University of Toronto), Bangladeshi Student Association (University of Toronto), Indian Alumni Association (University of Toronto), and Muslim Student's Association (University of Toronto).

Finally, what proved to be the most successful strategy for participant recruitment was the advertisement of the study through Instagram. An Instagram account (@samentalhealthproj) was created to promote the study. Several members of the South Asian community and Toronto based organizations or networks that focus on mental health and serving youth and/or racialized communities were contacted to share the recruitment poster through Instagram. The recruitment poster was shared with over 20 Instagram accounts.

Sampling. This study used purposive sampling as the research project was looking for South Asian youth who are experiencing mental health problems. In particular, maximum variation and snowball sampling was used. Maximum variation sampling aims to capture a heterogeneous sample, so that participants varied in terms of age, gender, whether or not they grew up in Canada, and whether or not they have accessed mental health services (Paggett, 2012). In order to achieve maximum variation, the recruitment poster was shared in different

spaces that would allow for information on the study to reach a diverse number of South Asian youth. For example, sharing the recruitment poster with Access Alliance and Instagram accounts of other mental health organizations increased chances of recruiting participants who already sought out mental health services. Similarly, reaching out to organizations that support queer South Asians allowed for the perspectives of queer South Asian youth experiencing mental health problems. Next, snowball sampling, which involves reaching out to participants to recruit others in the target population, was used as many participants described knowing other South Asian youth who had shared similar experiences regarding accessing mental health services (Paggett, 2012). In a follow-up email thanking participants for taking part in the study, participants were also encouraged to share this project within their networks.

Sample size. Based on Hennink & Kaiser's (2021) systematic review assessing saturation in qualitative research, saturation can be reached within 25 interviews. As such, this study was aiming to interview 20-25 participants as this number allowed for a relatively heterogenous sample while still allowing for depth in individual experiences to be analyzed and shared (Paggett, 2012). Participants were asked about their mental health, substance use, any experiences they had accessing mental health services, and the impact of COVID-19 on mental health, service utilization and substance use. As the data were being collected and analyzed during the same time period, data collection was completed when there was a saturation of themes among the interviews.

Data Collection

Procedure. Once participants expressed an interest in the study, they were sent a Qualtrics survey with the consent information and a short demographic survey (Appendix B). Participants identified a time to schedule the interview with the researcher which was then

conducted online over Zoom. Prior to the interview, the participant was sent the interview questions. The interview time varied greatly depending on how many experiences participants had accessing mental health services and ranged from 30 to 80 minutes. The interview guide is available in the appendix (Appendix C). The interview covered the following topics: understanding mental health problems and any substance use, experiences with accessing mental health services, barriers to accessing services, what the participant considers helpful mental health supports, and the impact of the pandemic in all these experiences. The interview was recorded through Zoom and then stored on a secure OneDrive folder. After the interview was over, participants received an electronic gift card as their honorarium as well as a resource sheet with mental health supports in the GTA.

Establishing the Quality of the Data

The quality of the data was established through several means. According to Whittemore, Chase, & Mandle (2001), credibility and authenticity in qualitative research is established when the research reflects the experiences of participants. Sustained engagement with the participants throughout the research process helped ensure that the research reflected the experiences of participants. For example, following the creation of the interview transcript, participants were sent their transcript to review. This gave participants space to clarify points in the interview as well as ensure that participants were still comfortable with the information shared. Only one participant responded with changes to the transcript. Afterwards, during the data analysis stage, participants were engaged again to participate in one-to-one member checks. Overall, seven participants participated in the member check. Participants reviewed the themes identified, addressed gaps, and formulated recommendations for service providers (see Future Directions). Participants discussed if the themes identified resonated with their own experiences, whether any

theme was unclear or confusing, and if they felt any information was missing. This process helped ensure that the main findings from the data resonated with participants and accurately described their lived experiences.

Data Analysis

Thematic analysis. All interviews were audio-recorded through Zoom and transcribed verbatim. Transcripts were coded using NVivo qualitative research data analysis software Version 12. Using Nvivo, transcripts were coded and organized into themes and subthemes. The present study used thematic analysis outlined by Braun & Clarke (2006). Thematic analysis involves identifying and reporting patterns within the data (Braun & Clarke, 2006). As Braun & Clarke (2006) explain, this form of analysis aligns with constructivist thinking as the themes identified from the experiences of participants reflect "the sociocultural context, and structural conditions, that enable the individual accounts" (p. 85). Thus, the thematic analysis was part of the meaning making process that both the researcher and participants were engaged in. The analysis was completed using the six steps outlined by Braun & Clarke (2006). The first step involved familiarizing myself with the data which involved transcribing and reading the data and noting down initial thoughts and common experiences with a number of memos (Braun & Clarke, 2006). The next steps involved generating initial codes and searching for themes among the codes (Braun & Clarke, 2006). Next, definitions and names for the themes were identified (Braun & Clarke, 2006). The final step involves the final write up of the themes (Braun & Clarke, 2006).

The thematic analysis conducted for this project was a combination of inductive and deductive approaches. While themes were identified from the data inductively, as Braun & Clarke (2006) note, a researcher cannot be completely free from theory or background literature

and as such, the adapted AsianCrit framework provided certain sensitizing concepts that guided thematic analysis such as themes and subthemes that focused on the impact of race on accessing mental health services.

It should be noted that in identifying patterns from the data, I have inevitably generalized the experiences of South Asians. While South Asians may come from the same geographical region, their countries are very different. This is not simply a difference in language or customs, but rather these countries have vastly different sociopolitical histories which include violence and discrimination amongst each other. In conducting a thematic analysis, I work under the assumption that, despite the heterogeneity of this population, experiences with mental health problems and service utilization in the Canadian context will be similar because of similar racialization processes explained by Iftikar & Museus (2014).

Ethical Considerations

This project was approved by the Research Ethics Board of Wilfrid Laurier University (REB#6971). As this project is working with individuals who may experience increased marginalization due to issues of race, gender, age, and mental health problems, several ethical considerations were made. Racialized communities have experienced a history of mistreatment in psychological research which has left many hesitant and suspicious of participating in research (Williams, 2005). In order to overcome any hesitancy, I made the research objectives clear prior to the interview and during the interview. Rather than playing the role of the interviewer, I played the role of a peer as I am also a South Asian youth who has experienced mental health problems. This involved using informal language and sharing my own experiences when appropriate throughout the interview. This resulted in the participants leaving the interview on a

positive note as many said they enjoyed having the conversation and were glad that importance was being placed on the mental health of South Asians.

Additionally, as this project dealt with sensitive topics such as mental health and substance use, it was possible that the interview questions may put participants in a vulnerable position as they may potentially discuss negative experiences that have arisen as a result of mental health problems. Participants were provided with the interview questions prior to the interview to ensure that they had time to review the questions and make clear if there were any questions they wanted to skip. When asking participants at the end of the interview if they felt distressed or required support, all the participants reported that they had a positive experience from the interview, however steps were established if a participant felt overwhelmed or negative during the interview, including providing them with the space to talk through their feelings, ending and/or rescheduling the interview, and checking in with the participants afterwards to see if they required further support.

A resource sheet with mental health and substance use resources was also provided after the interview. Even if participants are not in a vulnerable position, this may still be useful as our conversation is around access to mental health services. Participants may have expressed interest in seeking out mental health services and so, a document listing mental health services serving racialized communities and/or youth in the GTA was provided.

Another important step to ensure that the process of consent remained continuous was to encourage participants to review and edit their transcript. This allowed individuals to make clarifications or remove parts they no longer felt comfortable discussing, thus ensuring that there was still an informed consent even after the interview was completed. Additionally, member

checking after the data analysis process also helped ensure that participants were comfortable with the outcomes of the project.

Finally, participating in this study may have risked the personal privacy of the participants. Several steps were taken to ensure informed consent about the risks associated with the study and minimize this risk when possible. Firstly, participants were made aware of this risk through the consent form and explanation of the project. As the interviews were taking place over Zoom, participants were given an oral explanation of the study and had a summarized version of the consent form read out loud (see Appendix C for interview guide and script). The full consent form was provided ahead of time prior to the interview. Additionally, participants were told they could skip any questions or end the interview at any point. There was also allotted time during the interview for the participants to ask any questions. During the data collection and analysis stage, transcripts of interviews were coded such that participants remained anonymous throughout the process.

Positionality

I am a South Asian woman who has experienced mental health problems and also felt the inadequacy of the mental health services I sought. By exploring my own mental health and furthermore my cultural background, which I felt was never properly understood by the health professionals I talked to, I began to realize that this issue I was facing was not entirely my fault. The barriers I faced were not reflective of individual problems, but like every other aspect of Canadian life, they were interwoven with larger systems of racism, white supremacy, and neoliberalism. Thus, my own lived experiences allow me to enter this project with an understanding of this issue beyond academia. That being said, I acknowledge that my experiences are only my own and that many other South Asian youth have had experiences

vastly different from mine including those with positive experiences of accessing mental health services.

Reflection as a Peer Researcher

There are many strengths and limitations that came from being a researcher working with people who share similar social identities and lived experiences as myself. Being a peer assisted in building rapport with participants and allowed for trust in the research process. There was an implicit understanding that I would understand the experiences of the participants, often seen when participants start their responses with "you probably know this…" or "you know how it is." Having this understanding of participant's experiences was especially important in this current study as one of the greatest concerns participants expressed when accessing mental health support was feeling like their experiences were not well understood. It became clear when participants stated that they had a positive experience from participating that providing a welcoming and understanding space for participants to discuss their mental health and experiences with mental health services was valuable in and of itself.

