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Exploring Disparities in Access and Utilization of Mental Health Care Among South Asian Youth: A Mixed-Methods Study

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Exploring Disparities in Access and Utilization of Mental Health Care Among South Asian Youth: A Mixed-Methods Study

by

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Abstract

Background: Mental health plays a crucial role in overall wellbeing. The mental health of youth in earlier ages (i.e., 15 to 24-years-old) sets the foundation for their mental health later in life. Youth in Canada may experience delayed or even poor access to mental health care (MHC). Racialized youth may face a greater risk of mental health problems and face barriers to help-seeking. South Asian Canadians have a high proportion of unmet mental health needs but a low utilization of services. We sought to understand what disparities, if any, may exist in the patterns of access and utilization of MHC among South Asian youth.

Methods: A convergent mixed methods design was used. Phase I utilized the 2022 Mental Health and Access to Care Survey to conduct descriptive analyses. Phase II entailed a qualitative descriptive methodology with semi-structured interviews to understand experiences of South Asian youth with mental health and MHC. Phase II data was analysed using reflexive thematic analysis. Both phases were then integrated.

Results: Key findings from Phase I indicated that most South Asian youth turned to informal mental health support. Lower perceived needs may mediate the relationship between South Asian identity and the use of professional MHC. Findings from Phase II involved three larger themes which described mental health of South Asian youth in the local context: (1) *Cultural Factors Fostering Positive Mental Health*; (2) *Cultural Factors Promoting Negative Mental Health*; (3) *The Journey to Accessing Mental Health Supports*. Integration showed areas of convergence, divergence, and expansion.

Discussion: A reliance on support networks appeared to foster positive mental health. Factors that promoted mental wellbeing could contribute to a low perceived need for formal MHC services and mediate use of formal supports. Cultural factors such as stigma, gendered

expectations, pressures to excel, and disconnect with parents could be connected to the low utilization of MHC.

Conclusion: The findings from our mixed-methods study generated a comprehensive understanding of factors impacting access and use of MHC among South Asian youth so that we can support populations in a meaningful manner.

Keywords: South Asian youth, mental health, cultural safety, mixed methods.

Preface

Chapters 1, 2, and 3 of this thesis are the original, independent, and unpublished work by the author, J. Gill. This work was completed with guidance from the supervisor, A. Kassam, and the supervisory committee, B. Salami and S. Patten. The study presented in Chapter 2 was covered by ethical approval issued by the Conjoint Health Research Ethics Board (CHREB) (REB24-0488) for the project "Exploring Disparities in Access and Utilization of Mental Health Care Among South Asian Youth: A Mixed-Methods Study" on July 29th, 2024.

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Dedication

This thesis is dedicated to my family. Thank you to my parents, Dadi ji, and brother for always believing in my power to achieve whatever I set my mind and heart to. Thank you to my parents for supporting my dreams and efforts. Your journey, sacrifices, and hard work guide my every decision.

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Chapter 1

Introduction

This thesis aims to address mental health care access and utilization among South Asian youth from 15 to 24 years of age through a quantitative analysis of a cross-sectional nationwide dataset and interviews with 15 South Asian youth in the local context of Calgary, Alberta, Canada. In the first chapter, I will highlight the rationale of the study and why it is important to examine specific mental health needs within the South Asian community and then focus specifically on the youth population. This will be executed through a review on structures of mental health care faced by visible (ethnoracial) minorities in Canada, the complex nature of mental health, and an exploration of mental health among youth from the four largest visible minority groups in Canada. This chapter also contains a critical appraisal of what is known of South Asian mental health more broadly around the world, such as cultural norms and practices that may impact mental health. The second chapter will detail the main thesis research project: a mixed-methods study that examines mental health care access and utilization among South Asian youth. Each phase of the study (i.e., qualitative, quantitative, and integration) will be described within Chapter 2. This chapter will situate the findings within existing literature as well as detail the strengths and limitations of the study, implications, and future directions. Lastly, the third chapter will build upon the discussion from Chapter 2 to highlight future directions and proposed ways our findings could be mobilized within the community in a meaningful way.

Background

Mental health during youth (i.e., 12 to 25 years old) sets the foundation for mental health throughout the rest of one's life (Steinberg, 2017; Stewart et al., 2022). Seventy-five percent of mental disorders have an onset before the age of 25 and can have a potentially compounding

effect if left untreated (e.g., reduced life expectancy and increased risk of substance use) (Malla et al., 2018; Stewart et al., 2022). Inadequacies in mental health care support can be seen in delays (i.e., long wait times), youth disengagement, and difficulty in transitioning from child to adult-focused MHC services (Stewart et al., 2022). Racialized groups may face additional inadequacies seen in the lack of culturally responsive care and other social conditions (e.g., socioeconomic status (SES), discrimination) that can perpetuate inequities in existing MHC systems (Malla et al., 2018). Furthermore, there is a lack of mental health services that are accessible, sensitive to needs (e.g., cultural, social, financial, etc.), and evidence-informed (Canadian Mental Health Association, 2018; Stewart et al., 2022).

"Race" can be defined as a social construct which is used to categorize people based on perceived differences which serve to perpetuate social power differences (Canadian Race Relations Foundation 2016; Stanbrook & Salami, 2023). While, ethnicity can be defined as a characteristic associated with community, shared cultural group membership, and sociodemographic characteristics (e.g., language, religion, migration, geographic origin). Ethnoracial identity will be used to refer to a combination of race and ethnicity, illustrating that these are both social constructs and linked (Stanbrook & Salami, 2023). Similarly, for the purposes of this study, the term "racialized minorities" encompasses individuals from South Asian, Chinese, Filipino, Black, and other racialized groups because this term replaced the widely used term "visible minority" (Statistics Canada, 2021). However, when discussing findings for Phase I, the data source (2022 Mental Health Access to Care Survey, MHACS) uses the term "visible minorities". Note that these terms within the current study refer to the same groups.

Disparities, or differences, in the quality or access to care depending on ethnoracial identity frequent mental health services (Canadian Mental Health Association, 2018; McGuire & Miranda, 2008). These disparities can be seen in the interactions that racialized youth have with MHC in Canada (Health Canada, 2023). Identities (e.g., sex, gender) may contribute to differences in outcomes as well (Health Canada, 2023). Specifically, racialized youth comprise a growing demographic in Canada, yet they face challenges in MHC access. In 2021, 16.1% of the Canadian population fell into one of three racialized populations; 7.1% identify as South Asian, 4.7% as Chinese, and 4.3% as Black (Statistics Canada, 2022b). However, racialized youth in Canada may face systemic barriers (e.g., lack of representation, longer wait times, financial barriers) when accessing MHC (Chiu et al., 2018; Fante-Coleman & Jackson-Best, 2020; Gadalla, 2010; Islam et al., 2017). Despite comprising the largest racialized group in Canada, South Asians had the lowest odds of accessing MHC and face many barriers (Statistics Canada, 2023a). Broadly, South Asian populations have also had lower utilization of mental health care services in the United Kingdom (UK). Overall, this indicates a need for a deeper understanding of the patterns of mental health care access among racialized youth in Canada, particularly the South Asian demographic, which, despite its significant growth, exhibits a disproportionately low rate of service utilization (Gadalla, 2010).

Literature Review

A literature review was conducted using PubMed, PsycINFO, and Google Scholar. The search was initially limited to studies less than 10 years old (i.e., 2015) and then expanded to include more depth and breadth due to a paucity of literature. The search strategy used terms such as 'South Asian youth mental health,' 'racialized youth mental health,' and 'South Asian mental health' to identify relevant studies.

Health inequities can be described as disparities in health outcomes (e.g., mental health) or access to resources to support health (e.g., MHC) (World Health Organization, 2018). Inequities are defined as unfair health differences between groups based on the distribution of social determinants of health (SDOH) (Borras, 2021; Health Canada, 2017; Kelly et al., 2022). This can be contextualised within the current study to be defined as disparities in access or unfair, unequal, differences in access to MHC services (Canadian Mental Health Association, 2010). Further, the term "intersectionality" is used to describe how individual experiences with phenomena such as MHC may also be shaped by multiple intersecting identities (e.g., sex, ethnicity, age, socioeconomic status) within different contexts (Crenshaw, 1989; Delgado et al., 2023; Misra et al., 2020).

Mental health is a component of overall health and is especially important to consider in youth (Steinberg, 2017; Stewart et al., 2022; Wiens et al., 2020). Given that three quarters of mental disorders in youth occur before the age of 25, mental health problems start early in life and may have a compounding effect if left untreated (Halsall et al., 2019; Steinberg, 2017; Stewart et al., 2022). Irrespective of the high prevalence of mental health problems in youth in Canada, youth may continue to face poor or delayed access to MHC (Halsall et al., 2019; Moroz et al., 2020). This has consequences in terms of a potentially reduced life expectancy, an increased risk of substance use (e.g., smoking), lost productivity, and reduced quality of life (Halsall et al., 2019; Stewart et al., 2022). Thus, it is important to understand the broader contextual factors that may be influencing the delivery of mental health services, highlighting the rationale for this study.

Mental Health Care in Canada

Based on a study done by Wiens and colleagues, using eight cycles of the annual Canadian Community Health Survey (CCHS), there has been an overall increase in the proportion of youth aged 12 to 24 that are accessing mental health services across Canada (Wiens et al., 2020). Yet, there has also been a significant increase in the proportion of youth with poor/fair perceived mental health and an increase in professionally diagnosed mood and anxiety disorders (Wiens et al., 2020). Together, this illustrates both an increase in demand and utilization of MHC services across Canada. However, this does not provide a clear picture of individuals that may face barriers to MHC in Canada and whether services are able to support demand or meet needs of populations. Despite importance and demand of quality MHC services for youth, structures of services can create barriers (i.e., fragmentation, fee-for-service, lack of primary care) (Campbell et al., 2020; Gill et al., 2017; Moroz et al., 2020; Saunders et al., 2018).

There is a divide between child and adolescent mental health services and adult mental health services, which falls at the age of majority (i.e., 18-years-old in Alberta) (Mental Health Commission of Canada, 2017, 2021). Once youth pass this critical age, they must usually transition to adult services, but this is not a simple process. This fragmentation of services is problematic, complex to navigate, and limits the continuity of care for youth through prominent life transitions (e.g., adolescence to emerging adulthood) (Mental Health Commission of Canada, 2017; Tobon et al., 2015). The transition can cause disruptions, disengagement from services altogether, prolonged wait for support in adult MHC services, and diminished quality of the therapeutic relationship (Mental Health Commission of Canada, 2017). Furthermore, navigating youth mental health in Canada is complex.

Limited affordable access to MHC and privately funded MHC (i.e., outpatient services) disproportionately impact racialized youth (Bartram, 2019; Fante-Coleman & Jackson-Best, 2020; Salami et al., 2021). Further, low incomes and fee-for-service are associated with higher rates of contact with emergency departments (EDs), resulting in overcrowding of EDs (Moroz et al., 2020). This increased first contact for mental health services with EDs serves as an indicator of potential insufficiencies in outpatient services and overall poor access (Chiu et al., 2018; Gill et al., 2017; Saunders et al., 2018). Risks for first contact with EDs for mental health support include rurality, poor access to primary care, and cultural differences (Gill et al., 2017; Saunders et al., 2018).

A study examined the use of EDs as a first point of contact for mental health concerns among youth found poor access to primary care increased risk of accessing the ED for mental health support (Gill et al., 2017). This illustrates how a lack of adequate primary care support can contribute to a worsening of symptoms, which can result in youth showing up to EDs with more severe symptoms. This shows the value and role of primary care in managing the mental health of youth and populations. Further, cultural differences and aspects such as stigma can also shape help-seeking behaviours among youth in Canada (Campbell et al., 2020; Sheikhan et al., 2023).

Stigma from health providers such as minimization of symptoms and microaggressions against racialized youth can foster negative perceptions in youth regarding treatment, thus discouraging engagement with services (Campbell et al., 2020; Sheikhan et al., 2023). For clarification, microaggressions can be defined as subtle intentional or unintentional, and indirect nonverbal or verbal behaviours of discrimination (Sue et al., 2007). Similarly, immigrants and refugees have a higher risk of engaging with EDs for MHC (Campbell et al., 2020). This is more costly and can result in worse outcomes, which may be a result of cultural differences, a system

too complex for newcomers to navigate, pervasive stigma surrounding mental illness, and limited language proficiency (Campbell et al., 2020).

One study explored the predictors of the mental health of immigrant children from Hong Kong, People's Republic of China, and the Philippines children in Canada (Beiser et al., 2014). This study showed that parenting styles of immigrants can play a role in the mental health of youth, with the Chinese population showing harsher parenting practices. Cultural differences in parenting and how these influence experiences of youth are important to consider given Canada's diverse population. While this study was limited regarding the countries of origin they explored, it still offered insightful points of inquiry for other communities.

From 2001 to 2021, racialized (i.e., first, second, and third generation) populations in Canada increased by 130% (Statistics Canada, 2023b). Racialized populations in Canada include Arab, Black, Chinese, Filipino, Japanese, Korean, Latin American, Southeast Asian, South Asian, and West Asian groups (Statistics Canada, 2023b). To promote health equity, it is important to acknowledge and understand the rich diversity of identities in racialized populations to inform definitions of health and MHC in Canada thereby ensuring cultural safety (Mental Health Commission of Canada, 2021).

Cultural Safety

"C*ultural Safety*" within the context of care can be defined as care that aims to provide a space free of discrimination and racism (BC First Nations Health Authority, 2016; Public Health Agency of Canada, 2023). This was a concept first originated in the 1980s by Māori nurses as a response to the poor health experiences of the Indigenous population in New Zealand (Lokugamage et al., 2023; Wepa, 2015). As Canadians, understanding how the racism and discrimination faced by Indigenous populations has and continues to contribute to inequities

within healthcare is imperative (Public Health Agency of Canada, 2023). Care is not provided in a vacuum, rather it is provided within specific contexts. For example, colonization and its harmful legacies contribute to SDOH and inequities in health outcomes (Curtis et al., 2019). By acknowledging these historical harms, we can focus on creating patient-provider relationships that feel safe and validating. Focusing on experiences of patients, cultural safety aims to acknowledge and address power imbalances that are inherent to healthcare as an institution (BC First Nations Health Authority, 2016).

The use of cultural safety as a principle in healthcare allows us to further consider racism, discrimination, and power imbalances that may be experienced by racialized or visible minorities and how these play a role in the experiences that populations have when accessing or utilizing health care services (BC First Nations Health Authority, 2016; Bulle et al., 2023). Cultural safety is a process, engaging in "*cultural humility*", a self-reflective process to recognize on own biases and privileges (BC First Nations Health Authority, 2016; Curtis et al., 2019; Lokugamage et al., 2023; Polaschek, 1998). Through cultural humility, health care providers can create a respectful therapeutic relationship and build trust with patients. By acknowledging personal and/or systemic biases and being open to learning, it creates a mutually respectful relationship. This ultimately fosters a sense of safety for patients (Public Health Agency of Canada, 2023).

In discussions of cultural safety, it is important to acknowledge another term used is "*cultural competence*" (Public Health Agency of Canada, 2023). However, cultural competence does not focus on the safety that patients feel when engaging with the health care system and providers. Instead, it focuses on understanding cultures and specific values that can be incorporated into care at the level of individual healthcare providers. Cultural safety goes beyond recognizing specific knowledge to instead recognize systems, structures and context (e.g., power

imbalances) and biases, to focus on building therapeutic relationships in which patients feel safe and heard (BC First Nations Health Authority, 2016; Curtis et al., 2019; Polaschek, 1998; Public Health Agency of Canada, 2023). That being said, understanding cultural values and beliefs is still important in cultural safety (Curtis et al., 2019). Given the disparities and inequities faced by youth in terms of MHC, it is pertinent that we understand their experiences and use this to inform care that is culturally safe.