However, there were drawbacks in the research that came from sharing so many similar experiences to the participants. Primarily, as a peer, there may have been times when I was not appropriately probing for information because I have made implicit assumptions based on my worldview as a South Asian. While this does not necessarily mean that I misunderstood a participant's experience or imposed my own ideas onto the participant, it does leave gaps in the data analysis stage where certain subjects could have been elaborated on. For future studies, this problem may be resolved by ensuring the interview guide has more detailed probes and having pilot interviews. Additionally, this challenge is reflected in any knowledge mobilization piece, as I have to step back from my experiences and knowledge as a South Asian to describe what the

findings of this project mean to someone who is not South Asian. This was done by having my supervisor and other researchers who are not South Asian review my results and provide feedback.

Results

Overall, 20 South Asian youth were interviewed to discuss their mental health experiences and any experiences they had accessing mental health services. Table 1 shows demographics of participants using descriptive statistics. Participants were South Asians between the ages 16-27, identifying as experiencing mental health problems, residing in the Greater Toronto Area, and English speaking. Participants self-identified as being part of various South Asian ethnic groups including Sri Lankan, Indian, Pakistani, Gujarati, Bengali/Bangladeshi, and Sikh. Majority (80%) of participants identified as women, 10% were men, and 10% were gender queer or gender non-binary. Participants ranged from 16 to 27 years old with the average age of participants being 24 years old. Majority (80%) of the participants were born in Canada or grew up in Canada (in other words, arrived in Canada before the age 10).

Table 1 Demographic characteristics of participants (N=20)

Variable	%
Gender Identity	
Woman	80%
Man	10%
Gender Queer/Gender Non-binary	10%
Age	
17-19	5%
20-27	95%
Country of Birth	
Canada	50%
South Asian Country (e.g., India, Pakistan, Bangladesh)	50%
Arrived in Canada before the age 10	30%
Arrived in Canada after the age 10	20%

Almost all the participants had accessed some form of mental health support with majority (65%) of participants having had accessed university mental health services. Other mental health services include community organizations and private mental health services offered through participants' workplaces. Overall, six themes arose from the interviews based on experiences accessing mental health services and the impacts of COVID-19. When discussing facilitators and barriers to mental health services, three themes arose from conversations: 1) a lack of diversity among service providers, 2) difficulties building and maintaining relationships with service providers, and 3) compounding mental health stigma. Next, when discussing the impacts of COVID-19, the following themes arose: 4) the impact of the pandemic on mental health, 5) substance use, and 6) accessing mental health services during the pandemic.

"Having someone that, you know, looks a little bit like you does help (008)" –A Lack of Diversity Among Service Providers

Nearly all participants discussed a lack of diversity among the service providers they have met. Accessing mental health services that predominantly involved White service providers contributed to feelings that mental health services were not well equipped to assist South Asians. Participants discussed that the prevalence of White service providers results in an emphasis on Western beliefs and values ultimately leading to difficulties in the therapeutic session and the extent to which participants felt connected and understood by their service provider. When asked about their experiences seeking mental health services, one participant stated: "*When I look at them for myself, I can't confidently say that I'll access them just because like, I don't think they're going to understand where I'm coming from*." (015) This uncertainty of not being understood by service providers ultimately led the participant to not seek out services for several

years. While the participant did eventually seek out mental health services, it was only after they felt their mental health had further worsened.

Explaining Your Culture. A consequence of the lack of diversity among service providers is that South Asians are often required to explain the cultural context in which their experiences are situated. Participants discussed how a lack of understanding or opportunity to discuss the cultural norms or traditions that can influence their experiences can lead to service providers misunderstanding or potentially judging them. Additionally, some participants described that this process of unpacking cultural norms and values can be difficult and emotionally laborious, ultimately taking away from the therapeutic session. For example, one participant stated:

> It constantly feels like you're … having to explain, like, not only your own issues, but also your culture to kind of justify what you're talking about, or like to justify your feelings, or to explain why certain things are happening (019).

As the participant describes, this process becomes more about justifying their experiences to a service provider than simply providing context to experiences shared during a therapeutic session.

This process is further complicated when trying to navigate stereotypes as some participants felt they had to rely on stereotypes to explain cultural norms or traditions: "*you feel like, pressure to like, qualify your statements … like, 'oh, you've probably heard of this, you know, stereotype' …*" (011) Using stereotypes to explain the South Asian culture can ultimately paint a negative image for South Asians. Another participant discussed this dilemma and felt that when they had to rely on negative stereotypes to explain their culture, they were reaffirming

Western beliefs of racial communities being less progressive than Western communities which they wanted to avoid.

In contrast, many participants who had experiences with service providers who were South Asian or persons of colour described feeling that their service provider understood where they were coming from and expressed experiences as positive and helpful. One participant stated: *"For me, my therapist was actually like a brown woman. So, it was like this person clearly, like, understood, like my background and like where I was coming from. So, I found that to be really helpful"* (012). Overall, this complex navigation that participants are made to do to ensure that their experiences are properly understood or validated lead to overburdening the client and provide less space for the service provider to offer support.

Incompatible Services. Another consequence of the lack of diversity among service providers and resultant emphasis on Western values and norms is that various aspects of accessing mental health services often do not align with the participants' needs or expectations of mental health support. This manifested in many ways including incompatible therapy modalities, issues with the assessment process, and receiving unhelpful support from service providers. As mentioned, majority of participants accessed mental health services through their university, however many participants described how university mental health services were incompatible with what they felt they needed. Some universities offered group support services where participants described not feeling comfortable discussing personal issues or feeling like their issues did not come up in group discussions. Additionally, services such as cognitive behaviour therapy offered in universities did not give participants space to discuss family problems or culture which they felt would have been helpful for them. For example, one participant stated *"It*

didn't feel like an actual like, session. It just felt like I was in a classroom learning about things that I should have known beforehand" (005).

Beyond issues with the types of services offered, issues with the incompatibility of services trickle down to how service providers support participants throughout the assessment process and therapeutic sessions. Service providers failed to recognize issues such as mental health stigma which make it difficult for participants to answer questions regarding family history of mental illness, a question that commonly occurs in mental health assessments. One participant described their frustrations during the assessment stage as follows: *"'The symptoms showed up for you when you were 14-15. Are you sure there's no [family] history?' And I was like, Listen, lady, I told you three times. We don't talk about this."* (003)

Likewise, some participants discussed that during therapeutic sessions, service providers often provide unhelpful advice or suggestions to participants. This is primarily seen in discussions around family dynamics. The majority of participants discussed their family as a source of mental health stress, however when discussing family issues to service providers, the advice provided by service providers are often not feasible for most South Asian families. For example, many service providers stated that clients should openly communicate with parents on why their behaviour is harmful. Participants described the difficulty of receiving this kind of advice from service providers: *"they might just say that, 'why don't you just talk to your parents?' Simple as that. But it's not like talking to them about mental health – it's just not something that has really ever occurred"* (015) and *"the counselor would give me like ideas on things to do but they just seemed like impossible to do in my family"* (018). Finally, when service providers were met with conversations that were far removed from their own experiences, such as conversations around race, culture, or religion, there seemed little attempt to address the

participants' concerns. For example, one participant stated: "*when I talked about my internalized racism with my therapist in Guelph, we never brought it back up … I don't know if it was like, because I've been seeing her sporadically, or she just had no idea what to do with it.*" (003)

In contrast, one participant who spoke with a racialized service provider stated: *"They were still able to kind of provide that competency and really have that understanding … in terms of like, family dynamics and stuff like that."* (017) Speaking with a service provider who had shared social identities with participants, for example a service provider who was South Asian or a person of colour, who knew where the participant was coming from, allowed the participant's concerns to be understood and created a space where the service provider was better able to assist the participant with their needs.

Intersecting Identities. Another challenge regarding the lack of diversity among service providers discussed by participants is the increased difficulty experienced by South Asians who experience further marginalization due to other intersecting identities. In particular, a number of participants who identified as Lesbian, Gay, Transgender, or Queer (LGBTQ+) discussed their difficulties in finding a service provider who understood their unique experiences as a South Asian queer individual. These participants noted that discussing family dynamics or experiences with race or culture are already difficult and not often well received by service providers and so, this problem is further complicated when participants also discuss issues such as homophobia within the family.

Participants discussed a desire to find a service provider who was a person of colour and also queer friendly. As one participant described: *"when I was going to racialized therapists, there wasn't really that intersection of queerness that I needed"* (012). However, given the lack of diversity among service providers, it is difficult to find a service provider who is able to meet

these criteria, and this often led to participants compromising and choosing what they felt was more important for them at the moment. These participants described that this feeling of compromising makes it difficult for participants to bring themselves fully into a therapeutic session and ultimately can lead them to changing service providers to continue looking for one with the specializations they require.

"I think the hardest thing was to find someone … that was able to understand my concerns and just… hear me out." (008) – Difficulties building and maintaining a therapeutic relationship with service providers

Another major barrier discussed by participants in accessing mental health services is building rapport with service providers and being able to maintain a therapeutic relationship. Firstly, many participants encountered difficult experiences with service providers which prevented rapport building. Next, participants who are interested in a therapeutic relationship with their service provider are faced with additional barriers in acquiring regular therapeutic sessions.

Feeling Unsupported by Service Providers. Many participants discussed difficult experiences they have had with service providers. Participants described several negative experiences including feeling like their concerns were being dismissed as well as feeling unwelcomed or judged by their service provider. Participants attributed this dismissive behaviour to their young age or ethnicity. For example, some participants felt that their opinions or perspectives were dismissed when it came to receiving a diagnosis for their mental health problems. When discussing the process of being diagnosed with ADHD, one participant stated: *"When I asked to be medicated, I was told, 'Oh, you need to just wait. Like, I don't think you have ADHD.'"* (015) The participant attributed the service provider's dismissal as a result of

service providers having little experience working with racialized youth: *"They're dealing with a community that hasn't talked about it. So, when they get a young person to talk, talking about mental health, it's like, what do we do?"* (015).

Another participant also discussed their difficulties in receiving a diagnosis of depression: *"So, she was like … your symptoms aren't strong enough to be clinically to be diagnosed as like, you know, depression … then she looked really agitated, like, I was wasting her time."* (017) As illustrated by the quote, the participant struggled to have the service provider affirm their mental health concerns as the service provider did not acknowledge the severity of their symptoms. This participant also attributed the difficulty receiving a diagnosis as a result of a lack of support for racialized communities. They further explained: *"It really kind of made me realize, like, how much how the current mental health services we're really lacking in terms of providing supports to persons of color…"* (017). Not only did this create feelings of frustration for participants, but it also halted their attempts to begin managing their mental health issues by delaying further support such as medication.

In addition to difficulties receiving mental health support through a diagnosis, many described having negative experiences with service providers. For example, as one participant stated: *"… there's the sense that I always get like, as if I'm wasting their time, and it's really frustrating"* (017). Another participant discussed a service provider's response to certain difficult situations in the participant's life: *"… it was just hard when she would look shocked or like visibly, like, alarmed because then you start feeling like they're judging you."* (019). Perceiving a negative reaction from the service provider ultimately led the participant to feel that their attempts to discuss their problems were "pointless" (019) and stop meeting with their service provider. The participant attributed the shock and judgement displayed by the service provider as

a result of not having an adequate amount of experience with racialized communities. They felt this lack of experience made the service provider react negatively to experiences shared by the participant that were far removed from their own expectations or experiences. Overall, being met with this lack of support made participants begin the process of seeking out new services or stop seeking out services altogether.

In contrast, participants who felt heard and understood by service providers described the positive experience they had. One participant stated: *"And, you know, she didn't pressure me to do anything. And she was just so validating. And I just felt very seen and safe with her which was really important."* (006) Participants understood that they were not always going to find a service provider who had similar shared identities or experiences as their own, but it was important that despite any differences, service providers were able to meet participants where they were at. For example, one participant stated: *"He didn't judge me based on like, where I'm coming from, or what my values are because obviously … his values and my values are completely different."* (009)

Financial barriers and long wait times. In addition to building a therapeutic relationship with a service provider, participants also discussed difficulties with maintaining this relationship. Participants discussed the unaffordability of many mental health services and the issue of long wait times, which reflect problems with Ontario's mental health services, as a whole. They mentioned that these two issues often go hand in hand as free mental health services, rather than private practice, tend to have longer wait times due to higher demand. Majority (85%) of the participants have had experiences accessing or on a waitlist to access publicly-funded services or university services covered under student insurance. The remainder of the participants accessed mental health services through work benefits.

Many participants experienced a long wait time when trying to access a mental health service, whether it is accessing services for the first time or the time in between sessions. Participants described waiting for months and up to years to access mental health services as well as weeks in between appointments. Not being able to meet a service provider on a regular basis created several issues for participants, including not feeling like they were able to build a connection with the service provider or address their immediate concerns as they arose. They felt that this not only reduced the effectiveness of the service, but also discouraged service utilization as a whole.

This issue arose prominently for participants accessing university mental health services. One participant described their experience accessing university mental health services: *"And the process took so long, they're always always always backed up, which is, I think the one thing that really … discourages students … just knowing that they don't have space for you."* (005). Beyond the university setting, participants discussed similar issues for drop-in centres where there was no consistency with the service provider they met with: *"… it was difficult to know that I wasn't seeing the same person again, like it's hard to open up to one person."* (013) Another participant stated: *"When you're not talking to someone consistently … I don't find that you're building any rapport with them"* (015) As the quotes illustrate, participants who were not able to meet a service provider on a regular basis struggled to form any rapport with the service provider. Without this foundational level of trust and comfort, participants expressed not being able to have complex conversations around culture or family.

Hand in hand with the issue of wait times is the financial investment involved in meeting a service provider on a regular basis. As a result, most participants discussed only accessing publicly-funded services or accessing their university's mental health services, where services

are covered under student insurance. As previously discussed, these services tend to have long wait times and are often not structured to create lasting relationships with a single service provider. Thus, participants are often in a difficult position where they are not being adequately supported through university mental health services and not being able to afford other mental health services. Participants who were not enrolled in post-secondary education also discussed the financial barriers preventing them from accessing services. Most described requiring benefits from their work to access mental health services*: "... after university, I didn't see a counselor after that, because I wanted to kind of search for my own later on when I get a full-time job and benefits for one."* (003). Another participant discussed work benefits as incentive for seeking out mental health services: *"Once I get those benefits, I feel like ... I have a way bigger incentive to be able to, like, you know, seek out that kind of help."* (001) Thus, costs associated with mental health services were a big concern for participants as they either sought out free mental health services or sought out service covered through work benefits.

Compounding Mental Health Stigma

Stigma was a prominent concern that all participants had to navigate, which had implications for service access. While the participants themselves did not experience self-stigma that made them wary or dubious of mental health services, participants did experience stigma from those around them which negatively impacted their ability to access mental health services. Based on the conversations with participants, there were three key areas where they experienced mental health stigma. For some participants, stigma deterred them from accessing services and for others, it created additional barriers to navigate when accessing services.

Family stigma. Stigma from family members, in particular participants' parents, was a major source of stress for nearly all participants. For example, one participant stated*: "I have two*

sisters like, yeah, they understand mental health, but like my parents don't. So, it's not something that I can talk to them about." (005) Participants described parents being dismissive of mental health and distrusting of mental health services. Navigating this stigma often resulted in secrecy around accessing mental health services as one participant states*: "I need a way to leave here, my house, to get there. Make up an excuse, because I, I will be honest, I do not want to tell my parents."* (002) Additionally, many participants described the increased stress associated with this secrecy: *"I'd rather just like not deal with, you know, this uncomfortability. I'd rather just like not go to therapy."* (012) These participants discussed that the additional stress associated with accessing services whether it be making up excuses to leave the house or hiding medication at home can ultimately outweigh the perceived benefits of service utilization and lead to participants choosing not to access mental health services.

Cultural Stigma. Hand in hand with family stigma is the issue of cultural stigma. As one participant stated: *"I grew up in my community where mental health was a very taboo subject."* (017) Many participants discussed the difficulties in navigating mental health within the South Asian community where there was no space to talk about it. This can create issues within the household as parents are wary of community members finding out about their children experiencing mental health problems or accessing services. One participant describes the shame associated with disclosing mental health issues to community members: *"I was literally sat down and said if anyone finds out from like, outside our home, it's gonna … bring shame to our family."* (015)

Similarly, one participant discussed how cultural stigma combined with gender expectations made it difficult as a South Asian man to seek out mental health support:

> So, it's like, for you to be a man who's South Asian and seeking this is like, even worse … if you meet like a really outdated like, uncle or something, just, like, you know, 'just go out, like, be a man, like, you're not supposed to complain or whatever.' So that was like an additional barrier.

Overall, the general stigma within the South Asian community further contributed to the secrecy around accessing mental health services as participants did not feel like they could have an open dialogue to discuss these issues.

Stigma Among Health Professionals. For many participants, their first point of contact in terms of receiving mental health support was with their family doctor. However, many discussed negative experiences they have had with family doctors when discussing their mental health. Participants stated: *"she was very, like, traditional in her idea that like, she's like mental health … isn't real, but it can be solved with like, exercise and sunlight and stuff"* (018) and *"I recall, talking to my family doctor, as well, and he was really dismissive … he was like, why do you struggle with depression and anxiety? You're such a young person, like you haven't experienced that yet."* Many participants discussed family doctors being dismissive of their mental health and, as the second quote demonstrates, this was partly due to the fact that participants were young. Experiencing this dismissal often led to frustration as participants had to find other avenues of support including finding new family doctors and as a result, this often delayed access to mental health services that required referrals from a family doctor.

Adjusting to Life During the Pandemic

Shifting now to the impacts of COVID-19 on the experiences of South Asians youth experiencing mental health problems, many participants felt that the pandemic had worsened

their mental health. A number of factors contributed to the worsening of mental health including the disruption of life events, staying at home more, and living in uncertain times.

Disruption of Transitional Life Events. The majority of the participants interviewed were in their early 20s and described key transitional moments in their life such as starting new jobs or graduate school, completing university, and moving out of their family home. However, the pandemic had disrupted these transitional moments in their lives and as a result, participants needed to navigate these new chapters of their lives while also responding to the pandemic. This meant adjusting to working from home, attending virtual school courses, or not being able to meet friends. For example, one participant described the negative impact of attending their first year of university remotely: *"I didn't have the opportunity to meet new people, so I was stuck with a lot of people from high school that weren't good for me"* (005). Navigating these changes was difficult for many participants and negatively impacted their mental health.