Racialized Youth and Their Mental Health

Racialized individuals face a greater risk of mental health problems and are more likely to experience mental health problems in a different manner (e.g., physical symptoms) (Saunders et al., 2018). Income, migration, social connectedness, discrimination, racism, education, social inclusion, and access to affordable health care services are all examples of SDOH (Government of Canada, 2020; World Health Organization, 2024). SDOH are factors that shape our day-to-day lives and the conditions in which people navigate the world (Government of Canada, 2020; Statistics Canada, 2023b; World Health Organization, 2024). To illustrate this in the context of mental health, low income is barrier to accessing MHC services, but immigrant racialized minorities may be more likely to feel financial limitations (Government of Canada, 2020). Different racialized minorities have different backgrounds (i.e., immigrants, gender identities, culture, parenting, etc.) that may shape variation in patterns of access and utilization of MHC services (Beiser et al., 2014; Chiu et al., 2018; Fante-Coleman et al., 2024; Islam et al., 2017; Sato et al., 2022). Considering cultural safety involves a recognition of how power imbalances and privileges of certain populations result in disadvantage among some groups, it must be emphasized when having conversations about health inequities (Curtis et al., 2019; Polaschek, 1998).

Racialized people are an equity-denied group, facing systemic barriers and corresponding inequities in terms of access to resources such as MHC (Government of Canada, 2024b). Considering intersectionality allows for nuanced understandings of how different identities produce varying experiences with MHC (Salami et al., 2022). Origins of intersectionality stem from Critical Race Theory (CRT), thus it is critical to discuss CRT when explaining intersectionality (Crenshaw, 1989; Delgado et al., 2023; Graham, 2011).

Critical Race Theory (CRT)

CRT, originating in legal studies, emphasizes the role of racism on racialized minorities (Delgado et al., 2023; Graham, 2011; Snyder & Mohammed, 2024). CRT posits that race is ultimately socially constructed and determines the allocation of critical resources such as health care; thus, it focuses on how racism and discrimination could be contributing to racial disparities (Graham, 2011; Snyder & Mohammed, 2024). Within CRT, there is an emphasis placed on how race and racism shape the experiences of racial and ethnic minorities with certain phenomena (Graham, 2011; Snyder & Mohammed, 2024). There are four overarching themes within CRT which emphasize the following: 1) racism is always present; 2) there should be an emphasis on narratives and voices in order to shine light on lived experiences to decenter "whiteness"; 3) intersectionality should be addressed as a part of CRT indicates that individuals are multifaceted and the impact of oppression can occur from a combination of "isms" (e.g., sexism, racism, etc.); 4) research and policy should focus on racialized individuals and drift away from colourblind approaches aiming to benefit everyone (Graham, 2011; Snyder & Mohammed, 2024).

Structural determinism describes that health injustices and inequities may be felt as a result of existing systems or structures being embedded with racism and discrimination (Graham, 2011; Snyder & Mohammed, 2024). Further, when conducting research and examining health

inequities is important to consider the impact of race, but also the compounding effect of multiple oppressed identities (e.g., gender, sexuality, religion, immigration status, etc.) (Graham, 2011; Snyder & Mohammed, 2024). Thus, it is crucial that when talking about inequities in access and utilization patterns of MHC, we think intersectionally and give voice to racialized youth to understand multifaceted experiences due to compounding effects of the intersection of multiple oppressed identities (e.g., gender, sexuality, religion, immigration, etc.) (Graham, 2011; Snyder & Mohammed, 2024).

Intersectionality and Mental Health

Originating from CRT and critical legal studies, intersectionality considers how other aspects of identity such as gender, sex, ethnicity, age, SES, and disability (e.g., mental illness) may be overlapping and intersecting to produce an "intersectional experience" (Crenshaw, 1989, 1991). The term "intersectionality" as described in 1989 by Kimberle Crenshaw illustrated how race and gender interacted to produce a compounding effect (Crenshaw, 1989). The impact of identities cannot be assessed individually (Crenshaw, 1989). Intersectionality indicates that the intersection of identities is not merely a sum, but rather a multidimensional effect that may burden some individuals more than others (Crenshaw, 1989). It provides consideration of how identities may interact within social structure and systems to sustain experiences of disadvantage (Crenshaw, 1989, 1991; Misra et al., 2020). Similarly, intersectionality should be addressed with an understanding that experiences of inequality are complex and identities are connected and difficult to untangle (Crenshaw, 1991; Misra et al., 2020).

Central to this discussion of intersectionality is the idea of power and oppression, power manifests in different ways and is linked to identities (e.g., race, class, gender) (Misra et al., 2020). The experiences one has with social structures (e.g., policies, practices) are shaped by a

"matrix of domination", as stated by Patricia Hill Collins (Misra et al., 2020). This "matrix of domination" is a power hierarchy that illustrates oppression in a society (Misra et al., 2020). The goal of intersectional research is thus to empower those who may be disadvantaged and recognize how multiple socially constructed dimensions may interact (Crenshaw, 1991).

The privileges of one group, may link to the oppression and disadvantage of another, making some categories invisible (Misra et al., 2020). To elucidate this, it is beneficial to step out of binary categorizations (Misra et al., 2020). To illustrate this, we can consider Two Spirit, lesbian, gay, bisexual, transgender, queer/questioning, intersex, and additional people who identify as a part of sexual and gender diverse communities (2SLGBTQI+) (Canadian Mental Health Association, 2023). Existing literature suggests that individuals in Canada between the ages of 15 to 24 years identifying as young women, non-binary young adults, or 2SLGBTQ+, are more likely to report that they are struggling with their mental health (Canadian Mental Health Association, 2023; Kingsbury & Findlay, 2024). Similarly, Black and Latinx transgender youth experienced higher rates of mental health problem symptoms than cisgender Black and Latinx youth (Vance et al., 2021). Adding layers of identities (e.g., transgender, racialized) produce a differential vulnerability (Crenshaw, 1989). Also, experiences of sexual and gender minorities (SGM) in Canada with racist, homophobic, or transphobic providers reduces the likelihood of SGMs accessing MHC services (Wells, 2024). Whereas social and community connectedness supported the mental health of racialized SGMs (Wells, 2024).

Irrespectively, there remains a dearth of research examining mental health, as well as access and utilization of services from an intersectional lens (e.g., ethnicity, SES, gender). Further, different racialized minorities have different cultural backgrounds that may shape differences in perceptions of mental health, outcomes, as well as barriers and facilitators to

access or use of MHC services (Fante-Coleman et al., 2024; Gao, 2021; Islam et al., 2023). Utilizing an intersectional approach, can allow us to understand disparities and how this varies between different stratifying identities (e.g., gender and race), not just between White and racialized populations. Comparisons across multiple racialized groups in MHC access and utilization allow us to capture unique cultural and socioeconomic factors influencing mental health, ensuring equitable treatment, and prevent oversimplification of experiences. To contextualize this, we must consider how experiences may be shaped by barriers specific to racialized groups (e.g., Anti-Black Racism).

Black Youth and Mental Health

Anti-Black Racism (ABR) can be defined as practices (e.g., MHC) that reinforce prejudice, beliefs, stereotyping, discrimination, and/or attitudes directed towards individuals of Black-African descent (Black Health Alliance, 2018; Canadian Race Relations Foundation 2016). ABR was one of the most frequently reported factors in contributing negatively to Black youth mental health (Fante-Coleman et al., 2023; Salami et al., 2022). A lack of provider understanding of ABR or culture leaves Black youth explaining these concepts, limiting adequacy and ability of services to meet mental health needs of Black youth (Fante-Coleman et al., 2023). Mistrust, fear of misinterpretation, lack of provider cultural awareness or acknowledgement of racism are associated with frustration and disengagement from mental health services (Fante-Coleman & Jackson-Best, 2020; Fante-Coleman et al., 2023). Further, racism, gaps between generations, stigma, high academic expectations, lack of identity, financial stress, and traumatic events were found to be negative contributing factors to the mental health of Black youth in Canada (Salami et al., 2022).

Fear of being misunderstood or disregarded by parents may prevent Black youth from accessing support or voicing their concerns (Salami et al., 2022). This goes hand in hand with the stigma associated with mental health services, clinics labelled as "evil" (Salami et al., 2022). Stigma delays or discourages help-seeking, perhaps worsening mental health issues (Salami et al., 2022). Further, being a Black man was found to be a factor contributing to poor mental health, this is seen in the notion of masculinity and bias that Black men are "thugs" (Salami et al., 2022). This illustrates how overlapping and intersecting identities of race and gender may interact to produce differential experiences. Black youth may also avoid seeking MHC due to long wait times, poor access to Black mental health professionals, financial barriers to care, and limited access to services in low-income communities (Fante-Coleman & Jackson-Best, 2020). On the other hand, normalized conversation about mental health, sense of community support, and spirituality all fostered mental health among Black youth (Fante-Coleman & Jackson-Best, 2020).

Religiosity has been found to be both a barrier and facilitator to access and utilization of MHC for Black youth (Fante-Coleman et al., 2024). Mental illness has often been labelled as a lack of faith, being evil, being cursed, or presence of Jinn (i.e., Islamic folklore) (Fante-Coleman et al., 2024; Salami et al., 2022). In addition to the exclusion faced in faith-based spaces, Black 2SLGBTQ+ youth had their mental health concerns dismissed and attributed to their identity as 2SLGBTQ+ (Fante-Coleman et al., 2024). On the other hand, religious organizations (i.e., Churches or Mosques) provided referrals to MHC services and provided a space for positive social support, which has been found to be a positive contributing factor to mental health (Fante-Coleman et al., 2024; Salami et al., 2022). This illustrates the intersectionality of race (i.e., Black), sex- and gender-based identities, and religion as it relates to mental health of Black

youth. Furthermore, religiosity, ABR, being male, identifying as 2SLGBTQ+, SES, provider characteristics, financial barriers, geographic barriers, stigma, and structural problems all contribute to Black youth and their access and utilization of MHC in Canada.

Chinese Youth and Mental Health

Discrimination, linguistic barriers, limited knowledge about MHC in Canada, and stigma are some common barriers to MHC among Chinese immigrants (Gao, 2021). Low use of MHC among Chinese individuals may also indicate a cultural preference for traditional Chinese or alternative medicine perhaps due to mental illness being attributed to evil spirits or other spiritual/cultural origins (Chiu et al., 2018; Gao, 2021). Chinese immigrants suffering from mental health concerns often report them as somatic symptoms, which may go unaddressed by Western methods (i.e., individualistic standards of symptomology, instead of holistic) (Gao, 2021). The term "Western" referred to conceptualizations of mental health or illness in Europe, North America, and Australia/New Zealand (Krendl & Pescosolido, 2020). There is a dearth of research surrounding mental health as well as access and utilization of MHC services among Chinese youth, much of this research is older than 10 years. Gaps include a lack of comparisons to other racialized minorities to examine patterns and differences in the way multiple intersecting identities shape MHC access and utilization patterns in Canada. Further, Asian men, which includes Chinese, South Asian, Filipino, and Korean men, have been found to indicate that mental health problems or illness hinder their ability to uphold a standard of masculinity, resulting in self-stigma (Livingston et al., 2018). This is an example of how Asian men may experience and approach mental health differently than other men from other ethnocultural identities (Livingston et al., 2018). However, this has not been widely studied and of note is the diversity within people who identify as Asian (i.e., South Asian, Chinese, Filipino).

A study examined the predictors of the mental health of immigrant children in Canada (Beiser et al., 2014). They examined immigrant families from Hong Kong, the People's Republic of China, and the Philippines. They found that parenting of Chinese youth was associated with an increase in emotional problems among youth. They indicated that Chinese parents often followed a more disciplinarian parenting style, which was harsher than other Asian cultures (e.g., Hong Kong, Filipino). Overall, their findings described that poor parental mental health may be a risk factor for youth mental health. Cultural differences, even within Asian cultures contribute to differential findings in terms of mental health of youth. This has implications on recognizing and exploring the diversity within labels such as "Asian", given the differences seen between immigrant families from the People's Republic of China, Hong Kong, and the Philippines.

Filipino Youth and Mental Health

As of 2023, the Filipino population comprises the fourth largest visible minority group in Canada (Statistics Canada, 2023b). While recognizing this, discussions of Filipino youth and their mental health should contextualize experiences such as immigration to provide a broader picture. It should however be noted that limited studies explore experiences of youth, focusing mostly on adults.

A study conducted in Norway on Filipina immigrants aimed to explore help-seeking for mental health problems (Straiton et al., 2018). They found that a reluctance to seek mental health support was associated with stigma and fears of their behaviours impacting their family reputation. Alternative care or medicine was also indicated to be used due to higher costs of other care and a lack of familiarity with general practitioners or need to decide where to put their money (i.e., mental health care or supporting family back home). Causes of mental illness often attributed to biological aspects, evil spirits, and others. There was limited distinction between

physiological and psychological aspects, and participants indicated a holistic definition for mental wellbeing (i.e., mental, physical, and spiritual).

A study conducted in Canada using a population-based dataset with Southeast Asian, including Filipino immigrant youth, found that recent immigration was associated with higher odds of despair (Hilario et al., 2014). Whereas, they found that family and cultural connections appeared to play a protective role in despair experienced by Southeast Asian youth (Hilario et al., 2014). Further, a systematic review found that Filipino individuals often rely on family and friends for mental health support, which could influence professional or formal help-seeking behaviours (Martinez et al., 2020).

A qualitative study conducted in with Filipino-Canadian men explored cultural perspectives on mental health (Sato et al., 2022). They found that often men who were born outside of Canada (i.e., in the Philippines) had a harder time defining their mental health. They also found that participants associated being mentally ill with the notion that there is something wrong with you or your family. Further, stigma prevented discourse on mental health and hindered help-seeking behaviours. Stigma and gendered expectations of conduct shaped the experiences of Filipino men, such that they were afraid of being labelled as weak.

Filipino youth mental health and help-seeking behaviours appear to be influenced by stigma, gendered expectations, and factors such as their definition of mental health (i.e., attributing to supernatural causes) (Martinez et al., 2020; Sato et al., 2022; Straiton et al., 2018). Stigma and shame around fear of what the Filipino community will think, as well as fear of social exclusion, deterred help-seeking behaviours (Martinez et al., 2020; Sato et al., 2022; Straiton et al., 2018). This stigma at times also manifested in the form of self-stigma, such that Filipino individuals broadly labelled mental illness as a sign of weakness, experienced fears of

being a burden, and felt shame or embarrassment (Martinez et al., 2020). Factors such as increased spirituality and ethnic group belonging were associated with increased wellbeing of and a sense of comfort. Furthermore, there are a variety of factors that influence help-seeking behaviours of Filipino individuals.

The South Asian Diaspora

South Asian individuals living outside of countries of origin can be defined as the "South Asian diaspora" (Rangaswamy, 2005). Countries of origin can be identified as India, Pakistan, Sri Lanka, Nepal, Bhutan, the Maldives, Afghanistan, and Bangladesh (Gee et al., 2023; Kallivayalil et al., 2020; Rangaswamy, 2005). However, we see that the South Asian Diaspora is spread across many countries such as the United Republic of Tanzania, UK, Uganda, and Fiji. The South Asian community is incredibly diverse in terms of ethnic, religious, lingual, and immigration identities (Tran, 2005). For example, ethnicities amongst South Asian populations include Kashmiri, Punjabi, Pakistani, Indian, Tamil, Sinhalese, Bangladeshi, Bengali, Gujarati, and others (Rangaswamy, 2005; Tran, 2005).

British colonial legacies and relationships between the UK and South Asia have resulted in a larger presence of the South Asian diaspora in the UK (Rangaswamy, 2005). After slavery was abolished in British colonies, many Indian labourers were exploited (Rangaswamy, 2005). Specifically, in addition to the detrimental impacts of colonization on the Punjabi community (i.e., impoverished), they continued to faced discrimination when they migrated or tried to migrate to North America (e.g., Komagata Maru) (Rangaswamy, 2005). In 1914, due to intentionally exclusionary regulations set by the Canadian government, only immigrants who had continuous passage from their point of origin to the destination would be accepted into Canada (Johnston, 2024). Given that the continuous journey regulation had been overruled before for

another ship (i.e., Panama Maru), the Komagata Maru set sail on a continuous journey with Punjabi Sikh, Muslim, and Hindu passengers immigrating from Hong Kong to Canada (Johnston, 2024). However, the government adjusted these discriminatory regulations three months before the departure of the Komagata Maru to avoid the issue they had with the Panama Maru (Johnston, 2024). Ultimately, these regulations intended to keep South Asian migrants out of Canada and the passengers of the Komagata Maru were forced to return to pre-independence India (i.e., British colony), where upon arrival many were killed (Government of Canada, 2024a; Johnston, 2024; Rangaswamy, 2005). After independence from the British, many South Asians migrated to various counties such as Uganda (Rangaswamy, 2005). Later, there was an increase of migration to Canada and the United States of America (USA) (Rangaswamy, 2005). It is crucial to recognize that the South Asian diaspora continued to face discrimination in the countries to which they migrated or tried to migrate to. Anti-Asian (e.g., islamophobia) hate and rhetoric continues to fuel this racism and isolation for many South Asian immigrants in Canada, shaping their experiences (Government of Canada, 2024a). Such rhetoric can contribute to stress, isolation and negative impact on mental health among South Asian populations (Kallivayalil et al., 2020). A recognition of historical and present-day experiences of the South Asian diaspora helps us contextualize the dispersion of South Asian individuals across the world.

Mental Health of the South Asian Diaspora

Given the description of dispersion of South Asian individuals across the world, much of the literature on mental health of the South Asian diaspora is from regions such as the UK and the USA.

A systematic review from the UK explored experiences of South Asian individuals that accessed mental health services found that often a general lack of awareness of mental health as

well as resources available posed as a barrier to help-seeking (Prajapati & Liebling, 2022). Similarly, the review also found that often a general lack of awareness of mental health as well as resources available posed as a barrier to help-seeking. Further, South Asian individuals often indicated family was their predominant form of support for their mental health. A reluctance to seek help was also noted, it was indicated this could be due to fear of consequences (e.g., labelling/stigma). Gendered differences in terms of expression were also described, such that men often conformed to notions of masculinity (i.e., limited expression of emotion). Conceptualization of "*izzat*" (i.e., honour in Punjabi/Urdu/Hindi) permeated help-seeking behaviours as seeking MHC had implications on the reputation of families within the community.

A focus group study done in Derby, UK, discussed how the concept of izzat among South Asian women can control help-seeking behaviours, contributing to feelings of shame and fears of seeking help (Gilbert et al., 2004). Similarly, a qualitative discourse analysis was conducted in the UK to examine the concept of "*sharam*" (i.e., shame in Punjabi/Urdu/Hindi) and izzat as it pertains to the mental health of South Asian girls aged 13 to 14-years-old (Sangar & Howe, 2021). This study found that sharam can regulate help-seeking behaviour in order to maintain izzat of the family. This concept of sharam is gendered, wherein there may be an overprotection of females and women of families due to the notion that izzat of families is upheld by the conformity of women to cultural norms. This is also evident in the patriarchal nature of South Asian families.

The concept of izzat serves as a form of control in social settings over South Asian women and sharam serves as a hindrance to the maintenance of izzat in South Asian communities (Gill, 2009). While keeping in mind the diversity within the South Asian

population (e.g., ethnicity, language, religion, etc.), we should recognize that these concepts are not limited to any specific South Asian subgroup, rather they are prevalent among many subgroups in South Asia (Gill & Brah, 2014; Rangaswamy, 2005; Tran, 2005).

A study conducted in the USA with national surveys examined the mental health of South Asian Americans (Masood et al., 2009). They found that women experienced greater distress, wherein familial stressors accounted for most of this distress. Lower social position (i.e., status in community), higher financial stressors, and family conflict were associated with higher distress among men. Further, they found that gendered differences in terms of anxiety among South Asian American men and women were not significant over a 12-month or longer period (i.e., lifetime). South Asian men and women experience differences in gendered pressures, which then may play a role in the differences seen in stressors contributing to distress. They also found that positive mental health among South Asian families in the USA is associated with coping with support from family (i.e., immediate and extended) (Masood et al., 2009).

A qualitative study done in the USA on South Asian women aged 18 to 30-years-old aimed to explore the stigmatization of mental health as a barrier to eating disorder treatment. (Goel et al., 2023). They found that stigma promotes silence among South Asian women as well as a fear of judgement (Goel et al., 2023). This is relevant when considering notions of izzat and sharam, as they influence the extent to which women of South Asian families can express their mental health and seek help without feeling shame (Gilbert et al., 2004; Goel et al., 2023; Sangar & Howe, 2021).

A review study conducted in the USA, aimed to focus on the experiences of South Asian individuals surrounding mental health (Karasz et al., 2019). They described how somatization, feeling physical symptoms for mental health concerns, may be more prevalent within the South

Asian community. This has implications on help-seeking behaviours, as they may present to their primary care provider with physical symptoms for mental health concerns. They also mentioned how other factors such as gender norms or religion may mediate what MHC services that South Asian youth access. This review also described the stressors associated with immigration (i.e., acculturation) and the harmful effect it can have on mental health.

The aforementioned study also explored notions of the implications that family dynamics (e.g., collectivist families) have on other aspects such as distribution of power, gender norms, patriarchal norms, and notions of obedience are emphasized (Karasz et al., 2019). This is similar to the concepts of izzat and sharam that we saw from the UK studies, illustrating a patriarchal structure that influences help-seeking behaviours due to restrictions on what behaviours are considered acceptable (Gilbert et al., 2004; Karasz et al., 2019; Prajapati & Liebling, 2022; Sangar & Howe, 2021). A study conducted using surveys in the USA also found that South Asian cultural norms focus on and emphasize keeping mental health within the family. They indicated this was associated with seeking help from family members instead of perhaps professional support (Leung et al., 2012).

South Asian Youth and Mental Health in Canada

Comprising the largest racialized group, the South Asian group saw the biggest increase in population in Canada from 2016 to 2021 (Statistics Canada, 2023a). Irrespective of this, when compared to other racialized groups, South Asians had the lowest odds of accessing MHC in Canada perhaps due to the many barriers they face (Gadalla, 2010; Islam et al., 2023). In Ontario specifically, a lack of culturally responsive or sensitive care, stigma, fragmentation between services, and long wait times are some of the structural barriers hindering South Asian youth from accessing and utilizing MHC (Islam et al., 2017). High parental expectations, migration,

and “shadeism” (i.e., discrimination based on skin colour within own racialized group) contribute to mental health issues within South Asian youth (Islam et al., 2023). Parental fear of community finding out their child is accessing MHC has varied effects based on gender: fear of their daughters not finding a good husband, fear of their sons not finding a good job (Islam et al., 2023). South Asian men face pressures of toxic masculinity, which perpetuates unhealthy coping (e.g., substance use) and hinders help-seeking behaviours (Islam et al., 2023). Furthermore, this shows a difference in South Asian youth experiences while navigating MHC and mental health problems based on gendered expectations from parents (i.e., men versus women).

A qualitative study done in the Peel region in Ontario by Islam and colleagues (2017) found that differences between culture of origin and Western/Canadian culture is often a root cause of conflict between South Asian youth and their parents. This conflict appears to stem from migration and acculturation. Lack of mental health education, limitations in adequacy of services, lack of representation in service providers, financial barriers, and limited models of care (i.e., Western, medicalized) were identified to be barriers in accessing MHC for South Asian youth. A major barrier reported by South Asian youth accessing MHC is stigma; fear of what others in the community might say or think (Islam et al., 2017).

Islam and colleagues (2017) also found that intergenerational conflict was a major stressor for mental health. Intergenerational conflict can be described as the clash between an individual’s values and those of their elders, especially in contexts of first or second-generation immigrants. This conflict intensified when youth were faced with pressures from parents to conform to community expectations of achievement in academics. Similarly, they highlighted that newcomers and immigrant populations in Canada face additional acculturation stressors (e.g., language barriers). The South Asian community has so much diversity within it as well.

For instance, Punjabi youth may differentially experience cultural pressure regarding substance use. In addition to this, they found systemic (e.g., long wait times, financial burdens, westernized models of care) and family/community-level barriers (e.g., stigma) to South Asian youth accessing MHC. In terms of religiosity, youth indicated that religious leaders of their community/subgroup would have a lot of influence on the way their parents approached mental health and MHC. Further, they also found that South Asian youth in the Peel region in Ontario were not familiar with culturally specific resources that exist to support them. This study examined barriers to MHC and highlighted some unmet needs of South Asian youth (e.g., education, culturally responsive care).

There is still limited research on the experiences of South Asian youth with MHC in Canada. South Asian Canadians have a high proportion of unmet mental health needs but a low utilization of services (Gadalla, 2010; Naeem et al., 2024). Similarly, South Asian Canadians delay help-seeking because of stigma, which is associated with then accessing MHC in a hospital setting (Chiu et al., 2018). The range of diversity within South Asian youth has not been addressed, this can include the cultural, religious and spiritual diversity of subgroups (e.g., Pakistani, Punjabi-Sikh, Muslim, etc.) and how this may influence help-seeking behaviours among youth. Furthermore, even though literature on Black, Chinese, Filipino, and South Asian youth in relation to their experiences with MHC are increasing there are still many gaps that need to be addressed.

Summary of Gaps in Literature

The body of research on mental health concerns and MHC for Black, Chinese, and South Asian youth presents significant gaps. First, existing literature on mental health and MHC for Black, Chinese, Filipino, and South Asian youth is limited and even more so regarding

intersectionality (Wells, 2024). There has been some research into how Black youth experience MHC and mental health concerns as it pertains to their racialized identity interacting with 2SLGBTQ+ identity (Vance et al., 2021). Research specifically examining these has not been conducted within the Canadian context with Chinese, Filipino, or South Asian youth. Critical to note, the intersection of 2SLGBTQ+ identity with racialized identity could compound effects of disparities in access to MHC (e.g., exclusion contributing to isolation, stigma) (Ortiz & Costigan, 2022; Vance et al., 2021). Similarly, with limited discussion of men's mental health, gender was only briefly touched upon in instances of toxic masculinity or cultural pressures (e.g., pressure for South Asian women to get married) (Islam et al., 2023; Masood et al., 2009; Salami et al., 2022; Sangar & Howe, 2021). Gaining a deeper understanding of the intersection of these identities is crucial in being inclusive in our research regarding barriers and facilitators to MHC for racialized youth, this is because the interconnections may compound to produce inequities (Black Health Alliance, 2018; Statistics Canada, 2023b).

Second, the role of religiosity and spirituality and how they impact mental health remains unclear. For example, religiosity and spirituality were both barriers and facilitators in mental health and accessing MHC for Black youth (Fante-Coleman & Jackson-Best, 2020; Fante-Coleman et al., 2023; Salami et al., 2022). Spirituality was only superficially discussed as a potential barrier (e.g., mental health problems entail evil spirits) for accessing MHC among Chinese and Filipino groups but was not addressed in South Asian groups (Chiu et al., 2018; Gao, 2021; Martinez et al., 2020; Ortiz & Costigan, 2022; Straiton et al., 2018). Taking an intersectional approach to see how religiosity/spirituality intersect with other identities (i.e., race) to create varying experiences with MHC could provide a much more nuanced understanding of the needs of racialized minority youth. Further, even though South Asian subgroups contain a

diversity of religious/spiritual beliefs (e.g., Punjabi-Sikh, Pakistani-Muslim) there were limited discussions on the influence of spirituality and religiosity on mental health and access/utilization of MHC for South Asian youth (Islam et al., 2017).

Last, the effects of colonization and corresponding considerations in interventions have been discussed for Black and Filipino youth, but not for South Asian youth (Ticar & Edwards, 2022). It is important to recognize the impacts of colonization, but should not assume it has the same effect on all (Ticar & Edwards, 2022). Despite colonization and associated harms or historical traumas experienced by the South Asian diaspora, there has been limited research on the impact of colonization on their mental health (Qureshi et al., 2023). Further, migration status was not clearly discussed in the literature (i.e., first-generation versus second-generation immigrants). Although Islam and colleagues (2017) touched upon intergenerational conflict and acculturation and the harms for South Asian populations, there was limited insight regarding MHC utilization differences in the generation status of immigrants.

For the purposes of the proposed study, these gaps in the literature and the increasing demographic of the South Asian community illustrated a need to quantify and examine patterns of access/utilization of MHC (e.g., type of support needed, type of support accessed, met/unmet mental health needs) among South Asian youth. Comparison across different racialized minority groups as they appear to face similar but different levels of access and utilization depending on many factors (e.g., religiosity, SES, stigma) is warranted. A comparison would identify patterns of use of MHC across Canada providing a foundation for deeper inquiries on factors specific to racialized communities. For example, within the City of Calgary, in the 2021 census, almost 11% of the population identified as South Asian, and this proportion only continues to grow (Statistics Canada, 2022a). Similarly, 26% of the racialized minority (i.e., visible minority) population in

Calgary identifies as South Asian (Statistics Canada, 2022a). Altogether, this highlights the importance of addressing the concerns of a growing demographic across both Canada and the local context and form the rationale for the thesis project (study) in Chapter 2. Next is described the research question, hypotheses and overview of the methods used for the study in Chapter 2.

Research Question and Hypotheses

The research question for the study was: *What disparities, if any, and patterns exist in the access and utilization of MHC for South Asian youth*? The quantitative component examined a population-based dataset to examine trends in South Asian youth MHC access and utilization across Canada while comparing Black, Chinese, and Filipino youth. The qualitative component aimed to understand patterns and experiences regarding access and utilization of MHC among South Asian youth depending on subgroup identification (e.g., religion, culture, spirituality, gender, immigration status) within the local context. The study presented in Chapter 2 describes patterns and potential disparities/inequities surrounding MHC access/utilization of South Asian youth across Canada and within the local context. The use of descriptive intersectional methods within Phase I (e.g., regression with analysis of interaction) and exploring varying identities in addition to being South Asian (e.g., gender, immigration) in Phase II (i.e., sharing positionality) allows an intersectional lens, as well as the background being informed by CRT and intersectionality (Bauer et al., 2021; Zhang et al., 2021).