Staying at Home. As a result of public health measures such as lockdowns, many participants were staying at home more often with family members. Many participants described increased friction with family members as a result of the increased time spent together:

> … But then after a couple months was like, oh okay, now we're just all in or like everyone's just up in each other's like emotions and business and all these things started popping up. That's when I was like, felt like suffocated. (003)

As noted, family problems were often a source of stress for South Asian youth and so, spending more time with family members can exacerbate the preexisting problems. Likewise, the increased time spent at home often led to a loss of routine and social activities*: "… university was one of the places where I had a really big community, I have my chosen family. So being cut*

off from that and stuck at home was definitely detrimental to your mental health." (017) Participants discussed that losing this system of support was very difficult for them especially in conjunction with increased stress associated with being with family members more.

Increased Anxiety in an Uncertain World. Finally, many participants described an increased anxiety associated with the pandemic and other current events. Anxiety around the fear of testing positive for COVID-19 or family members testing positive, how long the pandemic will last and job loss as a result of the lockdowns were described by participants. For example, one participant stated: *"The fear of the unknown was what really got to me like, when will this be over? When will I be able to see my friends again?"* (013)

Increased Cannabis Use Since the Pandemic

Participants were asked about alcohol and substance use and changes in consumption associated with the pandemic. Participants who reported consuming alcohol described consuming less during the pandemic. They described a decrease in social gatherings due to public health measures such as lockdowns and this resulted in less opportunities for alcohol consumption.

On the other hand, participants who reported consuming cannabis prior to the pandemic reported an increase in cannabis consumption. Participants associated the increase in cannabis consumption with a number of factors. Firstly, some participants described using more due to boredom during the lockdowns: *"it was more just to have something to do because it was so like boring and like mundane just being at home in the summer."* (018). Next, consumption was also associated with coping with anxiety and other mental health problems, for example one participant described how smoking helped avoid overthinking and worrying about circumstances

in their life. Finally, participants described using cannabis to cope with work demands and relaxation after work. Participants who had long and demanding work hours described how cannabis use helped them stay focused or relax after work.

"I really didn't reach out to my therapist, because I know I would have to hold a session at home, and it wasn't a safe space (017)" – Lack of convenience of remote services

When discussing the impact of COVID-19 on participants' ability to access mental health services, many expressed increased difficulties associated with service utilization during the pandemic. While they appreciated the increased awareness of mental health during the pandemic, they did not feel that the supports offered were adequate to addressing their mental health concerns. Many factors contributed to the difficulty accessing services during the pandemic including finding services to access, difficulties accessing remote services, and problems with remote services.

Navigating Available Services. A consequence of the pandemic, and in particular the lockdowns, is that it became difficult for participants to reach out to mental health services. It was unclear which services were still operating during the lockdowns. This often meant participants were left with unanswered voicemails or emails. In some cases, mental health services that participants accessed prior to the pandemic had shut down forcing participants to look elsewhere for new services. Relatedly, participants who have preferences for in-person services, phone services, or virtual services needed to navigate what their options were for any particular organization offering mental health services. This can be difficult if participants are not able to reach out to the organization. For example, one participant described this process: *"… There's that headache of trying to figure out like, okay, do they do it on the phone, in person, on*

Zoom? Do they use like something else other than Zoom? And just kind of navigating all of that just feels like a lot of effort." (010)

Difficulties Accessing Remote Services from Home. With the pandemic came the shift to more remote services such as accessing mental health services through videocalls, phone calls, and smartphone apps. Many participants discussed the difficulties in accessing services while under the same household as family members. Due to family stigma, participants' households were often not a safe space to access mental health services which led to participants deciding not to access mental health services or adjust how they communicate during their sessions. As a participant discussed: *"... During the initial months of COVID, I really didn't reach out to my therapist, because I know I would have to hold a session at home, and it wasn't a safe space."* (017) Likewise, as many participants identified family issues as being a major source of mental health stress, participants described needing to speak quieter or avoid directly mentioning family members during conversations with service providers.

Ineffective Remote Services. When discussing how participants felt about the shift to more remote services as a result of the pandemic, most participants felt it negatively affected the quality of services. Firstly, remote services, particularly those offered through the phone, can make it difficult to build trust between the service provider and client. As a participant mentioned: *"I feel like you're missing a lot of things through a phone call, like you're missing a person's body language or facial expressions."* (005) Not being able to see the service provider or see how they are reacting to what the participant says can make it difficult to openly discuss sensitive topics.

As a result of the pandemic, there has also been an increase in mental health smartphone apps and participants discussed these applications as being generally unhelpful. These apps tend

to be self-directed, and homework based with limited interactions with a service provider. One participant described how they felt this was an issue:

> Which I personally felt kind of, you know, went against like what I was looking for in terms of therapy like you want like that, kind of like open-ended conversation where you're able to bounce ideas off of each other (005)

Finally, these applications provide limited space to discuss issues previously described as important to them such as family or culture.

Discussion

The present study highlighted several areas of concern in the field of mental health that pose barriers to South Asian youth accessing services. A lack of diversity among service providers and difficulties building rapport with service providers can lead to negative experiences for South Asian youth accessing mental health services. Further, financial barriers, wait times, and mental health stigma can further create barriers to service utilization. These barriers to service utilization often led to participants constantly switching service providers and can ultimately lead to delayed mental health support and more lifelong mental health problems. These barriers are further complicated when considering the effect of COVID-19 on the mental health of South Asian youth and their ability to access mental health services. Overall, participants reported a worsening of mental health and increased substance use since the pandemic and described increased difficulties accessing remote mental health services during the pandemic.

Barriers to Accessing Mental Health Services

The study's findings suggest the need for improved mental health services for South Asian youth. Consistent with previous findings, particularly those noted by Islam et al. (2017), issues related to the lack of diversity among service providers, the emphasis on Western values for mental health services, waitlists, and costs for services were all concerns emphasized by participants. These findings also align with Bowl (2007), Inman et al. (2014), Li & Browne (2000), and Memnon et al. (2016) who all highlighted problems associated with a lack of cultural awareness as a key barrier to accessing mental health services for South Asians. In addition, participants in the present study emphasized the importance of finding a service provider who is welcoming and understanding. Participants felt that reaching out to service providers can be daunting when clients are not sure how the experiences they share will be received and so, when South Asian youth are met with this lack of support and unwelcoming environment, it can reaffirm the idea that mental health services are not equipped to support South Asians.

Similarly, experiences participants had where service providers were dismissive of their mental health and symptoms suggest generally dismissive attitudes service providers have toward youth experiencing mental health problems. One study in Scotland by Buston (2002) interviewed 32 youth (14-20 years old) regarding experiences discussing their mental health concerns to a health practitioner and found similar results of the dismissive attitudes towards youth from health professionals due to their age and the need to build empathetic communication skills by practitioners with youth. Similarly, Byrne et al. (2021) studied the experiences of youth (12-25 years old) seeking out support in emergency departments for self harm and found that participants often described hospital staff as disinterested and dismissive. Notions that young people do not experience serious mental health concerns can be detrimental to youths' mental health and willingness to seek out support. Further, participants attributed the lack of support

from service providers as a result of service providers not having experience working with South Asian youth. Participants discussed that this can create barriers to help-seeking because there is little incentive for them to pay for mental health services when there is no guarantee that their service provider is going to be understanding of their concerns or create a welcoming environment for them.

A key finding that arose from the interviews was the importance of university mental health services as a resource for many South Asian youth. The majority of the participants described having experiences with university mental health services and feeling unsatisfied with them. Some literature supports the concerns participants expressed. Robinson et al. (2016) surveyed 400 university students and found that majority (74%) of students reported being aware that their university offered mental health services, but only 8% of students reported being likely to access services and of the students who expressed mental health challenges, about 13% said they would access mental health services. Similarly, Storrie, Ahren, & Tuckett (2009) described stigma and feeling like service providers would not understand their concerns as major barriers identified in a systematic review of 11 articles regarding university students accessing mental health services.

However, there is very limited research on the experiences of racialized university students and the extent to which university services are able to provide culturally sensitive services, especially in the Canadian context. One study by Giamos et al. (2017) interviewed 41 students regarding their mental health and experiences accessing campus mental health services. Similar to the current findings, Giamos et al. (2017) highlighted long wait times and a lack of cultural sensitivity in services. Overall, the experiences of racialized students accessing campus mental health support is a clear gap in current mental health research.

When it comes to the issue of stigma as a barrier to mental health services, contrary to Arora, Metz, & Carlson's (2016) findings that South Asian college students showed increased personal stigma which discouraged help seeking behaviour, participants did not describe any personal stigma that discouraged them from accessing mental health services. Instead, public stigma, in other words the stigma from others around them, was often a barrier to accessing mental health services. However, this may because the participants of this study are more inclined to discuss their mental health as the recruitment poster for this project explicitly state that the interview involved discussing mental health experiences. Thus, those who may hold more stigmatizing views on mental health or stigmatizing experiences are less likely to participate in this study. Similarly, it should be noted that Arora, Metz, & Carlson (2016) do mention gender differences in personal stigma where women are more willing to seek mental health services, and majority of the participants in the present study are women.