Based on existing literature, we hypothesized that there will be disparities present regarding access and utilization of MHC for Black, Chinese, Filipino and South Asian youth. Literature indicated that spirituality/religion as well as immigration status can influence help-seeking behaviours and utilization patterns of MHC, thus we hypothesized that spirituality and immigration status will both play a role in access and utilization patterns of MHC among South

Asian youth (Islam et al., 2017; Islam et al., 2023). These research questions, objectives, and hypotheses were addressed through the mixed methods study design.

Objectives

This mixed-methods study was comprised of two phases; (I) Quantitative Component; (II) Qualitative Component (see Appendix A).

Phase 1: Cross-sectional Analysis of 2022 Mental Health and Access to Care Survey (MHACS) National Data (Statistics Canada, 2024)

- Examine patterns of MHC access and utilization (e.g., provider type, reasons for disengagement with services, unmet/met perceived needs) among South Asian youth across Canada.
- Examine patterns of MHC access and utilization among South Asian youth as it pertains to intersecting aspects and identities such as spirituality, immigration, and gender.
- Describe patterns of MHC access and utilization (e.g., provider type, disengagement with services, unmet/met perceived needs) between South Asian, Black, Chinese, Filipino, and referent group youth.

Phase 2: Semi-Structured Interviews with South Asian Youth

- Understand patterns of access and utilization of MHC (e.g., types of support accessed, provider type, unmet mental health needs) among South Asian youth.
- Understand experiences with mental health and MHC access/utilization for South Asian youth in relation to gender, religion/spirituality, and immigration status.

A convergent mixed-methods design was used to address the objectives. The study is described in Chapter 2.

Chapter 2

The Study

This chapter will discuss the study entitled: *Exploring Disparities in Access and Utilization of Mental health Care Among South Asian Youth: A Mixed-Methods Study*

Introduction

Youth mental health during the ages of 15 to 25 sets the foundation for their mental health for the rest of their life, highlighting the importance of this developmental period (Steinberg, 2017; Stewart et al., 2022; Wiens et al., 2020). There is a high prevalence of mental health problems among youth in Canada and they also face poor or even delayed access to MHC (Halsall et al., 2019; Moroz et al., 2020). Although there has been an increase in the proportion of youth from the ages of 12 to 24 that access mental health services across Canada, there is limited insight on whether services are sufficient to meet needs of youth (Wiens et al., 2020). Further, poor access to primary care has been associated with an increased risk of youth accessing EDs for their mental health concerns (Gill et al., 2017). This not only highlights the gaps seen without connection of youth to primary care, but also the value of primary care in managing the mental health of youth. However, it is important to consider that racialized populations can face additional barriers as it pertains to accessing professional MHC services.

From 2001 to 2021, racialized populations in Canada increased by 130% (Statistics Canada, 2023b). To provide responsive MHC, it is crucial to understand how our services can best address the needs of a growing population in Canada. Racialized individuals face a greater risk of mental health problems and are more likely to experience mental health problems in a different manner (e.g., physical symptoms) (Saunders et al., 2018). Different racialized minorities have different backgrounds (i.e., immigrants, gender identities, culture, parenting,

etc.) that may shape patterns of access and utilization of MHC services (Beiser et al., 2014; Chiu et al., 2018; Fante-Coleman et al., 2024; Islam et al., 2017; Sato et al., 2022).

CRT places an emphasis on how race and racism shape the experiences of racial and ethnic minorities with phenomena such as mental health (Graham, 2011; Snyder & Mohammed, 2024). Originating from CRT, intersectionality entails the examination of how identity factors such as gender, ethnicity, age, and disability (e.g., mental illness) may be overlapping and intersecting to produce experiences that youth have with MHC (Crenshaw, 1989, 1991).

The largest racialized population in Canada is the South Asian community (Statistics Canada, 2023a). Irrespective of this, when compared to other racialized groups, South Asians had the lowest odds of accessing MHC in Canada (Gadalla, 2010; Islam et al., 2023). The "South Asian diaspora" is defined as South Asian individuals living outside of countries of origin, which include India, Pakistan, Sri Lanka, Nepal, Bhutan, the Maldives, Afghanistan, and Bangladesh (Gee et al., 2023; Kallivayalil et al., 2020; Rangaswamy, 2005). Despite the low use of MHC among South Asian youth and a growing South Asian population, there is limited research on the experiences of South Asian youth with MHC in Canada. Specifically, there is a paucity of research in understanding the mental health needs of South Asian youth and how facets of their identity (e.g., immigration status, gender) may influence access and use of MHC.

To better support our increasing South Asian youth population, we aimed to explore disparities and patterns in the access and utilization of MHC among South Asian youth through a mixed-methods study. The research question for the study was: *what disparities, if any, and patterns exist in the access and utilization of MHC for South Asian youth*?

Mixed Methods: Pragmatism as a Paradigm

An overarching pragmatic research paradigm was applied as a mixed-methods approach is pragmatic by nature (Allemang et al., 2022). Using multiple sources of information to study a real-world occurrence is inherently pragmatic. Pragmatism indicates that reality is negotiated based on context and knowledge is constructed based on interactions that individuals have with other people and their surrounding environment (Allemang et al., 2022). The quantitative phase quantified potential patterns and disparities faced by South Asian youth, then compared it to other racialized minority youth (i.e., Black, Chinese, Filipino youth) and White or other non-visible minority youth. The qualitative phase provided an in-depth understanding of South Asian youth and their access/utilization of MHC. The focus on South Asian youth as opposed to all four racialized groups (i.e., Black, Chinese, Filipino, and South Asian) in the qualitative component was due in part to the scope of master's level thesis. This allowed for a deeper understanding of experiences with MHC and addressed the real-world problem of low service utilization and unmet mental health needs in South Asian youth while contextualizing it within experiences of other racialized minorities. The qualitative component of the study was informed by a paradigm of critical theory and utilized qualitative description as a methodology.

Phase II: Qualitative Phase

Critical Theory and Intersectionality

Critical theory, as a paradigm for Phase II, suggests that reality is shaped by values (Denzin, 2018). These values could be social, political, ethnic, cultural, and gender values. Epistemologically, critical theory aims to understand and challenge oppressive social structures, specifically the struggle for power and the balance between privilege and oppression (Denzin, 2018). Typical research utilizing critical theory involves examination of questions that question

existing systems of oppression (Denzin, 2018). Utilizing a critical theory paradigm for Phase II allowed us to emphasize how experiences of privilege and oppression with institutions and systems can be shaped by factors such as race/ethnicity or sexuality (Denzin, 2018). Phase II placed an emphasis on how South Asian identity but also specific subgroup identification can shape experiences of youth, potentially contributing to inaccessibility of MHC due to factors of race/ethnicity or culture. Critical theory, as a paradigm, allowed for research with multiple methods and forms of outcome data, which made it a fit for the current mixed-methods study (Denzin, 2018). An emphasis was placed on production of pragmatic knowledge, that can be applied to the field to change social institutions and empower the community (Denzin, 2018). This is congruent with the mixed-methods and overarching pragmatic nature of the study. Similarly, CRT emerged from critical legal studies and CRT is the application of critical theory to understand the role that race may play in the power structures (Delgado et al., 2023).

Intersectionality suggests that the intersection of identities and interactions within broader social structures is crucial to understanding how experiences of disadvantage are sustained (Crenshaw, 1989, 1991; Misra et al., 2020). Intersectionality emerged from CRT and legal studies, illustrating that socially constructed dimensions of identity interact to produce systems of oppression (Crenshaw, 1989; Misra et al., 2020). These interactions impact the experiences that individuals may have with social structures such as MHC. Taken in conjunction critical theory, CRT and intersectionality have the aim to understand and challenge oppressive structures to empower participants who may be disadvantaged and oppressed based on socially constructed dimensions such as race (Crenshaw, 1991; Denzin, 2018; Misra et al., 2020). In order to do so, we must understand details of interactions that participants have with MHC and the details shaping these experiences.

Methodology: Qualitative Description

Qualitative description (QD) research aims to summarize descriptive details of experiences (e.g., when, who, what, where) (Colorafi & Evans, 2016; Doyle et al., 2020; Sandelowski, 2000). This aligned with the goal of the study, which was to examine and understand experiences of South Asian youth with MHC. MHC is a structure in place and access to it can be impacted by multiple identities (e.g., race, gender, sexuality, immigration status). The research question aligned with ideals of critical theory as a paradigm and the use of intersectionality as a lens, it aimed to address the complexity of identities and how they can contribute to advantage or disadvantage when accessing and/or using MHC among South Asian youth. This allowed for an examination of how race and other identities shape interactions one has with MHC and potential health disparities due to this. Further, QD also allowed the use of interpretative theories and conceptual frameworks to view the data (Colorafi & Evans, 2016). QD is congruent with a pragmatic paradigm, as it is frequently utilized in mixed-methods research (Doyle et al., 2020).

For the purposes of this study, reflexive thematic analysis was utilized as a method for QD. Reflexive thematic analysis for QD has dimensions of description and interpretation but remains more inductive (data-driven) (Vaismoradi et al., 2013). Reflexive thematic analysis is theoretically flexible and is a method of data analysis that is not limited to specific frameworks, so that it can allow for integration of CRT and intersectionality (Braun & Clarke, 2021c; Denzin, 2018). Reflexive thematic analysis proposes that subjectivity is important and since you cannot remove the researcher from the process, it is crucial to be reflexive. (Braun & Clarke, 2021a, 2021c) This is further discussed in the methods.

Methods

A concurrent sequential mixed-methods design (see Appendix A) was employed in this study; a mixed-methods methodological approach in data collection for both phases occurred simultaneously (Creswell & Plano Clark, 2018). In this study, the mixed-methods design allows for a deeper understanding of the quantifiable mental health disparities as well as an integration of voice from lived experiences of South Asian youth. Data for Phase I was accessed through the public use microdata file (PUMF) provided by Statistics Canada (Statistics Canada, 2024). The MHACS questionnaire was used to inform generation of an interview guide (see Appendix B). Following analysis of both phases, integration occurred to combine results from both phases.

Phase I: Cross-Sectional Analysis of 2022 Mental Health and Access to Care Survey (MHACS)

Data Collection

The MHACS 2022 was a voluntary survey which aimed to obtain information on mental health of Canadians as well as access to or need for formal and informal mental health services and supports (Statistics Canada, 2024). It was conducted using Internet-Based Electronic Questionnaires from March 17 to July 31, 2022. A total of 9,861 valid responses were obtained. The questionnaire was reviewed by Statistic Canada's Questionnaire Design Resource Centre (Statistics Canada, 2024). Under legislation (the Statistic Act), processes are in place to ensure that data cannot be linked to a specific individual. The PUMF meets security and confidentiality standards set by the aforementioned legislation prior to release. Given that the PUMF was developed using the master files, variables that could potentially identify an individual were deleted or moved into broader categories (Statistics Canada, 2024).

The survey frame consisted of respondents to the 2021 long-form Census of the Canadian population 15-years-old and older, living in the ten provinces. The survey excluded responses from persons living on reserves or aboriginal settlements, persons in collective dwellings (e.g., institutional residences), those who immigrated to Canada after May 11, 2021, and those who are full-time members of the Canadian Forces (Statistics Canada, 2024). Excluded populations represent around less than 2.5% of the target population (Statistics Canada, 2024).

The survey design aimed to oversample from the four largest visible minority groups in Canada; South Asian, Black, Chinese, and Filipino populations (Statistics Canada, 2024). The MHACS 2022 was of cross-sectional design and had a stratified simple random sample. Within the MHACS, there was an oversampling of people from visible minority groups to ensure that there is enough data to conduct subgroup analyses (Statistics Canada, 2024).

It should be noted that to protect individual identities, a two-category gender variable was utilized (Statistics Canada, 2024). Data aggregation into this two-category variable was to protect confidentiality, especially given that certain genders may have smaller populations. The first category was “women+”, which it includes women (and girls), as well as non-binary persons. The second category was “men+” which includes men (and boys), as well as non-binary persons (Statistics Canada, 2024).

Data Analysis

The software utilized to conduct data analyses was Stata 18 (version 18.5, StataCorp LLC, College Station, TX, USA). Data analysis for Phase I was conducted from November 2024 to January 2025. Given the exploratory objectives of the study, a series of descriptive parameters were estimated. This included proportions and odds ratios with 95% confidence intervals (CIs). Comparisons in intersectional research allow for understanding of differences, but also hidden

similarities (Canadian Mental Health Association, 2018). Special considerations were given to sex, gender, and migration status using interaction terms in weighted logistic regression models where possible, given sample size constraints.

For estimates to be representative, survey weights were included in calculations. These weights correspond to a certain number of people that are represented by this respondent. The weights also include adjustments for non-response. Bootstrap weights (i.e., 1,000 sets of weights generated, a set of a weight per respondent) were used within the MHACS design to generate valid estimates of parameters (Statistics Canada, 2024). The bootstrapping procedure was incorporated into the analysis along with the Fay adjustment factor of 0.67, as recommended, to produce estimates (Statistics Canada, 2024). The current study utilized Balanced Repeated Replication (BRR) weights, which produces similar estimates to bootstrap weights (Statistics Canada, 2024).

Referent Group for Analysis. The choice of non-visible minorities and other minorities, and as the referent was based on preliminary analyses. The author (JG) wanted to ensure that the designation of the reference group was meaningful, intentional, and did not arbitrarily center "Whiteness" (Braveman, 2006; Elliott et al., 2022; Kauh et al., 2021). When other visible minorities (Arab, Latin American, Southeast Asian, West Asian, Korean, Japanese, and visible minority) were included in preliminary results for understanding disparities in accessing professional mental health services and other outcomes, it appeared they did not significantly differ from the non-visible minority referent group. Further, preliminary analyses indicated potential advantage in terms of mental health access or utilization among White, non-visible minorities, and other visible minorities. Therefore, the comparator or referent group has been

kept as White or non-visible minorities and other visible minorities. Our findings still allow for a descriptive comparison of the South Asian population with other racialized groups.

Quantitative Rigor

The following quantitative components for rigor will be considered in bolstering the quantitative rigour and credibility of the current study:

1. ***Validity:*** This component includes both internal and external validity (Creswell & Plano Clark, 2018). Validity overall refers to the quality of the work (Noble & Smith, 2015). Internal validity is the quality of the data, this entails details on the MHACS survey itself. The MHACS survey was derived from the 2012 CCHS and qualitative testing was done on the questions (Statistics Canada, 2023c). External validity is the generalizability of findings (Creswell & Plano Clark, 2018; Noble & Smith, 2015). The external validity can be impacted by the sampling, in the case of the MHACS 2022 data adjustments in the sampling designs and use of weights ensures that estimates made are generalizable and representative of the national population (Statistics Canada, 2023c).
2. ***Reliability:*** This component can be defined as the consistency of procedures and consideration of potential biases (Noble & Smith, 2015). The MHACS 2022 data obtained has a sample size that is sufficient to produce reliable estimates (Statistics Canada, 2023c). The guidelines provided by Statistics Canada also ensure reliability of results disseminated and produced, this includes the use of weights and bootstrapping methods.

Phase II: Qualitative Description (QD) of Interviews with South Asian Youth

Participant Recruitment

Purposive, convenience sampling was used to recruit South Asian youth. Recruitment entailed placement of physical and digital posters (see Appendix C). Inclusion criteria included South Asian youth between the ages of 15 and 24-years-old who were open to sharing their experiences with mental health and mental health care. Recruitment started in mid-September 2024 and ceased mid-November 2024. Posters and recruitment material utilized a QR code that linked to a Qualtrics survey (see Appendix D). Initial emails were sent to the 117 participants that completed the Qualtrics survey. Every participant, excluding those who responded to the initial email, were sent two follow up emails, each one week apart. A total of 15 individuals replied to recruitment emails and participated in the interviews. Each participant was presented with a $25 gift card as honorarium.