An important facet of public stigma is courtesy stigma which refers to how family members may be stigmatized due to their affiliation with someone who experiences mental health problems (Gary, 2005). Courtesy stigma can negatively impact the family member's reputation and status in the community (Gary, 2005). Stigma from family members and the need to conceal family member's mental health status often impeded participants' ability or willingness to access mental health services.

The present study suggests that more work still needs to be done regarding addressing mental health stigma among South Asian youth including youth's experiences with discussing mental health in their culture and perhaps a deeper dive into the experiences of South Asian men. For service providers, these dimensions of stigma should be acknowledged and addressed with clients to find supports that are feasible for clients. As participants have made clear, experiences

with family and cultural stigma can make it difficult to have open conversations with family members about problems that contribute to poor mental health and so, other avenues of support should be sought out.

Substance Use

There is limited research on substance use among South Asian youth. Studies by Rastogi & Wadhwa (2009), Bhattacharya (1998) and Islam et al. (2017) point to substance use being a means to cope with mental health problems and integrate into North American culture. In the present study, only the former was seen as participants discussed primarily using cannabis to help cope with anxiety, stress, and work demands. Among participants who grew up in Canada and those who moved to Canada at a later age, cannabis use was not perceived to be linked with wanting to "fit in" with Western culture.

While participants did not describe their cannabis use as something that is negatively impacting their life, in other words as misuse, it should be noted that the majority of participants who used cannabis reported an increase in use since the pandemic. This aligns with the survey conducted by Rotermann (2020) that reported increased substance use among Canadians who reported poorer mental health since the pandemic. Similarly, Bartel, Sherry, & Steward (2020) found that self-isolation and depression contributed to greater cannabis use. Thus, further investigation on the experiences of South Asian youth should be conducted to better understand the ongoing impact of the pandemic on substance use.

The Impact of COVID-19 On Mental Health & Service Utilization

Consistent with earlier studies by Rotermann (2020), CAMH (2020), and Moyser (2020), participants stated that the pandemic has negatively impacted their mental health. Particularly,

the present study sheds light on Moyser's (2020) survey that found that South Asians in Canada reported the highest prevalence of self-rated poor mental health and anxiety since the pandemic. While Moyser's (2020) survey was not specifically focused on South Asian youth, the present study suggests some explanation for the survey results as the loss of social support and increased time spent at home with family members was found to be a major source of stress for South Asian youth. Family obligations and conflict that South Asians experienced described by Islam et al. (2017), Sharma, Shaligram, & Yoon (2020), and Rastogi & Wadhwa (2009) may have been exacerbated during the pandemic, which can contribute to a worsening mental health. Aside from increased conflict from increased time spent at home, the other issues that participants described including navigating changes as a result of the pandemic and anxiety associated with the pandemic point to a heightened need for effective mental health services for South Asian youth.

The present study provides critical insight on the current state of mental health services during the pandemic especially the shift towards more remote services. A recent study by Strudwick et al. (2021) reviewed digital mental health interventions and identified 31 mobile apps and 114 web-based mental health resources (such as telemedicine, virtual peer support, etc.) across Canada. Similar to the present study, the authors found that the digital interventions are disadvantageous to people who do not have access to a private or safe space when accessing remote mental health services (Strudwick et al., 2021). Further, they recognized the difficulty in establishing a therapeutic alliance between service providers and service users as a barrier to remote services. The current findings highlight a need to further investigate the effectiveness of remote mental health services and the extent to which they are accessible for different marginalized groups.

Returning to Asian Critical Theory

The present study is the first to apply an AsianCrit theory to understanding the experiences of South Asians in Canada. The study highlights how systems of oppression such as White Supremacy are subtly perpetuated in Canada's mental health system. Issues of racial inequity continue to contribute to poor experiences and barriers to accessing mental health services (Corneau & Stergiopoulos, 2012). Participants from the current study struggled to communicate and validate their unique experiences as South Asian youth to non-South Asian service providers including issues around culture, family, and navigating their social identity. Despite the willingness of many to seek out mental health services, many are left frustrated and unsupported. These barriers to effective mental health support may be the result and further perpetuate the feelings of otherness described by Iftikar & Museus (2014). As the authors explain, Asians are often racialized as foreigners, and this results in Asians being systematically excluded in Canadian health policy and programs (Iftikar & Museus, 2018). This includes mental health services where we see that service providers are not well equipped to assist South Asian youth. South Asian youth who are met with this lack of support may be discouraged from further seeking out mental health support and likewise, may experience poorer mental health as a result of their circumstances.

Other forms of racialization such as the model minority stereotype commonly attributed to South Asians can also create an impact on South Asian youths' ability to access mental health services as this stereotype may be internalized by South Asian community members. Mental health stigma exhibited by family members or the South Asian community may be a result of attempting to uphold the model minority stereotype and lead to a concealment of mental health problems (Arora, Metz, & Carlson, 2016). The perpetuation of this stereotype can ensure that South Asians, while perhaps still considered foreigners, are at the very least considered

successful foreigners. When considering the double stigma described by Gary (2005), concealing mental health problems and internalizing the model minority stereotype may be seen as a way to deter discrimination that otherwise may come as a result of being South Asian and experiencing mental health problems. However, this comes at the cost of leaving mental health problems unaddressed and unsupported. In this case, the experiences of South Asian mental health and service utilization speaks to a larger issue relating to difficulties navigating in a system that favours White people.

Beyond the racialization processes described by Iftikar & Museus (2014), the authors additionally describe the importance of re-constructing the collective Asian historical narrative. We can understand this gap in mental health services for South Asians as a result of South Asians being silenced for much of Canadian history. With the increase in Asian hate and Islamophobia, there is a need to raise the voices of South Asians (Lee & Jang, 2021). The present study makes a small step towards highlighting the voices of South Asian youth in the context of mental health service utilization. Further recognition needs to be made of the experiences of South Asian youth who represent diverse social identities including gender, sexuality, and disability. For example, findings from the present study suggests that queer South Asian youth face unique challenges to accessing mental health supports and often feel that they are compromising parts of their identity when seeking help, for example they may not disclose their sexual identity when talking to service providers who do not offer a specialization in LGBTQ+ issues.

Overall, the mental health concerns and barriers to accessing mental health services described by participants in the present study can be understood when acknowledging the difficulties in navigating White Supremacy. Excluding South Asian voices from Canadian

history has led to mental health services that are ill equipped to address the concerns of South Asians leaving many to constantly seek out new service providers or avoid service utilization altogether. Addressing this service gap will involve both program and systemic level changes in the ways that incorporate South Asian voices into research, programs, and policy.

Future Directions

Nearly all the participants who accessed mental health services sought out mental health services at their university's wellness centre and likewise, almost all the barriers described by participants were experienced in these settings. There is a great need to improve the capacity and quality of care provided by universities as it is often the first time youth are accessing mental health services and likewise, it is often the only viable option for them due to financial barriers. Hiring more mental health support workers particularly those with diverse backgrounds, providing adequate training to workers to support the university's diverse population, and providing students with autonomy to choose their service provider are key ways in which universities can improve the quality of the services they provide.

Beyond university service settings, there is an increased need for more information and awareness of mental health services that better address the needs of South Asian youth. Social media can potentially be a powerful tool for increased knowledge of the diverse types of mental health services allowing youth to search for the kind of mental health services best suited for them, whether it is finding a service provider who is a person of colour, queer friendly, or offers other forms of specialization, or options for low cost/free mental health services. Participants discussed existing social media accounts that share information regarding South Asian mental health, however there is still a need for a repository of local services and service providers.

The current study also highlights key areas of interest for future research. As mentioned, research taking an intersectionality lens should continue to explore the experiences of LGBTQ+ South Asians and their unique challenges finding a service provider that meets their needs. The findings from the current study show that LGBTQ+ South Asian youth often have to compromise themselves to access mental health services and rarely are able to find service providers who are queer friendly and have the cultural understanding they require.

Next, research suggests that issues around mental health stigma may be different for South Asian men than women and so, future research should explore how personal or public stigma may influence service utilization among South Asian men. While the current study comprised of mostly women participants, insights of the men participants does suggest that gender expectations can further contribute to mental health stigma and prevent service utilization. Similarly, family stigma was a major barrier for youth and often led youth to only access mental health services once they were enrolled in university and likely better able to advocate for themselves. Understanding how to reduce family stigma and incorporate parents into the process of youth accessing mental health services can be an important avenue to study and seek change in order to reduce more lifelong mental health problems.

Further, the current project focuses on the experiences of participants in the GTA, however experiences of South Asian youth may differ elsewhere in Canada. In particular, as the majority of South Asians live in Ontario and British Columbia, exploring the state of mental health services in British Columbia may result in different experiences (Statistics Canada, 2007). Exploring these geographical differences may have implications for the kinds of services that best meet the needs of South Asian youth.

Finally, while the current study attempted to look at how Canadian born and immigrant South Asian youth may have different experiences accessing mental health services, the number of newcomer South Asians interviewed was limited. Similarly, when looking at the experiences of these groups, there were no unique experiences among those born and raised in Canada and those who recently immigrated to Canada. Thus, future research should continue to work with these subgroups to explore potentially unique needs and experiences of Canadian born and immigrant South Asian youth.