South Asian Diaspora. Recruitment for South Asian youth was kept broad to account for the diversity in the South Asian diaspora (see Appendix D). For purposes of the present study, we took a broad approach to South Asian identification and allowed for youth to label themselves as they chose. This was implemented so that we could account for the dispersion of the South Asian diaspora across the world and to obtain a deeper understanding of their journeys.

Data Collection

For Phase II, Semi-structured interviews consisted of open-ended questions with a positive focus. The interview guide was compiled based on questions used in 2022 MHACS (see Appendix B). This allowed for a direct mapping of questions to generate a more nuanced understanding from the interviews. Further, 15 interviews were conducted virtually by the author (JG). The average interview length was 32 minutes. The shortest and longest interviews were 17

and 49 minutes long, respectively. The interviews were recorded and transcribed verbatim. All identifying information was removed from transcripts. Participants were assigned an ID ranging from 1 to 15.

Data analysis was carried out by two independent coders, JG and AK, in NVivo. This was an iterative process. Member checking was conducted using transcripts to ensure that transcripts accurately reflected descriptions of youth's experiences with mental health and mental health care. This form of member checking is useful when confirming factual information of events and experiences (Birt et al., 2016). Given use of a QD methodology, it is crucial to ensure that details around events and experiences reflect participant accounts. For the purposes of our study, both the author (JG) and supervisor (AK) were not outsiders and shared South Asian identity with participants. Reflexivity on positioning of the author (JG) is further discussed in the reflexivity section. Being insiders offered a lens to the research which was similar to that of the participants. Due to this insider position, as well as the descriptive purpose of the study, the transcript verification method for member checking was employed (Birt et al., 2016; Braun & Clarke, 2023; Motulsky, 2021). Four participants did not respond to the member checking, four made changes and adjustments to the transcript, and seven sent emails indicating agreement with the transcript content.

Data Analysis

Themes can be defined as general patterns of meaning within the data, while subthemes are enveloped under themes and focus on specific details of a theme (Braun & Clarke, 2021c). Thematic analysis allows for identification and analysis of themes or patterns across interview data collected (Braun & Clarke, 2006; Braun & Clarke, 2021c). Reflexive thematic analysis, as proposed by Braun and Clarke can be theoretically flexible (Braun & Clarke, 2013). Theoretical

underpinnings for the current study included CRT and intersectionality. Theoretical underpinnings taken in conjunction with the study design allow a deeper understanding of how experiences are shaped by power, resulting in privilege and disadvantage based on interactions of identities such as race (Delgado et al., 2023).

Both deductive and inductive analyses were used for theme generation, allowing for examination of underlying ideas and meaning directly from data and informed by theories (i.e., CRT and intersectionality) (Braun & Clarke, 2021b). For the purpose of this study, a mainly inductive approach was taken to ensure that codes and themes were grounded in the data through direct linking to quotes (Braun & Clarke, 2021b). The deductive approach was taken as phenomena do not occur in a vacuum and neither does the analysis; theories such as CRT and intersectionality provide explanations for the role of race and identities in creating diverse experiences with systems such as MHC (Crenshaw, 1991; Delgado et al., 2023; Misra et al., 2020; Snyder & Mohammed, 2024). Reflexive thematic analysis allowed for a descriptive account of experiences that South Asian youth have with access and utilization of MHC, along with any barriers/facilitators to that experience.

There are six steps in Braun & Clarke's framework for reflexive thematic analysis: (1) Familiarization with data; (2) Generation of initial codes; (3) Initial themes; (4) Developing and reviewing themes generated; (5) Defining, refining, and naming themes; (6) Producing written product (Braun & Clarke, 2006; Braun & Clarke, 2021c). Coding was semantic, depended on the questions of interest in the interview guide, and aimed to describe participant experiences (Braun & Clarke, 2021c).

A secondary coder (AK) independently reviewed the data alongside the author (JG). The goal with having multiple coders was not to obtain consensus, but rather to obtain diverse, rich

and nuanced insights about the data (Braun & Clarke, 2021c). Following discussion, JG engaged in theme generation and presented findings to the supervisory committee (BS and SP). The supervisory committee (BS and SP) reviewed transcripts and consulted on preliminary themes and subthemes. A thematic map of themes and subthemes to give an overview of results was constructed and revised through author (JG) and supervisor (AK) discussions. This thematic map also included a discussion of relationships between subthemes. A committee member, (BS), provided edits to themes and definitions.

Reflexivity

This reflexivity statement is a part of understanding that as a researcher, I (JG), am part of the research process; it is inherent to the process of reflexive thematic analysis (Braun & Clarke, 2021c). Due to the nature of this study and the focus on intersectionality, it is crucial that I clarify my position within systems or structures of power (Kelly et al., 2022; Misra et al., 2020; Public Health Agency of Canada, 2022). Identifying as a youth from the South Asian population, I remain be aware of any assumptions or preconceived notions based on my own lived experiences with MHC in Canada during the interviews. Specifically, I am second-generation Canadian and also identify as Punjabi-Sikh. This makes me an insider researcher, or a member of the community that is being studied (Braun & Clarke, 2021c). However, for some youth such as those who identify as any gender other than women, I may be an outsider. I may also be an outsider to those not pursuing graduate or undergraduate-level education. Thus, this highlights a need for reflexivity, subjectivity is not bad, rather is a tool that serves as a resource during the research process (Braun & Clarke, 2021c). My undergraduate background was in Psychology, and I am regularly involved with South Asian youth mental health organizations in Calgary, Alberta. Given this, my identity and previous experience as both an insider and outsider to

participants, provides an opportunity for reflection. As per the reflexive thematic process, I kept a reflexivity journal to document the thoughts that stood out to me during or after interview. This journal included some reflections during both the data collection and analysis process: notes after interviews, after coding, and any other thoughts (Braun & Clarke, 2021c).

Ethical Considerations for Phase II

Ethical approval was obtained from the Conjoint Health Research Ethics Board (CHREB) (REB24-0488). Participants in Phase II were fully informed about the study, including any risks (e.g., psychological distress) and benefits prior to participation. Given that participants were above the age of 14, consent was gathered from youth using a decision-making capacity approach. If participants understood the risks and benefits of the study, as well as an understanding of the study, then this indicated decision-making capacity (Government of Canada, 2018). If participants under the age of majority exhibited decision-making capacity, consent forms were obtained. Forms stated that any participation in this project is voluntary, and the participant could withdraw at any point. Steps were taken to anonymize results and ensure individual identity was protected in Phase II. Any specific identifying information was removed. Data derived from the interviews was kept on an institutional server. Further, towards the end of interviews, mental health resources and information on support were provided if needed.

Qualitative Rigor

To enhance the credibility of this qualitative research, the semi-structured interviews were recorded to allow for revisiting of data (Noble & Smith, 2015). Other aspects of qualitative rigor were followed (see Appendix E). Rich and thick verbatim extracts used from the transcripts allow readers to understand if themes align with actual accounts from participants. Member

checking (respondent validation) in the form of sending participants a cleaned transcript was utilized to ensure it accurately reflects answers (Birt et al., 2016).

Phase I: Quantitative Results

The demographics of participants after restricting age from 15-years-old to 24-years-old are indicated in Table 1. A total of 2,047 participants were included, after restricting the age.

Table 1

Demographic Characteristics of the Population Studied under MHACS in 2022

Demographic variables	Unweighted (n)	Weighted (%)	95% CI
All Participants (15-24 years old)	2,047	-	-
Gender			
Men+	1,021	51.50	[51.21, 51.80]
Women+	1,022	48.50	[48.20, 48.80]
LGBTQ2+	277	16.42	[14.45, 18.59]
Immigrant	710	21.97	[20.27, 23.76]
0-9 years ago	365	50.33	[45.78, 54.87]
Greater than 9 years ago	345	49.67	[45.13, 54.22]
Black	227	5.93	[5.76, 6.12]
Gender			
Men+	93	48.94	[47.43, 50.46]
Women+	133	51.06	[49.54, 52.57]
2SLGBTQ+	20	8.30	[5.12, 13.18]
Immigrant	129	51.18	[44.09, 58.22]
0-9 years ago	78	61.50	[52.12, 70.10]
Greater than 9 years ago	51	38.50	[29.90, 47.88]
Chinese	306	5.16	[5.04, 5.27]
Gender			
Men+	144	49.82	[48.90, 50.74]
Women+	161	50.18	[49.26, 51.10]
LGBTQ2+	44	15.12	[11.10, 20.26]
Immigrant	158	49.49	[43.63, 55.37]
0-9 years ago	78	49.49	[41.83, 57.18]
Greater than 9 years ago	80	50.51	[42.82, 58.17]

Filipino	196	3.52	[3.43, 3.62]
Gender			
Men+	102	50.66	[49.43, 51.90]
Women+	94	49.34	[48.10, 50.57]
LGBTQ2+	26	12.80	[08.80, 18.27]
Immigrant	133	65.99	[59.25, 72.15]
0-9 years ago	71	54.86	[46.00, 63.41]
Greater than 9 years ago	62	45.14	[36.59, 54.00]
South Asian	256	9.42	[9.14, 9.71]
Gender			
Men+	129	54.20	[52.53, 55.86]
Women+	126	45.80	[44.14, 47.47]
LGBTQ2+	18	6.34	[4.07, 9.74]
Immigrant	131	49.43	[43.30, 55.59]
0-9 years ago	75	57.17	[48.55, 65.37]
Greater than 9 years ago	56	42.83	[34.63, 51.45]
Not a Visible Minority	794	65.30	[63.50, 67.05]
Gender			
Men+	374	52.54	[51.12, 53.96]
Women+	419	47.46	[46.04, 48.88]
LGBTQ2+	148	19.83	[17.02, 23.00]
Immigrant	57	6.25	[4.81, 8.09]
0-9 years ago	20	31.76	[20.80, 45.20]
Greater than 9 years ago	37	68.24	[54.80, 79.21]

Note. Weighted estimates (i.e., weighted proportion, confidence interval) were scaled to percentages. Additionally, note the lack of an explicit category for other gender identities outside of "man+" or "woman+". Totals may not add up to the specified "n" for each column due to missing data and/or suppressed cell counts.

Objective 1: Examine patterns of MHC access and utilization (e.g., provider type, reasons for disengagement with services, unmet/met perceived needs) among South Asian youth across Canada.

Proportions for nonprofessional and professional supports accessed by South Asian and non-South Asian youth are reported in Table 2. As seen in Table 2, out of all types of supports, South Asian youth more frequently accessed their friends for support (29.81%; 95% CI [24.57,

35.65]). The professional support reported to be accessed the least by South Asian youth were psychiatrists (4.85%, 95% CI [2.80, 8.28]). Overall, 15.86% of South Asian youth accessed professional services (n = 44 (unweighted); 95% CI [11.95, 20.74]). Further, 8.62% of South Asian youth utilized other health products (e.g., herbs, minerals, homeopathic medicine) for their mental health in the past 12 months (n = 23 (unweighted); 95% CI [5.79, 12.66]).

Table 2

Professional and Nonprofessional Supports Accessed by South Asian and Non-South Asian Youth

Support Type Accessed	Unweighted (n)	Weighted (%)	95% CI
South Asian Youth			
Family Doctor	23	8.40	[5.62, 12.36]
Psychiatrist	14	4.85	[2.80, 8.28]
Nurses and Allied Health	27	9.61	[6.64, 13.72]
Friend	80	29.81	[24.57, 35.65]
Family	44	16.81	[12.61, 22.06]
Coworker/Boss	11	3.73	[2.12, 6.51]
General Youth Population			
Family Doctor	194	12.71	[10.95, 14.70]
Psychiatrist	76	5.08	[3.95, 6.49]
Nurses and Allied Health	246	16.09	[14.05, 18.36]
Friend	455	26.41	[23.98, 29.00]
Family	366	23.57	[21.26, 26.05]
Coworker/Boss	73	5.09	[3.92, 6.58]

Note. Weighted estimates (i.e., weighted proportion, confidence interval) were scaled to percentages. Please note that we aggregated nurses and allied health providers (i.e., social workers/counsellors and psychologists) due to low cell count.

The majority of South Asian youth indicated that their overall perceived mental health needs over the past 12 months were met, either entirely or partially (74.53%, 95% CI [62.86, 83.50]). Out of the South Asian youth that received support in the form of information, medication, and counselling over the past 12 months, 61.02% (n = 34 (unweighted), 95% CI

[47.28, 73.21]) indicated that they felt they received as much help as they needed. Exploration of which providers South Asian youth may have stopped seeing and why, were inconclusive due to limitations of data (i.e., low cell counts).

Objective 2: Examine patterns of MHC access and utilization among South Asian youth as it pertains to intersecting aspects and identities (spirituality, immigration, gender)

After comparison of stratified odds ratios, no evidence was found to show that the patterns of accessing different providers or accessing professional services differed between men or women. The umbrella term, "LGBTQ2+" was used within the 2022 MHACS to refer to individuals whose sexual orientation was not heterosexual and/or did not identify as cisgender (Statistics Canada, 2024). In general, LGBTQ2+ youth had 4.27 greater odds of accessing professional mental health services (95% CI [3.01, 6.05], $p < 0.0001$). Upon further stratification, there was a significant interaction effect indicating that South Asian LGBTQ2+ youth had 4.034 greater odds of accessing professional mental health services (95% CI [1.22, 13.32], $p = 0.022$). However, given that the confidence intervals are very wide this should be interpreted with caution. This could have been due to lower cell counts and frequencies of South Asian LGBTQ2+ youth, as mentioned in Table 1 (i.e., (unweighted) n = 18).

Using a weighted logistic regression model, the relationship between South Asian identity and youth indicating that spirituality plays an important role in their life. No significant interaction effect was found between South Asian identity and spirituality in terms of the influence on accessing different providers or in accessing professional support (OR 1.12; 95% CI [0.50, 2.48], $p = 0.789$). However, spirituality on its own was still associated with lower odds of accessing professional mental health services (OR 0.70; 95% CI [0.53, 0.94], $p = 0.019$).

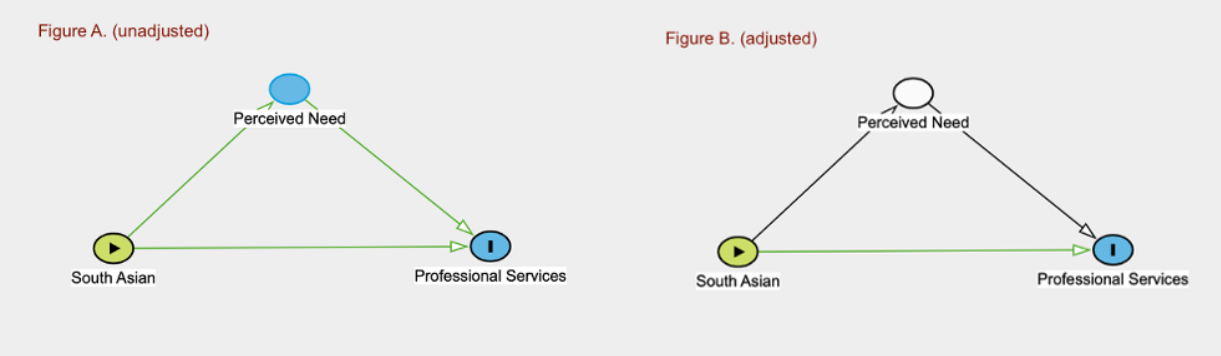
No significant interaction was found in a logistic regression model examining use of professional mental health services with immigration status and South Asian identity as predictors. Although, independently, immigrants had lower odds of seeking professional mental health support (OR 0.51; 95% CI [0.36, 0.72], $p < 0.001$). There was also no significant interaction between South Asian ethnicity and years since immigration when looking at the use of professional mental health services.