Recommendations for Service Providers

While grand, systemic changes may not always be feasible, service providers are also able to make their own personal changes to improve the quality of support they provide to South Asian youth. Below is a list of recommendations provided by participants to service providers, and the service organizations in which they are based, on how they think their experiences with service providers can be improved. These recommendations were provided during the interview and member check with participants. Service providers should:

1. Practice compassion and non-judgement and create affirming and empowering spaces for clients so that they feel valued, and their needs and concerns are also valued.
2. Understand and implement an Anti-Racism/Anti-Oppression framework into practice in order to better understand the realities of South Asians navigating in systems of oppression such as White Supremacy and Colonialism.
3. Be transparent about what they can and cannot help clients with, being clear about their own beliefs, values, and specialization.
4. Create a co-learning environment with the client and provide space for them to ask questions. It's okay to say: "I need to learn more and I'm willing to learn with you."

5. Recognize the intersection of identities that South Asian folks may have including disabilities, queerness, gender, and other complex identities and how this contributes to their experiences.
6. Explore different kinds of therapeutic supports with South Asians such as narrative therapies and brave spaces.
7. Practice cultural humility and cultural safety. Cultural humility involves recognizing their own positionality and biases and building active reflection into practice while cultural safety involves respectful engagement with clients where clients feel safe when receiving services (FNHA, n.d.)
8. Never leave a client empty handed. If it is not possible to take a client on, provide them with other resources they can access and take the time to learn about other service providers in your service network that may be a better fit for clients you are not able to support.

Limitations

Time constraints and undertaking the project during the COVID-19 pandemic, in particular during the Omicron variant wave, created various limitations regarding participant recruitment. Firstly, the extent to which Access Alliance was able to assist in the recruitment of participants was greatly limited and thus, potentially limited the ability to hear from service users from Access Alliance. As Access Alliance is an organization that focuses on assisting marginalized communities including the South Asian community, conversations with their service users may have yielded more information on ways to facilitate access to mental health services. Further, while the project attempted to explore the experiences of a diverse group of South Asian youth for the study, majority of participants were over 20 years old, women, and

born/raised in Canada. Time constraints for the project prevented more strategic approaches to recruit more South Asian men, younger youth and immigrant South Asians. Further, most of the participants were currently enrolled in or graduated from university. This sample may be privileged in ways that South Asian youth who do not have a university background are not. Next, the experiences of South Asians with intersecting identities and how this contributes to accessing mental health services was not extensively explored. Similarly, projects such as this invariably generalize the experiences of South Asians when in reality, the cultures, religions, and history of South Asians are heterogenous and may result in different experiences with mental health, service utilization, and stigma. Finally, the study eligibility requirement to speak English may have created barriers for newcomer/immigrant South Asians who may be experiencing mental health problems.

Knowledge Mobilization Plan

The long-term goal of this project, and any future studies, is to increase access to mental health services for members of the South Asian community by: 1) reducing mental health stigma and 2) tailoring mental health services to better fit the needs of South Asian individuals experiencing mental health problems. The current research project is the first step in exploring and identifying barriers to mental health services with this subgroup of South Asians. Findings can begin to inform service providers about the ways in which mental health services are not meeting the needs of South Asian youths so that alternative solutions that better align with these needs can be planned, funded, and implemented. In order to inform action, several knowledge mobilization approaches will be used including presenting in conferences, sharing community reports, sharing findings on social media, and publishing the findings in an academic journal.

Presentations. In working with Access Alliance, findings of the project will be presented to members of the organization. Audience members will include Access Alliance's network of service providers, community mental health researchers, and service users. The presentation will be an opportunity to share key findings including the recommendations shared by participants. Additionally, presenting findings in Community Psychology conferences as well as mental health and/or youth focused conferences hosted by non-profit organizations. This allows the dissemination of knowledge to researchers and mental health service providers.

Community Reports. In addition to presenting findings, two community reports highlighting the key points of the study have been created. One report highlights the findings related to barriers accessing mental health services among South Asian youth (Appendix D) while a second report focuses particularly on the experiences of South Asian youth during the pandemic (Appendix E). Creating two separate documents avoids having the reports become too long and allows for the distribution of this knowledge in different spaces. For example, in conferences or knowledge exchange events that focus specifically on the pandemic, the community report focused on the impacts of COVID-19 on South Asian youth is more relevant. The community reports will be shared with Access Alliance during the presentation. Additionally, the reports will be shared with the participants of the study.

Social Media. Social media can be a powerful tool to share information and has already proven to be helpful in participant recruitment for this study. Thus, it will be a useful space to share information about this project with South Asian youth and organizations focused on mental health, youth, and/or racialized communities. Key points from the background literature, results, and discussion including recommendations to service providers will be made into posts and

shared with other Instagram accounts following the submission of the thesis. Linking these posts to the community report will also allow for greater distribution of the report.

Published Paper. Finally, I intend to publish my findings in an academic journal. This project can further knowledge in the field of community mental health as it addresses the mental health concerns of a marginalized group and decenters Western conceptions of mental health. It is important that this kind of knowledge reaches an academic audience as it can be a driver towards more qualitative research with members of the South Asian community. Additionally, as mentioned in the Future Directions, the current findings of the project have suggested new avenues for research including further exploration of the mental health experiences of LGBTQ+ South Asian youth, university mental health supports, and remote mental health services.

Conclusion

While there is growing research and awareness on the mental health experiences of South Asian youth, the present study demonstrates that more still needs to be done. Findings suggest that South Asian youth are experiencing several barriers to accessing mental health services. In particular, the current findings suggest a need for increased diversity among service providers, creating supportive environments for clients, and addressing financial barriers and wait times as necessary steps to improve mental health supports. Additionally, mental health stigma from family members, the South Asian community, and health professionals such as family doctors can create additional barriers for South Asian youth to navigate. These findings present new avenues to explore in the context of research and program development in order to better meet the needs of this population.

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Appendices

Appendix A

LAURIER
Inspiring Lives.

Tell us your opinions on mental health services in Ontario

An Exploration on the Barriers to Accessing Mental Health Services Among South Asian Youth Project

This study is looking to recruit 25-30 **South Asian youth** who experience mental health problems to discuss their **attitudes and experiences regarding accessing mental health services** in the Greater Toronto Area. By bringing South Asian voices to the forefront of this project, we hope to address the barriers South Asians experience when accessing adequate mental health services in Ontario.

Who is eligible?

- Identify as South Asian
- 16-26 years old
- Self-reported mental health problems
- Reside in the Greater Toronto Area
- English speaking

What is involved?

- You will be invited to participate in a short demographic survey (5 minutes) and an interview (approximately 60-90 minutes) to discuss your mental health concerns, any experiences accessing mental health services, and changes in mental health as a result of the COVID-19 pandemic.
- This study is completely online and interviews will take place over Zoom.
- Your responses will be confidential.

You will be compensated with a $25 e-gift card for your expertise and time!

To register for the study, please email faru8240@mylaurier.ca
Oeishi Faruquzzaman, M.A. Student, Wilfrid Laurier University
Partner Organization: Access Alliance
REB #6971

Appendix B

WILFRID LAURIER UNIVERSITY

DEPARTMENT OF PSYCHOLOGY

Information Letter and Consent Form for Participant Studies

Study Title: An Exploration on the Barriers to Accessing Mental Health Services Among South Asian Youth

Principal Investigator: Oeishi Faruquzzaman, M.A. Student, Wilfrid Laurier University

Co-Investigator: Maritt Kirst, Faculty member, Wilfrid Laurier University

Community Partner: Access Alliance

WHAT IS THE STUDY AND WHY ARE WE DOING IT?

The purpose of this research is to investigate South Asian youths' experiences with accessing mental health services. Understanding the experiences of South Asians with mental health problems and whether or not they have accessed mental health services can serve as a method to critique and learn how to improve the current mental health system and empower members of the community by giving them a voice on an issue they have typically been excluded from. Potential participants will be those that (a) identify as South Asian, (b) 16-26 years old, (c) have self-reported mental health problems, (d) reside in the Greater Toronto Area, and (e) are English speaking. Approximately 25-30 participants will be recruited.

You are being invited to participate in this study through participation in an interview over Zoom. The interview will happen at a time that is convenient for you. Prior to the interview, we will be sending you a short online demographic survey. The survey will take approximately five minutes to complete. The study will last about 60-90 minutes. During the study, the researcher will ask you a number of questions about your life, including questions about your mental health, experiences accessing mental health services, and alcohol and substance use. We would also like to ask some questions about how you've been coping during the COVID-19 pandemic. Study questions will be given prior to the study. With your permission, the researcher will audio record the study. You will also be asked whether the Research Team can include anonymized quotes from your study in our final reports(s).

POTENTIAL RISKS

We do not believe that there will be any significant risks to your well-being by participating in this study. However, it is possible that if you have had a negative experience in your life, that you may become upset when asked to remember and discuss that experience. Experiencing negative feelings during the study is normal and should be temporary. If you continue to have negative feelings following the study, please inform the researchers and tell someone, such as a trusted friend/family member or service provider. Please remember that you can take a break, skip any questions you like, or stop the study at any time.

The researcher will send a list of available mental health resources following the study.

POTENTIAL BENEFITS

There may be some benefits from participating in this study. First of all, you may find it interesting to reflect back on your life and some of the experiences you have had regarding accessing mental health and services. We are conducting this research because we plan to use the information we collect to improve mental health services for South Asian youth. In the long run, we hope that your experiences will be useful in improving services for South Asian youth.

PROTECTING YOUR INFORMATION

Only the researchers of the study (listed at the top of the form) will have access to the information you provide during the study. The community partner, Access Alliance will not have access to any of the information you provide. Following the end of the study, Access Alliance will have access to the results of the study, however your participation in this study will not affect any service you may be receiving from Access Alliance.

Your responses to the study questions will be kept confidential. That is, your name will not be associated with anything you say during the study. **We will not tell anyone what you tell us unless we think someone might be hurt. If so and if possible, we will talk to you first about the best thing to do.** Electronic transcripts of the study will be identified by code number and stored securely on a webserver to protect the confidentiality of your responses. If you agree to let us quote you, they may be used in write-ups and/or presentations on this research; however, the quotes will not contain any information that would identify you to anyone reading them.

Study audio-files will be stored on the secure Wilfrid Laurier OneDrive. Only research team members will be able to access to the data. Audio files will be securely transferred to WLU and deleted once transferred. These files will then be stored securely on a secure drive at WLU, which is accessible only by members of the research team. The study audio recordings will be transcribed, following which they will be deleted. Five years after the study is finished (i.e., November 30th, 2027), we will destroy all identifiable information that we collect, including questionnaires, study transcripts, and digital recordings. We will securely store your contact information separately, and destroy any personal/contact information at the end of the study (i.e., November 30th, 2022).

Confidentiality of transcript cannot be guaranteed when transferred over the internet (e.g., email). Confidentiality cannot be guaranteed during Zoom sessions; however, researchers will follow Zoom best practices to help ensure participants' privacy and security. Zoom sessions will be by invite only. Once participants have joined the meeting, the researcher will lock the meeting in the security tab. Please note that Zoom sessions are hosted through data centers in Canada and United States only.

If you decide to withdraw, we will not keep your data in the study unless we have your permission.

WILL I BE COMPENSATED FOR BEING IN THIS STUDY?

There is no compensation offered for participating in the demographics survey. For participating in the interview, you will be compensated with a $25 electronic gift card (Starbucks, Amazon,

Tim Hortons, H&M, or Indigo) sent by email. You will be given reminders of this study through your email address. Participants who choose to withdraw from the interview will still receive the same amount of compensation. Additionally, if you are interested in participating in the optional member check-in, you will also be compensated with an additional $10 electronic gift card sent by email. Any compensation received related to participation in this research is taxable. It is the participant's responsibility to report the amount received for income tax purpose and Wilfrid Laurier University will not issue a tax receipt for the amount received.

PARTICIPATION AND WITHDRAWAL

Your participation in this study is completely voluntary and you have the right to decide that you do not want to take part in the research. If you withdraw from the study after the study, we will not transcribe any of your responses to the study. You have the right to withdraw your response to any question without penalty. You can stop the study at any time, and you will still receive compensation even if you don't answer all of the study questions. If you decide to stop the study or withdraw from the study at any time, your data will be destroyed.

WHO DO I SPEAK TO IF I HAVE ANY QUESTIONS OR CONCERNS?

If you have questions at any time about the study, procedures, compensation, or if you experience adverse effects as a result of participating in this study, you can contact the co-investigators, Oeishi Faruquzzaman by email at faru8240@mylaurier.ca and Maritt Kirst by email at mkirst@wlu.ca.

This project has been reviewed and approved by the Wilfrid Laurier University Research Ethics Board (REB #6971), which receives funding from the Research Support Fund. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Jayne Kalmar, PhD, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-0710, extension 3131, or REBChair@wlu.ca.

FEEDBACK AND PUBLICATION

Reviewing Transcript: Once a transcript of the interview has been created, it will be sent to you via email. You will have two weeks to review the transcript and make any changes you like. For example, you may want to clarify certain points or remove points you no longer feel comfortable sharing. If the Research Team does not receive a revised transcript after two weeks, we will use your transcript as it is.

Member Check-In: A summary of the results of this research will be discussed over a Zoom meeting after data collection is complete. This process will take 15-45 min to complete. The investigator will reach out to participants if they are interested in the member check in. Participants have the opportunity to provide feedback during this check-in. Participants in the member-check in will be compensated with a $10 electronic gift card sent by email.

Results from the study will be available by November 30th, 2022. Findings for this study will be used in the student researcher's (Oeishi Faruquzzaman) MA Thesis. Results will also be shared in a presentation and report to Access Alliance. Additionally, we plan to present the results of the

research at professional and scientific conferences and to publish the findings in professional and scientific journals. The results may be available through Open Access resources. Participants of the study will be sent a community report with the study results. Participants can also obtain a copy of the results through email by contacting Oeishi Faruquzzaman at faru8240@mylaurier.ca.

CONSENT TO PARTICIPATE

I, Click or tap here to enter text., understand that Wilfrid Laurier University is conducting a research study on the experiences of accessing mental health services for South Asian youth. I understand that I am being asked to participate in the study by participating in a semi-structured interview lasting 60-90 minutes and by completing the online demographic survey sent prior to the study. I understand that the study will be audio recorded, and that I can choose whether to be recorded or not.

I have been told the potential risks and benefits associated with my participation in this study. Any questions I have asked about the study have been answered to my satisfaction. I understand that my own participation is completely voluntary and that my decision to participate or not will be kept completely confidential. I further understand that I can withdraw from the study at any time without explanation or consequence.

I understand that information collected for this study is strictly confidential and that all data will be stored securely. I have been assured that no information will be released or printed that would disclose my identity unless required by law. All data will be destroyed (shredded or deleted) 5 years after the study if finished.

I am 16+ years of age and able to provide my own consent to participate. I have read the consent form and/or had the form read to me. I understand the information contained in the form. I have received a copy of the form for my records.

Please check the appropriate boxes:

☐ I have read and understand the above information and consent to participate.

☐ I voluntarily consent to be audio recorded, if necessary. If I do not consent to be audio recorded, the researcher will take written notes instead.

☐ I voluntarily consent to the Research Team using my de-identified quotations in any publications and presentations that result from this study. I will be sent my transcript after the interview by email and can make any changes I choose. Although I will not be provided with an opportunity to review my quotations, I trust that the Research Team will remove any information that could be used to personally identify me.

☐ Upon receiving my transcript, I understand that I have two weeks to review the transcript. If I do not provide any changes within the two weeks, the Research Team may use my transcript as is.

☐ I give permission to the researchers to contact me in the future to invite me to the member check.

Click or tap here to enter text. consents to participate

(Type participant name)

Demographic Survey

In order to better understand the experiences you will be sharing during the scheduled interview, we ask that you complete this demographic survey beforehand.

Do you self-identify as:

☐ Man

☐ Woman

☐ Trans-identified

☐ Gender queer

☐ Gender non-binary

☐ I prefer not to answer

☐ Prefer to self-identify: _____

How old are you?

_____

What South Asian ethnic group do you identify with?

_____

Were you born in Canada?

☐ Yes

☐ No

We thank you for your time spent taking this survey.

Your response has been recorded.

Appendix C

INTERVIEW GUIDE

AN EXPLORATION ON THE BARRIERS TO ACCESSING MENTAL HEALTH SERVICE AMONG SOUTH ASIAN YOUTH PROJECT

Introduction

This interview is an opportunity for you to tell the story about your experiences. I am interested in learning about your mental health and any experiences you have with accessing mental health services. This interview is an opportunity for you to share and discuss any positive or negative experiences you've had with your mental health journey using your own words. All of this will help us learn about the barriers that South Asian youth may be experiencing when accessing mental health services and help us understand what needs to be done to reduce these barriers in the future. For most people, it takes about 60-90 minutes, but how much time we take to do the interview is up to you. We can also take a break if you wish.

Just as a reminder, please be aware that your participation in the study is completely voluntary. You can decide not to participate, to withdraw your participation at any time, and to skip any questions that you do not wish to answer. You were sent these questions ahead of time and you may have found some of these questions sensitive. We will only proceed with the interview today if you're comfortable doing so. If you do have concerns or questions about resources or support, I will be able to provide you with information after the interview. I will hold everything that you say in confidence. Please note that your name will not be associated in any way with your responses.

Following the interview, you will have an opportunity to review your transcript once it has been created. This is optional and will not affect the compensation you receive for your participation. Additionally, once data analysis is complete, you will receive a summary of the findings in a second Zoom meeting if you decide to participate in the member check in. The member check in involves going over some of the key findings with you and receiving your feedback.

Finally, if you are comfortable, I will be recording this interview which will be destroyed after an anonymized transcript of the interview is created.

Do you have any questions before we get started? I'm going to start the recorder now – is that still okay with you?

Introduction

a. How are you doing today?
b. You mentioned that you are (a) born in Canada, did grow up in the GTA? (b) you moved to Canada, where did you move from?

Topic 1: Factors Contributing to Mental Health Problems

a. I want to first talk about your mental health, how would you describe your mental health right now and what would you say are your greatest concerns regarding your mental health? For example, issues with school, relationships or family.
b. Has COVID-19 affected your mental health? How so?
    a. Did you find the changes in restrictions made a difference in this process? For example, being in lockdown versus loosening restrictions?