South Asian youth reported lower odds of having perceived needs for care or support (OR 0.62; $p = 0.002$, 95% CI [0.46, 0.84]). In conjunction with a lower use of professional services, there presented a need to explore the relationship between lower odds of professional help seeking and lower perceived needs within South Asian youth. There was a potential for perceived needs to be acting as a mediator on the causal pathway, modifying the relationship between South Asian ethnicity and the outcome of accessing professional mental health support. Figure 1A. shows the relationship using a Directed Acyclic Graph (DAG).

Prior to adjusting for perceived needs, logistic regression modelling suggested that South Asian youth have 0.61 odds of accessing professional services (95% CI [0.43, 0.86], $p = 0.005$). However, after adjusted for perceived needs, this becomes non-significant (OR 0.60; 95% CI: [0.15, 2.40]; $p = 0.466$). Given, that the confidence intervals are quite wide, this should be interpreted with caution. As seen in Figure 1B, the DAG shows the pathway for which adjustments were made. An adjustment was made to indicate a direct effect of South Asian ethnicity on outcome of accessing professional services. Implications are discussed later.

Figure 1

Directed Acyclic Graph (DAG) for Perceived Needs as a Potential Mediator



Note. Green arrows indicate open, unadjusted paths. Black arrows (Figure B.) indicate adjustments have been made on that pathway.

Objective 3. Describe patterns of MHC access and utilization (e.g., provider type, disengagement with services, unmet/met perceived needs) between Black, Chinese, Filipino, South Asian and White youth.

As reported in Table 3, Black, Chinese, Filipino, and South Asian youth all had significantly lower odds of accessing professional services for support when compared to the referent group of other visible minorities and not visible minorities. When comparing proportions reported in Table 4, we can see there is overlap in the 95% CIs provided, indicating there may not be a significant difference between ethnicities.

Table 3

Odds Ratios of Accessing Professional Services for Support

Ethnicity	Odds Ratio	*P-Value*	95% CI
Black *	0.58	*0.007*	[0.39, 0.86]
Chinese *	0.62	*0.013*	[0.42, 0.90]
Filipino *	0.65	*0.029*	[0.44, 0.96]
South Asian *	0.56	*0.002*	[0.39, 0.81]

Note. An alpha value of 0.05 was used for significance.

Table 4

Proportions of Youth that Accessed Professional Services Based on Visible Minority Group

Ethnicity	Unweighted (n)	Weighted (%)	95% CI
Black	41	16.14	[11.75, 21.75]
Chinese	52	17.15	[12.82, 22.58]
Filipino	32	17.85	[13.25, 23.61]
South Asian	44	15.86	[11.95, 20.74]
Referent Group	243	25.02	[22.27, 27.99]

Note. Weighted estimates (i.e., weighted proportion, confidence interval) were scaled to percentages.

As seen in Table 5, Black, Chinese, Filipino, and South Asian youth all had lower odds of seeking support from family doctors. Also, in Table 5, Filipino and South Asian youth reported significantly lower odds of seeking support from nurses and allied health providers. Due to low cell counts, we aggregated Nurses and Allied Health Providers (i.e., Psychologists and Social Workers). Similarly, due to small cell sizes, detailed analyses on attrition from professional services were not feasible. Reported in Table 6 are proportions and unweighted frequencies of different providers accessed by Black, Chinese, Filipino, and South Asian youth.

Table 5

Odds Ratios of Accessing Different Providers Among Black, Chinese, Filipino, and South Asian Youth

Provider Type	Odds Ratio (OR)	*P*-Value	95% CI
Family Doctor			
Black *	0.44	*0.003*	[0.25, 0.75]
*Chinese**	0.64	*0.044*	[0.41, 0.99]
*Filipino**	0.41	*0.005*	[0.22, 0.76]
*South Asian**	0.58	*0.018*	[0.36, 0.91]
Nurses and Allied Health Providers			
Black	0.65	*0.076*	[0.41, 1.04]
Chinese	0.75	*0.196*	[0.49, 1.16]
*Filipino**	0.56	*0.026*	[0.34, 0.93]
*South Asian**	0.52	*0.004*	[0.34, 0.81]

Note. Asterisk beside ethnicity indicates significance of odds ratio based on alpha of 0.05. The category of "Allied Health Providers" includes social workers/counsellors and psychologists.

Table 6

Proportions of Black, Chinese, Filipino, South Asian, and Referent Group Youth Accessing Providers

Provider Type	Unweighted (n)	Weighted (%)	95% CI
Family Doctor			
Black	19	6.50	[4.00, 10.40]
Chinese	29	9.21	[6.43, 13.03]
Filipino	11	6.09	[3.48, 10.46]
South Asian	23	8.40	[5.62, 12.36]
Referent Group	243	25.02	[22.26, 27.99]
Nurses and Allied Health Providers			
Black	28	11.76	[7.95, 17.04]
Chinese	39	13.25	[9.31, 18.54]
Filipino	19	10.29	[6.63, 15.62]
South Asian	27	9.61	[6.64, 13.72]
Referent Group	160	16.89	[14.53, 19.54]

Note. Weighted estimates (i.e., weighted proportion, confidence interval) were scaled to percentages.

South Asian youth were found to have 3.94 greater odds (95% CI [1.19, 13.06], p = 0.035) of indicating that they had felt a health professional or service provider treated them unfairly over the past 12 months due to their visible or non-visible characteristics such as ethnicity, culture, race, skin colour, language, religion or sexual orientation. Whereas Black, Chinese, and Filipino youth did not appear to differ from the referent group.

Although other ethnicities had similar odds, Black youth had 0.66 lower odds of reaching out to non-professional supports (e.g., friends, family, boss, coworker, etc.) (95% CI [0.48, 0.93], p = 0.016). As seen in Table 7, Black, Chinese, and South Asian youth all had significantly lower odds of seeking mental health support from family members. Black, Chinese, South Asian, and Filipino youth all had similar odds of seeking support from friends.

Table 7

Odds Ratios and Proportions of Youth Seeking Mental Health Support from Family Members

Ethnicity	Odds Ratio (OR)	P-value	95% CI
*Black**	0.45	< 0.001	[0.30, 0.69]
Chinese	0.85	0.362	[0.61, 1.19]
*Filipino**	0.61	0.019	[0.40, 0.92]
*South Asian**	0.61	0.010	[0.42, 0.89]
	Unweighted (n)	**Weighted (%)**	**95% CI**
Black	33	13.01	[9.10, 18.27]
Chinese	66	22.00	[17.25, 27.62]
Filipino	32	16.69	[12.00, 22.74]
South Asian	44	16.81	[12.61, 22.06]
Referent Group	235	24.82	[22.13, 27.72]

Note. An alpha of 0.05 was used for significance. Weighted estimates (i.e., weighted proportion, confidence intervals) were scaled to percentages.

Similar odds (i.e., overlapping confidence intervals) were found across ethnicities (i.e., Black, Chinese, South Asian, Filipino) when compared to the referent group in terms of outcomes such as facing prejudice and discrimination due to their mental health concerns, likelihood of accessing specific supports, and perceived level of help from a friend.

South Asian youth also had 0.51 lower odds (95% CI [0.27, 0.97], $p = 0.039$) of receiving as much help as they needed. They had lower odds of indicating that they received enough support. Black, Chinese, and Filipino youth did not significantly differ.

Black and South Asian youth had similar odds to the referent group of White youth when asked if they had turned to alternative health products (e.g., herbs, minerals or homeopathic medicine) for their mental health over the past 12 months. Chinese youth had lower odds (OR 0.63; 95% CI [0.40, 0.99], $p = 0.046$). However, it is important to note how close the upper bound of the 95% confidence interval is to the null value of 1. Filipino youth also had lower odds

of turning to alternative health products for mental health over the past 12 months (OR 0.41; 95% CI [0.20, 0.83], $p = 0.014$).

Based on these findings we can reject the null hypothesis that there will be no disparities in access and use of mental health care for Black, Chinese, Filipino, and South Asian youth compared to referent groups. Based on our findings, we fail to reject the null hypothesis that spirituality/religion and immigration status will influence patterns of access and use of MHC among South Asian youth.

Phase II: Qualitative Results

Out of all participants, seven were immigrants, only one participant had immigrated less than 5 years prior. As seen in Table 8, majority of the participants were women, one participant identified as a man, and one participant identified as non-binary. As shown in Figure 2, three themes were derived from the data.

Table 8

Demographics from Participants in Phase II

Demographic Variables	Participants (n)	Percent (%)
Gender		
Man	1	6.67
Woman	13	86.67
Non-Binary	1	6.67
Country of Origin		
Bangladesh	1	6.67
India	8	53.33
Pakistan	3	20.00
Sri Lanka	1	6.67
Uganda	1	6.67
United Republic of Tanzania	1	6.67
Ethnic Origin		

Balochi	1	6.67
Bengali	1	6.67
Gujarati	3	20.00
Kannadiga	1	6.67
Pakistani	1	6.67
Punjabi	6	40.00
Sindhi	2	6.67
Sinhala	1	6.67
Religion/Faith		
Buddhist	1	6.67
Hindu	2	13.33
Muslim	6	40.00
Sikh	5	33.33
None	1	6.67
Immigrant Status		
Born in Canada	8	53.33
Born Outside of Canada	7	46.67

Note. Ethnic origin totals exceed participant count (i.e., 15) due to participants being able to select multiple ethnic origins.

Three main themes were derived from the data: (1) *Cultural Factors Fostering Positive Mental Health*; (2) *Cultural Factors Promoting Negative Mental Health*; (3) *The Journey to Accessing Mental Health Supports*. Themes and corresponding subthemes are shown in Table 9.

Table 9

Themes and Related Subthemes from Semi-Structured Interviews

Theme	Subthemes within Themes
1) Cultural Factors Fostering Positive Mental Health and Wellbeing	• Friendship • Sense of Belonging • Immediate and Extended Family • Spirituality/Religion

2) Cultural Factors Contributing to Negative Mental Health	• Taboo and Stigma • Disconnect with Parents • Pressures to Excel • Gendered Roles and Expectations
3) The Journey to Accessing Mental Health Supports	• Financial Barriers • Academic Institutions • Primary Care as an Entry Point • Cultural Safety and Humility • Holistic Definition of Mental Health

Theme 1: Cultural Factors Fostering Positive Mental Health and Wellbeing

Participants shared their experiences of what they believed fostered positive mental health and how they maintained wellbeing. An emphasis was placed by youth on a support network and collective approach to meeting their mental health needs. The five subthemes include for this theme include: 1) *Friendships*, 2) *Representation and Belonging,* 3) *Immediate and Extended Family*, 4) *Spirituality,* 5) *Holistic Definition of Mental Health*.

Friendships

South Asian youth relied heavily on their support networks, especially their friendships, to foster positive mental health. Instead of being able to turn to parents due to disconnect or taboo, participants indicated they would, "*confide in a close friend instead."* (P9). When navigating challenging life experiences such as loss or illness in the family, youth would feel increasingly supported by their friends. A participant described how her friends helped her cope while her grandfather was sick and in the hospital:

> *"... I had a lot of support from my friends, so I think friend support was a really big thing. And then also I am also in a research lab and my lab was so supportive through the*

whole thing because [especially] being able to [talk to] my graduate student about it, that was the one person I would talk to about what was going on with my grandpa." (P2)

Friendships created a supportive and healing environment for youth. A participant highlighted that instead of accessing formal support, they leaned on their friends:

"I feel like to improve my mental health, I don't really seek out mental health services. I usually just seek out my friends." (P12)

Youth longed for friendships in which they shared identities to feel validated in their experiences and feel supported. A participant in high school reported their friends helped them feel validated and confident when engaging in a presentation:

"They were hyping me up and it really helped instead of just being alone and having myself being really anxious […] helping me feel positively about myself and feeling more confident in doing the presentation." (P8)

Isolation during the pandemic and immigration were also described as hindering the opportunity to make friends and develop support networks. This was at detriment to the mental health of South Asian youth and elucidates the importance of social connection. One example illustrated the feelings of disappointment when their opportunity to make friends was cut short:

"And then university happened where a couple years were online due to the pandemic and everyone kind of hyped those years up where it's like, 'oh, these are the best years of your life. You find your lifelong best friends'. And that instantly just got cut for me, and then I had to graduate on my own. I didn't really have any friends." (P14)

When faced with a lack of friendships, a participant indicated "*…it was really hard not having anyone to rely upon*" (P10). Feeling as if they had to deal with their emotions and experiences alone. Thus, the isolation contributed to feelings of a lack of support and connection. Friendships

had strong positive influences on the mental health of South Asian youth in the form of providing a solid support system to cope with stressors and day-to-day life.

Sense of Belonging

Youth expressed a desire to be engaged in ways that made them feel seen and like they belong to a community. Especially for youth that were born here, with immigrant parents, they felt as if they were living "*a double life*" (P3). Some indicated a disconnect with parents, and thus a desire and need to feel connected to a group in a way that validated their experiences was reported as important for positive mental health. It provided a place of comfort to have a community or group that understood them in a way their parents did not:

> *"…it's very reassuring to know that I'm not the only one who's going through some of these things, and it especially helps that since we know each other's parents, we really understand those issues more than anyone ever would. So it's nice to be understood in that way."* (P6)

For immigrant youth, belonging entailed trying to fit into a new culture. Looking for a sense of belonging within a community that respected their values and offered a sense of relatability was important but often not found. A participant illustrated how she was struggling to fit in, which created a sense of alienation:

> *"…when I came here, I guess I was struggling to fit in the new culture here because everything was just so different. I felt so out of place, especially as a Muslim who was wearing a hijab too. I just felt like alien kind of."* (P10)

Another participant described how he faced difficulties in feeling a sense of belonging due to his accent, resulting in feelings of isolation:

> *"On top of that, my accent was very different from what it is now. While I wouldn't say I was discriminated against, I did feel a bit out of place because people often had trouble understanding me. It felt strange and, at times, a little isolating, as I was trying hard to fit into society."* (P11)

The participant also shared how even turning to an online platform resulted in "negative comments" after he indicated he was an international student:

> *"...when I posted something on the [redacted] subreddit mentioning I am an international student, I came across some negative comments."* (P11)

A lack of accurate, empowering representation of the experiences that South Asian youth have in general and with their mental health may have led to deeper feelings of isolation. A participant explained that even when she tried to find validation of her experience online:

> *"...if you go online and you're searching something up and you're like, something about South Asian mental health, there's no representation [...] it's hard to validate your feelings and how you feel if you don't see any other exposure of it online."* (P1)

Immediate and Extended Family

Youth expressed the importance their family's play in fostering positive mental health. A strong relationship between immediate family allowed for a psychological safety within the household, finding that these relationships often fulfil mental health needs. When asked about "what meets their mental health needs", a participant emphasized the importance of their relationship with their parents and siblings:

> *"My parents are just very present, very, making sure that I'm constantly okay. My sister, same thing, so I feel like it's just that support system or I guess you don't necessarily need a support system if you can do it yourself."* (P15)