Topic 2: Alcohol & Substance Use

a. Next, I want to ask about any potential alcohol or substance use – in the last 12 months, have you used alcohol or substances such as cigarettes or marijuana?
b. Under what circumstances are you using?
c. Have there been any changes in consumption since the start of the pandemic? Such as an increase or decrease in consumption.
    a. Can you tell more about what has lead to this change?
d. Do you consume alcohol or substances regularly? Such as monthly, weekly, daily?

Topic 3: Attitudes and Experiences with Mental Health Services

a. Next, I'd like to ask about mental health services, when you think about the types of mental health services available in Ontario, what comes to mind?
b. Have you ever sought out help for your mental health from a health professional, for example a family doctor, psychiatrist, or therapist?
    a. Did you feel like it met your needs? Could you say more?
    b. Were the services culturally appropriate for you? In other words, did you feel the services took into consideration your cultural identity? Please tell me more.
    c. Did you experience any barriers to seeking out the services? Please tell me more.
    d. Is there anything that would make your experience better?
    e. If no, did something stop you from seeking help?
c. Have you ever sought out support from non-professional mental health support groups such as a peer support group?
    a. What kind of non-professional mental health support was it?
    b. Did you find it helpful? Please tell me more.
    c. Did it meet your needs? Please tell me more.
    d. Did you experience any barriers to seeking out this support? Please tell me more.
    e. If no, did something stop you from seeking help? Please tell me more.
d. Have you ever sought out help for your mental health from a family member or friend?
    a. If yes, how was the experience? Did you find it helpful?
    b. If no, did something stop you from seeking help?
e. Has COVID-19 affected your ability to seek out mental health support?
f. What personal strategies do you use to help maintain your mental health?

Wrapping up

g. So, looking back at your experiences what do you think are key factors to improving access to mental health services for you?
h. Is there anything else you would like to share with me regarding your mental health journey?
a. As a part of this research project, I will be creating a few documents to share with community members and service providers. Do you have any recommendations on where you think the knowledge summarized through this project can create an impact to improve mental health supports for South Asian youth. For example, do you feel this I should focus on community members to address issues such as stigma or focus on sharing this information with services providers who can better tailor mental health supports for South Asian youth.

Conclusion

b. We are reaching the conclusion of this interview – how are you feeling right now?
c. I want to ask first, are you feeling distressed, or would you like to speak with anyone?
d. Thank you again for taking the time to participate in this study. If you would like, you can reach out to me again over email and I can help connect you with some of the resources in the resource sheet I will send following this interview.

(Provide resources sheet by email)

Thank you for participating!

Appendix D

AN EXPLORATION ON THE BARRIERS TO ACCESSING MENTAL HEALTH SERVICES AMONG SOUTH ASIAN YOUTH

Oeishi Faruquzzaman

MA Community Psychology, Wilfrid Laurier University

Introduction

Research shows that South Asians in Canada experience high levels of mental health problems (Karasz et al., 2016). However, South Asians often underutilize mental health services (Inman et al., 2014). Wait times, costs associated with services, and a lack of cultural awareness from service providers have been identified as barriers to effective mental health support for South Asians (Inman et al., 2014). The existing research focuses heavily on the experiences of South Asian adults with little research available on the experiences of South Asian youth and their experiences accessing mental health services (Islam et al., 2017). In order to address this gap, the current research project sought out to investigate the following questions:

- What are the experiences of South Asian youth with mental health problems of accessing mental health services in the Greater Toronto Area (GTA)?
- What are facilitators or barriers that have affected how South Asian youth are accessing mental health services?

To investigate these questions, we conducted interviews with 20 South Asian youth aged 16-27 living in the GTA about their experiences accessing mental health services. Overall, South Asian youth described three major themes regarding barriers to accessing mental health services.

A Lack of Diversity Among Service Providers

"Having someone that, you know, looks a little bit like you does help (008)"

Nearly all participants discussed a lack of diversity among the service providers they have met. Accessing mental health services that predominantly involved White service providers contributed to feelings that mental health services were not well equipped to assist South Asians. Participants described the burden of having to explain aspects of their culture to White service providers and accessing services that were not compatible with their South Asian lifestyle. Participants who identified as LGBTQ+ had trouble fully accessing therapeutic sessions because of difficulties in finding a service provider who was both queer friendly and able to provide an understanding of South Asian issues.

Difficulties building and maintaining a therapeutic relationship with service providers

"I think the hardest thing was to find someone … that was able to understand my concerns and just hear me out." (008)

Another major barrier discussed by participants in accessing mental health services is building rapport with service providers and being able to maintain a therapeutic relationship. Firstly, many

participants encountered negative experiences with service providers which they attributed to the service providers' lack of experience working with South Asian youth. Participants also faced additional barriers in acquiring regular sessions with service providers. Long wait times and the cost of services were commonly experienced by participants and discouraged service utilization.

Compounding Mental Health Stigma

"I'd rather just like not deal with, you know, this uncomfortability. I'd rather just like not go to therapy." (012)

Stigma was a prominent concern that all participants had to navigate, which had implications for service access. Participants discussed how discussions of mental health were often taboo within their household and within the South Asian community more generally. Based on the conversations with participants, there were three key areas where they experienced mental health stigma: family members, the South Asian community, and health professionals such as family doctors. For some participants, stigma deterred them from accessing services and for others, it created additional barriers to navigate when accessing services such as hiding medication or secrecy around service utilization.

Moving Forward

The current research findings highlight the systemic nature of the barriers experienced by South Asian youth who are accessing mental health services. Addressing issues around the Eurocentric nature of mental health services, wait times and costs associated with accessing mental health services, and the various levels of mental health stigma South Asian youth experience are key ways to improve access to effective mental health support for this population.

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Appendix E

IMPACT OF COVID-19 ON SOUTH ASIAN YOUTH EXPERIENCING MENTAL HEALTH PROBLEMS

Oeishi Faruquzzaman

MA Community Psychology, Wilfrid Laurier University

Introduction

Coronavirus disease (COVID-19) has disrupted the lives of everyone as it bears consequences beyond physical health with impacts on personal and social life, employment, school, and more. It is not surprising then that the pandemic has greatly impacted the mental health of Canadians as many indicate that their mental health has worsened since the start of the pandemic. A recent survey found that among other visible minorities, South Asians reported the highest prevalence of self-rated poor mental health and increased anxiety since the start of the pandemic (Moyser, 2021). Increased mental health problems among this population may be the result of increased exposure to the virus, isolation and anxiety, and increased conflict at home (Craig et al., 2022; Thobani & Butt, 2022). These issues may be particularly worse for South Asians who experience pre-existing mental health problems. In order to investigate this topic further, the current research project sought to explore the following questions:

- How has COVID-19 impacted the mental health of South Asian youth?
- Has the pandemic caused any changes to alcohol and substance use?
- How has COVID-19 changed how South Asian youth are accessing mental health services?

To investigate these questions, we conducted interviews with 20 South Asian youth aged 16-27 living in the Greater Toronto Area (GTA) about their experiences accessing mental health services. Overall, youth described how the pandemic impacted their mental health, substance use, and ability to access mental health services.

Adjusting to Life During the Pandemic

"… university was one of the places where I had a really big community, I have my chosen family. So being cut off from that and stuck at home was definitely detrimental to your mental health." (017)

Many participants felt that the pandemic had worsened their mental health. Firstly, the pandemic had disrupted many transitional life events for participants including working new jobs, starting university, and moving out of family homes. Additionally, due to lockdowns, participants discussed the increased friction that came from staying at home with family members more. As intergenerational conflict was often a source of mental health stress for participants, the pandemic created additional stress to navigate. Finally, many participants described an increased anxiety linked to the pandemic and other current events. Anxiety around the fear of testing positive for COVID-19 or family members testing positive, how long the pandemic will last,

and job loss as a result of the lockdowns were described by participants.

Increased Cannabis Use Since the Pandemic

"It was more just to have something to do because it was so like boring and like mundane just being at home in the summer." (018)

Participants who reported consuming cannabis reported an increase in cannabis consumption since the pandemic. Participants associated the increase in cannabis consumption with a number of factors including boredom during lockdowns, coping with anxiety and other mental health problems, and coping with work demands.

Lack of convenience of remote services

"I really didn't reach out to my therapist, because I know I would have to hold a session at home, and it wasn't a safe space (017)"

When discussing the impact of COVID-19 on participants' ability to access mental health services, many expressed increased difficulties associated with service utilization during the pandemic. While they appreciated the increased awareness of mental health during the pandemic, they did not feel that the supports offered were adequate to addressing their unique mental health concerns as a South Asian. Participants described difficulty accessing remote mental health services within their family home due to mental health stigma in the within the family and South Asian community. Most participants described parents being wary mental health services and disclosing mental health issues outside of the family. As a result, participants described having to be careful where they do their sessions or avoid mental health support altogether. Lastly, many remote mental health services did not meet participant's needs as there was limited interactions with a service provider and difficulties building rapport through remote services. Not building trust with their service provider can make it difficult discuss sensitive topics such as family and culture which participants described as being helpful for them.

Moving Forward

As Canada continues to recover from the COVID-19 pandemic, it is essential that mental health services become better equipped to serve South Asian youth. The participants in the current study discussed experiencing worsening mental health concerns since the pandemic as well as increased substance use. Further, the current state of remote mental health services do not seem to be meeting the needs of South Asian youth due to concerns of rapport building and a lack of space to discuss important issues such as a family and culture and thus, more work is needed to investigate the effectiveness of virtual/remote services for this population.

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