South Asian families often include grandparents and strong connections to extended families. These connections create a broader network of support. Living in multigenerational homes, youth often supported their grandparents and had strong relationships with them. However, this had the potential to create situations where youth may have to shoulder burdens for families especially during major life experiences (e.g., sickness of grandparents). Although the large support network was mostly positive, South Asian youth, especially second-generation immigrants often bridged the acculturation gap between older generations. A participant described how she supported her family when her grandpa was sick, translating between her grandpa and health providers:

> "*…a time I experienced negative mental health was last year when my grandpa, he was in the hospital for two, three weeks and because they don't speak English, they need someone to always be there to translate. And so my parents were working and I was the one who would be there and translate for him*." (P2)

The support felt from parents and siblings creates a network within the home that allows youth to feel supported, which fosters positive mental health. A participant expressed how her relationship with her mom fosters positive mental health, helping her feel understood:

> *"…positive mental health would probably be being able to share my emotions with my mom and her acknowledging my emotions and being there as an outlet that is something that has impacted me positively when it comes to academics, especially just having an outlet that someone who's not in school with me, who kind of understands that, to me is really powerful."* (P4)

Youth often also turned to siblings to have conversations about their mental health, especially if their relationship with their parents may have been strained or disconnected. Siblings were often

able to relate due to shared experiences in the same household, with the exception of how gendered expectations and age order influenced experiences. A participant shared how unlike her parents, she felt she could share her mental health experiences with her sister and not feel dismissed:

> "*... I mean if I explain to her [older sister], I think I have a depressive episode right now, I am feeling anxiety every time I wake up. I constantly need to fidget and I can't focus, I think I need to get diagnosed with ADHD. She doesn't dismiss me. She doesn't say, 'oh, that's not real'."* (P14)

The South Asian community largely values connections that extend beyond the nuclear family. Youth often turned to family friends and cousins for support. They often felt safe and validated as their extended families shared similar experiences and were able to understand them, while also providing relevant advice. This is due to the extended family being aware of nuanced family dynamics and cultural norms. A participant indicated that shared experiences with their family friends allowed them to have a safe space to talk about their feelings:

> *"...I have two family friends who are also Sri Lankan and we're all queer. So yeah, we share all these identities, so it's very, very easy to talk about this with them. And our parents are also friends, so anytime we have issues with our parents, we all kind of talk it out together. So that's my group therapy right there, is those people."* (P6)

Overall, South Asian youth emphasized the importance of their immediate (e.g., siblings, parents, grandparents) and extended family (e.g., cousins, family friends) in fostering positive mental health. They provided a space for youth to share how they were feeling, validated their experiences, and provided meaningful support due to enhanced understanding of individual contexts.

Spirituality/Religion

Most youth often turned to spirituality and faith in religion to foster positive mental wellbeing. Despite differences in religious affiliations (i.e., Buddhist, Hindu, Muslim, Sikh, etc.), most youth expressed that religion/spirituality helped them cope with day-to day life experiences and stressors (e.g., academics, uncertainty, etc.). A participant shared how turning to Buddhism helps them cope with day-to-day, but also broader life experiences:

> *"...so it does help me just deal with day-to-day things. And then also it helps me think of how I'm going to live my life into a bigger picture. Because a huge idea in Buddhism is that when you think thoughts you're not supposed to, it's best if you try not to assign any 'super-duper' strong emotions to those thoughts, whether it be really, really positive or really, really negative."* (P6)

In addition to being helpful in terms of day-to-day coping, many youth indicated that their faith is a grounding force that allows them to see the "bigger picture". Similar to P6, another participant expressed similar sentiment:

> *"I think it keeps you really grounded and it takes you back to the bigger picture. At least for me, your life here is not everything, so there is still so much else out there. You shouldn't be focusing on small things. That's me. I'm an overthinker, so I'll focus on the littlest of things and then going back to spirituality, it takes me back to everything else that's out there and beyond."* (P7)

Many youth, across varying faiths, described a wavering journey with their faith, reporting that they initially felt "forced" into it. A participant practicing Hinduism expressed this sentiment, indicating their relationship with spirituality has evolved to the point which they use it as a space to foster positive mental health:

> *"...when I was a kid, I think spirituality was kind of forced, but now I feel like I'm a lot more spiritual than I used to be, where I actually believe in a lot of the stuff that I'm doing now instead of just following what parents did. So I guess spirituality, it helps me in some ways where some days it makes me really relaxed when I think about it. And then, yeah, I think spirituality is a good place to vent sometimes as well."* (P12)

Similarly, a participant that identified with the Sikh faith, or Sikhi, acknowledged a similar initially wavering relationship when turning to their faith:

> *"I think when I was younger, I didn't have a really good relationship with it, but I think as I got older and I started – I think I had more exposure to Sikhism from my friends and online. I think I was slowly able to be like, 'okay, this is actually a really beautiful religion. Our teachings are, I knew our teachings are really, really good.'"* (P1)

The wavering journey with faith appeared consistently across youth, often showing a rejection of faith when younger. Overtime, they expressed growing into their faith and relying on it for support. Faith fostered not only positive wellbeing in the moment, but also long-term resilience in the face of challenges. A participant expressed how spending time with their Muslim faith, or Islam, made coping easier in the long term:

> *"And when you take that time to yourself, whether it's through prayer, meditation, anything, making these decisions become a little bit easier."* (P13)

Similarly, a participant also expressed how their Sikhi helps them feel as if *"someone's always got you."* (P1)

Theme 2: Cultural Factors Contributing to Negative Mental Health

Participants illustrated many factors that contributed to negative mental health. An emphasis was placed on culturally influenced factors that in turn had negative effects on their mental health.

This theme had four subthemes: 1) *Taboo and Stigma*; 2) *Disconnect with Parents*; 3) *Pressures to Excel and Be "Perfect";* and 4) *Gendered Expectations*.

Taboo and Stigma

Youth that mental health was not talked about in their homes or communities, emphasizing a sort of "*taboo*" around the discussion. This "*taboo*" contributed to the stigma, or the shame associated with talking about mental health. The lack of open conversation and strict avoidance of acknowledging mental health associated with cultural norms could result in an environment in which youth did not feel comfortable addressing their mental health. A participant described initial hesitancy to bring up her mental health, until she found connection with her mom:

> *"So it's kind of like a taboo, if that makes sense. It just doesn't exist I think, in this culture. But to be honest, our family never talked about this either until, I guess I was struggling a bit, but I was surprised to see that my mom was okay with it or was acceptive of it, but we just never further talked about it."* (P7)

The taboo and corresponding stigma contributed to poor mental health and in some cases internalized stigma wherein youth felt selfish for addressing their mental health or resistant to getting support even if they needed it. Some youth would "*deny the fact that there were any issues*" (P7) to avoid getting help. A participant described how they felt selfish accessing counselling resources, trying to focus on helping themselves:

> *"Before counselling, it was tough to make that decision because it felt selfish, and that I should be capable of helping myself in time of need as I did for others."* (P1)

Accessing professional services held negative connotations for some due to the taboo and stigma. Due to taboo preventing a lack of open conversations, youth more often than not went without

help. A participant described how although she was able to seek help, they know of other south Asian youth that cannot access support due to the taboo and stigma:

> *"...the other families with kids who are like me, who are South Asian, who aren't able to seek that help or sometimes are doing it behind their parents' backs or whatever they need to do. They're not able to openly have a conversation about it. So I just feel like there is a need for that, even though more and more people are starting to talk about it. I haven't seen a lot within the South Asian community."* (P13)

An emphasis was placed by families on the physical and biological manifestation of mental health issues, as opposed to the more invisible. A participant shared her experience of how the focus would be on how to make the mental health challenge invisible instead of addressing it:

> *"...it's definitely a sense of when you have a mental health challenge, it's more like, how do we make this go away or not visible as opposed to unpacking it."* (P9)

This focus on physicality positions the mental health challenges in a more biomedical, diseased approach. A participant shared how their parents consider mental health challenges as medical disorders or diseases and would just opt to medicate to absolve concerns they had:

> *"I feel like they [parents] consider depression or things like that more like medical disorders instead of mental health disorders. So I think if I talk to 'em [parents] about it, [they would] probably give me medication support."* (P12)

The taboo prohibits topics of mental health, which cultivates stigma (i.e., shame) associated with talking about it or accessing supports. Overall, this prevents youth from fully understanding or addressing their mental health needs, contributing to negative mental health. Further, stigma and taboo contribute to the disconnect seen between youth and their parents. This disconnect was seen to create an environment in which mental health challenges worsen or go unaddressed.

Disconnect with Parents

The lack of an open and supportive relationship with parents creates a space in which youth feel like they cannot talk about their mental health. A participant described how having parents that understand mental health would have helped them get through mental health challenges, but the disconnect makes it hard to ask for help:

> *"...parents being more supportive of it, being more open about it would've definitely helped me. So it's really hard for me to just reach out now and to talk about this stuff."* (P10)

Often as a side effect of stigma, the disconnect with parents appeared in the form of parents trying to reduce visibility of negative mental health symptoms in youth. Echoing the sentiment mentioned in the previous subsection of how stigma and taboo put youth under a pressure to make their struggles invisible, instead of unpacking it. A participant mentioned that although their parents never dismissed them, the solutions they suggested silenced their challenges:

> *"...They [parents] never made me feel bad or dismissed, but the solutions they gave were keep yourself busy, [and] private, you understand?"* (P12)

Similarly, a participant mentioned that although her mom briefly listened to her mental health concerns, she felt brushed off by both parents and those conversations never came up again:

> *"And then I think it was not too long, but after a while I did mention it to my mom first, and then I think we had a short convo about it, but that was it. And then if I ever did mention it to my dad, he would brush it off. Say that it wasn't a thing. It was probably something else."* (P7)

Silencing youth contributed to poor coping later, manifesting in youth not being able to reach out for help or being able to talk about their mental health openly. Youth would also often have to

utilize parental insurance due to the high financial cost associated with some professional resources. However, due to the disconnect with parents, youth would just opt to wait until they were no longer in their parent's home or turn to more accessible services behind their parent's back (i.e., crisis lines, school counsellors, etc.). A participant expressed that although they would like to access professional services for mental health support, they cannot while they live in their parent's home:

> *"I feel like right now it's more just I'm at my parents' house. I'm kind of just chilling here, so I don't really want to do anything I know they'd be against [therapy?] if I'm in their house and I don't want them to be aware of it."* (P12)

When youth are not able to express themselves or be themselves around their family, especially parents, this creates a disconnect and tensions within the home. A participant indicated that she feels like she lives in two different realities, one in her home and one outside, due to that disconnect:

> *"It's almost like living a double life. As soon as I exit my doors to my home, I'm living a whole different life […] I just mean there's different societal norms and there's different other things we conform to. Whereas at home that might be very different."* (P3)

Youth expressed a desire for wanting their parents to learn more about mental health. Some shared that due to their parents being aware of mental health and being open to conversations, this really helped their experiences with their own mental health. These conversations were often bridged by mental health care providers. One participant illustrated that their doctors answered any questions their parents had, which reduced the disconnect between them and their parents:

> *"In the past, I haven't been able to talk to them, but recently they've been a little bit more understanding about it. I feel like it's more due to the fact that the doctors telling them*

what's going on and the full details and if they have any questions, and so yeah, sort of I've been feeling more comfortable talking to them about it" (P8)

The disconnect with parents appeared to be prominent if parents were immigrants, regardless of if youth were born here or elsewhere. One participant whose parents were not immigrants expressed that she was able to have non-judgemental conversations with them:

"I think when they're very nonjudgmental about everything, even school, as long as you're trying, it's good. So I don't feel any issues talking to them. My mom also had me when she was 24, so there's less of an age gap. I don't know if that makes a big difference, so it's very older sister, so I just chat with her about everything" (P15)

She further described that due to her parents being born in Canada, they likely shared similar experiences which makes it easier to connect:

"I feel like there's more of a similar experience. I'm sure immigrating here, it's life changing and you go from living two completely different lives. So I think them being born here definitely makes it easier, that connection." (P15)

Overall, disconnect with parents contributed to tensions within the home, leaving youth feeling unseen and helpless. This disconnect was often fostered by the taboo and stigma of poor mental health which could impact the help-seeking behaviours of youth. Further, this disconnect with parents was increased by cultural expectations and pressures to succeed placed on youth.

Pressures to Excel

High pressures to excel academically and in other domains as part of South Asian cultural norms, was seen to foster competitiveness in the community and place burdens on youth. Similar pressures to maintain a certain image in the community, especially for women, prevent open conversations surrounding mental health. This is in part related to the stigma and taboo, but also

to connectedness of the community. A participant, who is an international student, expressed that cultural pressures to succeed academically take a negative toll on their mental health:

> *"But in cultures like ours, where there's so much pressure on things like GPA, failing a course can make you feel inadequate, and that takes a toll on your mental health. So, it's about feeling good about yourself versus not—it's that simple."* (P11)

Most youth expressed the toll of academic pressure and illustrated that it took utmost priority. A participant described that it did not matter to their parents how their mental health was, as long as their grades were good:

> *"I was raised in a way that's like, oh, grades are all that matter. It doesn't matter how you're feeling mentally. As long as it's good on paper, it doesn't matter."* (P14)

For youth that are immigrants themselves, perhaps as international students, they feel an added pressure to succeed in order to not disappoint their parents because of the sacrifices they made. A participant who came here as an international student described that financial pressure on his parents contributed to his negative mental health:

> *"My plan to study abroad meant my parents had to save a lot of money, which led to financial struggles from grade nine to grade twelve. Even though my parents tried to hide it from me, I could sense the pressure, and it affected my mental health."* (P11)

On the other hand, being the child of immigrants entailed having to bridge the gap parents experienced when navigating society, placing extra burden on youth to perform and provide for their family. A participant described how they were afraid to ask for help, because they felt they should be the one fixing things:

> *"I think being afraid of asking for help because your whole life, you were expected to know what to do. Your parent has a problem with [an] application, you have to fix it."* (P1)

Going against these cultural and parental expectations left youth feeling disconnected, feeling guilt, and like outcasts. A participant described the pressure to conform, leaving her restricted on what they can and cannot do:

> *"And if you don't do it that way, I feel like you're kind of put towards, oh, as an outcast. 'Oh, you don't listen to your parents', or if you just don't conform to it, you are automatically a bad person. And then whereas on the outside world, you might just be going out to grab a coffee with a coworker or trying to maybe meet up for something like this, or it's not always the worst is always assumed."* (P2)

These pressures to perform and excel *"encourages a lot of competition and encourages comparison"* (P12) between South Asian youth within communities. This creates a competitive culture, resulting in youth basing their self-worth on how much they accomplished or won. A participant shared this sentiment in expressing they felt their value was based on their wins, which contributed to negative mental health:

> *"I kind of realized how much value was on how much value we were given based on whether we won trophies or not, because I feel like our treatment was really shifted. So yeah, I guess I was winning trophies. That was an example of negative mental health."* (P12)

Trying to and meeting expectations of who you should be creates a toxic standard. Trying to put up a front to meet expectations in society, perhaps even avoiding accessing mental health supports to avoid being scrutinized in the community. A participant shared how cultural

expectations create a standard which can take precedence over everything, including your mental health:

> *"Well, it feels like you always have to have a kill switch almost. It is an interesting experience because it feels like sometimes this cultural expectation of being on and pleasant all the time can really override everything else."* (P9)

Gendered Roles and Expectations

Gendered roles and expectations influence the expression of emotion and the emotional burden carried. This gendered expectation is discussed in the form of a binary classification of gender. The brunt of the burden from division of household labour and representation of family honour falls on the shoulder of women and girls of South Asian families. A participant described that her gender effects the variable pressure she feels, especially when it comes to household tasks (i.e., cooking, cleaning) when compared to her brothers:

> *"There's one big thing I forgot to mention which affects my mental health: my gender. Being a South Asian girl feels so different from being a South Asian boy. I've always felt pressure to fit into traditional roles—I'm expected to cook, clean, and focus on family way more than my brothers."* (P10)

Similarly, a participant confirmed these experiences as a South Asian man, expressing that he is often treated better:

> *"Being the only son, I've been pampered a lot. My parents are very concerned about me, and sometimes their expectations can feel overwhelming."* (P11)

In terms of birth order, eldest daughters often shouldered the most expectations. One participant described feeling pressure to excel and succeed because they are setting an example for their younger siblings was frequently expressed as well. Not only are they supporting their siblings,

but also their parents, especially if their parents are immigrants. She described how as an eldest daughter she is essentially a third parent for her siblings and shoulders many responsibilities:

> *"Maybe being the oldest daughter in the household. I know it's like everyone can kind of attest to it to their own extreme being any color, but I think being in a brown or South Asian household, it's like expectations are 20 times higher, especially if you have siblings because you're kind of setting the way for them all, and then you're also being the third parent […] if you're first generation, your parents are basically immigrants and you're also helping support them, so you're kind like the leader of the household if you're helping both your siblings and your parents."* (P1)

In addition to paving the way for their siblings, eldest daughters of immigrants reported also having to pave the way for themselves. A participant shared how it has been difficult not having someone to look up to for support:

> *"…being the oldest child that doesn't have an older sibling to look up to. So I've kind of just had to figure out this path and it's always been really hard."* (P3)

Eldest daughters indicated keeping to themselves and trying to protect their siblings. A participant shared that as the older sister she did not want to talk about her mental health with her sibling to avoid being a burden:

> *"I didn't want her to have to think about things just because I was emotionally distraught or I was emotionally traumatized. I didn't want to add on, so I just kind of refrained from that for that reason."* (P4)

There was common sentiment from parents that women and girls will go through difficulties and outwardly express their emotions, this is not a cause for concern. Mental health challenges are

shrugged off as symptoms of being a woman. A participant described her experiences of being stuck in a cycle where her feelings are belittled and dismissed:

> *"…as a South Asian girl especially, maybe if I was a boy, I might've had chance to be more open towards my parents, but I guess as a girl, it's kind of in my culture, it's like, 'oh, every girl goes through difficulties. Every girl will not be happy in life. Every girl will feel this feel bad though'. It's being able to break out of that system seems so impossible"* (P14)

On the other hand, when men expressed emotions, it was associated with shame, perpetuating notions of toxic masculinity. A participant expressed that there is a stigma, especially around men expressing emotions, which promotes a harmful standard of masculinity:

> *"In our [South Asian/Pakistani] society, if a boy cries, he's often shamed with comments like, 'Are you a girl?'—which is sexist. It creates this stigma that showing emotions makes you less masculine. This kind of messaging is harmful. When boys are denied a safe space to express their feelings as children, it often manifests later as anger or aggression because they've never learned healthier ways to process emotions."* (P11)

Based on this, gendered differences often exist when we consider the expression of emotions and mental health. A participant describes how her brother, although younger, can be out until a later time:

> *"…there's 'women should be like this', or 'we should really be protective of our women', and 'you're not supposed to be out past at a certain time', whereas maybe your younger sibling and I have a brother who can be out past that time"* (P3)

Overall, gendered expectations and the divisions promote situations that may contribute to negative mental health in South Asian women and girls. South Asian men experience a stigma

around emotional expression due to toxic masculinity in the community. Women in South Asian households often shoulder many burdens to support their families, especially eldest daughters who pave the way for the rest of their siblings.

Theme 3: The Journey to Accessing Mental Health Supports

Many factors promote positive mental health among South Asian youth; they may not have a need for professional services. However, due to cultural factors promoting negative mental health (e.g., taboo/stigma, cultural pressures, gendered expectations, and disconnect with parents), youth may be hesitant to access professional mental health support or may not even know they need it. Every participant shared a few factors that played a role in the mental health care they received. Each youth had a different journey to accessing mental health support, many factors facilitated or deterred the journey. This theme had four subthemes: 1) *Financial Barriers*, 2) *Primary Care as an Entry Point*, 3) *Academic Institutions*, and 4) *Cultural Safety*.

Financial Barriers

Financial barriers associated with accessing specific professional mental health supports can hinder South Asian youth from seeking help. Services are financially not feasible, especially for international students in postsecondary education or youth in the workforce. A participant discussed how stigma in the home and financial constraints (i.e., paying for medication or therapy) deterred her from seeking support from services she desired:

> *"I really did want to get help and stuff, but it's like: A) I don't know how to tell my parents that; B) I didn't have my job back then, so I didn't know where I would get the money to pay for sessions. And then C) it's like I do have my job now, but it's like I looked online to Alberta counseling and it's like for the income that my family makes, I'd have to*

pay $250 a session and it's like, yeah, I have a job, but I also have to pay back my student loans at the end of the month and then I have to pay for medication." (P14)

Often youth were only able to attend counselling or access services through their parental insurance, but this required navigating the disconnect with parents as well as the taboo or stigma in the home. This was not feasible for many youth and could leave them feeling like a burden on their families. One participant shared how due to the *"communal living structure"* within South Asian families people may *"pull strings with money"* (P9). She described how because her parents used to pay for her therapy or she used parental insurance, her parents made her feel guilty for getting help:

"...my parents would take me out of therapy or would guilt me about how much it cost, even though it was not significant to them just because they could. So I also started paying for my own therapy as soon as I could so that I could be going regularly and not have to have them involved at all." (P9)

Youth also indicated they stopped their counselling once the *"coverage ran out"* (P6). This illustrates the helplessness of youth, especially in homes with pervasive stigma and taboo around mental health. Trying to overcome the stigma or taboo and corresponding disconnect with parents when trying to access supports using parental insurance can create a lot of additional challenges for youth. A participant shared how although youth may want to get help, they are stopped by both the taboo and financial constraints:

"The one thing that also stops them [South Asian youth] is not only the taboo, but also the financial constraints. Because sometimes I remember when I was researching trying to get mental health support, it would be like, pay $200 for the first session, or the first

session is free and then it's $200 for one. And I'm just like, no, that is just not practical." (P13)

Financial barriers were reported to create distance between South Asian youth and needed supports. If youth are not accessing support through Alberta Health Services (AHS), it can become very costly. When we consider immigration status, international students may also have to pay for medical insurance. Being a student and immigrant adds many layers of complexity. A participant shared his experience trying to access supports as an international student:

> *"I discovered that therapy sessions typically cost around $150 to $200 per hour. As a student, I realized how inaccessible that is for someone like me."* (P11)

Further, based on the experiences of youth, accessing professional mental health services may not feasible due to the financial burden.

Primary Care as an Entry Point

Participants reported accessing their primary care physician as a form professional mental health support. When asked about whether she accessed professional supports for mental health, a participant shared how her primary care physician has supported her and helps her take care of her mental health:

> *"...I think my family doctor, he's very, I've been going to him since I was a kid, so he kind of knows the ups and downs that I've had. He's, there's no stigma there or anything at all. He's very nice. And if I do go in with an issue, let's say mental health wise, we'll kind of go through all of, I guess the diagnosing checklists together, or he'll give me them to fill out on my own."* (P2)

Primary care physicians provided a connection to other resources in the community to help foster positive mental health in South Asian youth. This was a resource that was frequently accessed for

support. A participant illustrated how their primary care provider helped them get connected to a psychologist:

> *"...so the first person was definitely my family doctor and we had a talk about mental health and stuff and resources, and then eventually she referred me to a psychologist who is still my now psychologist."* (P8)

Regardless of whether youth decide to access support, the primary care physician plays a crucial role in recognizing need for the resources and prompting the discussion:

> *"...there was a time where I went to my family doctor about something and she recommended some resources and there was one connected to the university, I believe. I never accessed it."* (P7)

However, due to a shortage in primary care physicians, it may not be entirely accessible. A participant illustrates how she would go to the clinic as a walk-in appointment, which entailed clearing her whole day:

> *"I just haven't had the time to book it because [...] my doctor has a walk-in appointment and walk-ins take a whole day, and also you need a solid reason to be at your doctor."* (P5)

Overall, primary care physicians were found to be a common professional support accessed by South Asian youth. Acting as a facilitator, this resource allows youth to get the support they need without the excess financial burden.

Academic Institutions

For students, academic institutions provide accessible resources if they choose to access them. A participant in post-secondary education described how her institution has a variety of resources that make mental health care accessible:

> *"I feel like it's very accessible at this point. I could go anywhere and get help. Student wellness center, I feel like, I think they have people you can go talk to as well. I think if I were going look for it specifically, I'd look for an actual person I could talk to instead of using a help phone or the articles or stuff like that."* (P15)

Teachers and guidance counsellors in schools were described as a strong support for high school youth. When considering immigration status, immigrant youth described how they were supported by their school's mental health and other resources when they arrived. One participant who had recently immigrated shared how the school let her know what resources were available for her to access:

> *"Okay, so I feel like the school definitely told me what to do kind of. We have this counselor and the school, when I first came here, the school told me that I have all of these resources available if I never needed to talk to someone."* (P8)

Immigrating to a new country, starting a new school with new people, and trying to adjust to life was described as *"really challenging"* (P8). She further described how her counsellors and teachers helped her get diagnosed but also to set up a personal learning plan to support her. Teachers and school resources created a space in which youth could get specific supports they needed in order to thrive. Another participant who had also recently immigrated shared how her teachers were caring and supportive. She described how her teacher cared for her wellbeing and set her up with the proper resources to get her the support she needed:

> *"If I'm upset, my teacher, he would just ask me to stay to class […] I mean, my teacher, my homeroom teacher, he did actually ask me what was going on and what was happening and he was like, 'okay, you know what? Let me set you a meeting up with the school counsellor'."* (P5)

For those that are no longer a part of academic institutions, they reflect on their experiences and had hoped additional resources were a part of their experience. A participant described how she wished those resources were more common when she was in school. Although she could not turn to her parents, she would have had some support through her school:

> *"And then I guess back there in school, we didn't really talk about mental health back then a few years ago. I feel like it's becoming more common now, so maybe they could have brought those topics up in school and did presentations. So we had sources to reach out to as well if we couldn't go to our family."* (P10)

There may be fragmentation that occurs when youth are no longer part of academic institutions. A participant shared her experience of losing resources with the transition from post-secondary education to the workforce:

> *"...once you graduate as a student and once you move on, it's like you don't have access to these clubs or these connections anymore. So it would be nice to have something that's constant instead of just having it in school. I would sometimes think I'm like, this is great that I get the discounts. I get all of these things. I get access to the perks and the mental health and everything, but what's going to happen when I'm in the workforce?"* (P13)

Academic institutions provide mental health resources that South Asian youth can access without fear. Further, when using supports or resources, the most important aspect to youth was cultural safety.

Cultural Safety and Humility

Cultural safety is valued by participants if or when they choose to access professional mental health care supports. A participant explained how it is important for them to be able to share experiences without providers jumping to assumptions or judgement:

"...it helps to just talk about it sometimes to someone without feeling like I'm judged for it or interrupted or have the other person make assumptions about whatever I'm talking about." (P9)

This was a sentiment expressed by most youth. Another participant also described her desire for a mental health resource that is non-judgemental and safe:

"...a non-judgmental platform, where someone that can really just relate to you, someone that's not going to judge you based off your experience and oh, for instance, oh, your parents do that." (P3)

A participant expressed how it is much more helpful when providers take the time to look into cultural dynamics as it facilitates a smoother interaction without the youth having to spend more time defining key cultural terms:

"You're not doing that basic groundwork. You're actually able to engage in the therapeutic process just from the get go. It's nice having that relationship of a back and forth without having to feel like you have to put in an extra step to explain certain definitions when you just want to get your feelings out and your experiences out. Frankly, you're in therapy to work through things, not necessarily to be giving cultural heritage lessons." (P9)

Another participant indicated that *"in an ideal world, I would like someone who to provide mental help that is shares the same identity to a certain degree."* (P6). Other participants illustrated similar concerns in which they felt only providers from similar backgrounds would be able to truly understand their experiences:

"I think a lot of, I've had a lot of conflict over the years with my parents about certain things, and a lot of it still sometimes comes up. And I think talking to someone who's not

from the same background, it's a bit hard to explain those dynamics because the cultural dynamics are really different" (P2)

By recognizing the cultural dynamics, providers may help promote understanding within families around concepts of mental wellbeing. One participant described how her psychologist was able to answer any questions her mom had because the provider was South Asian:

"...when I first asked to be put on medication, my mom had questions about it and he was definitely able to explain it to her in a way that she understood versus if it was a different psychologist, they wouldn't understand the questions my mom had because she's South Asian and my psychologist is also South Asian." (P8)

Mental health care providers that respect or acknowledge the variety of cultural healing methods for South Asian youth (e.g., spirituality, alternative medicine) are valued by youth. A participant highlighted how her provider helps because she understands and respects alternative methods:

"I'm not sure about you, but there's a lot of home remedies or natural remedies that come up when talking about health, so she'll always go back to, oh, if you want to try this though first, because she knows medicinal benefits of something." (P7)

Another participant illustrated similar experiences, wherein she felt the coping techniques her providers gave felt very generic:

"Some of the coping strategies, I feel like, I don't know. It was kind of just very generic things. I don't think it was anything that I personally could have tailored to my own use. So because it was so generic, I just didn't find it useful or just kind of like it was too broad." (P2)

Holistic Definition of Mental Health

South Asian youth often referred to mental health in a holistic manner, emphasizing importance of mental, emotional, and physical wellbeing. This then reflected the journey that youth took to support their mental health or wellbeing. A participant described broadly what mental health meant to them:

> *"I guess mental health would be having good physical, mental, emotional, all of those kinds of aspects, having a good wellbeing overall."* (P10)

Another participant described how positive mental health encompasses many domains of their life and is not limited to just emotional wellbeing. Related to previously mentioned themes that focused on the importance of varying relationships in fostering mental wellbeing, they explained how being content with many areas of their life play a critical role in fostering mental health:

> *"Positive mental health, for me, is feeling content with most aspects of life—your relationships, your work, and especially how you view yourself. If you like who you are and your surroundings, your mental health improves."* (P11)

An emphasis was placed on a balance between emotional and physical wellbeing, with one participant even describing that "*mental health is as important as physical health*" (P11). Many other youth also illustrated how their bettering their physical health helps them promote positive mental health. A participant illustrated how when they felt they had exhausted all means to foster their mental health they turned to more physically focused strategies:

> *"So at that point I kind of just gave up and I kind of turned to other aspects. So I think going to the gym was really helpful for me, changing up my diet, going more outside those things definitely did help me a lot with my mental health."* (P2)

Some also expressed positive mental health as an ability and capacity to be emotionally available for others. The capacity to be emotionally available is tied to cultural pressures to be perfect, which was discussed earlier. Emotional intelligence or being able to feel and acknowledge your emotions was described frequently as being associated with positive mental health. A self-acknowledgement that their feelings are valid and "*it's okay to feel certain ways about different things*" (P2). A participant indicated that positive mental health means being able to recognize your own emotions but also being able to support others:

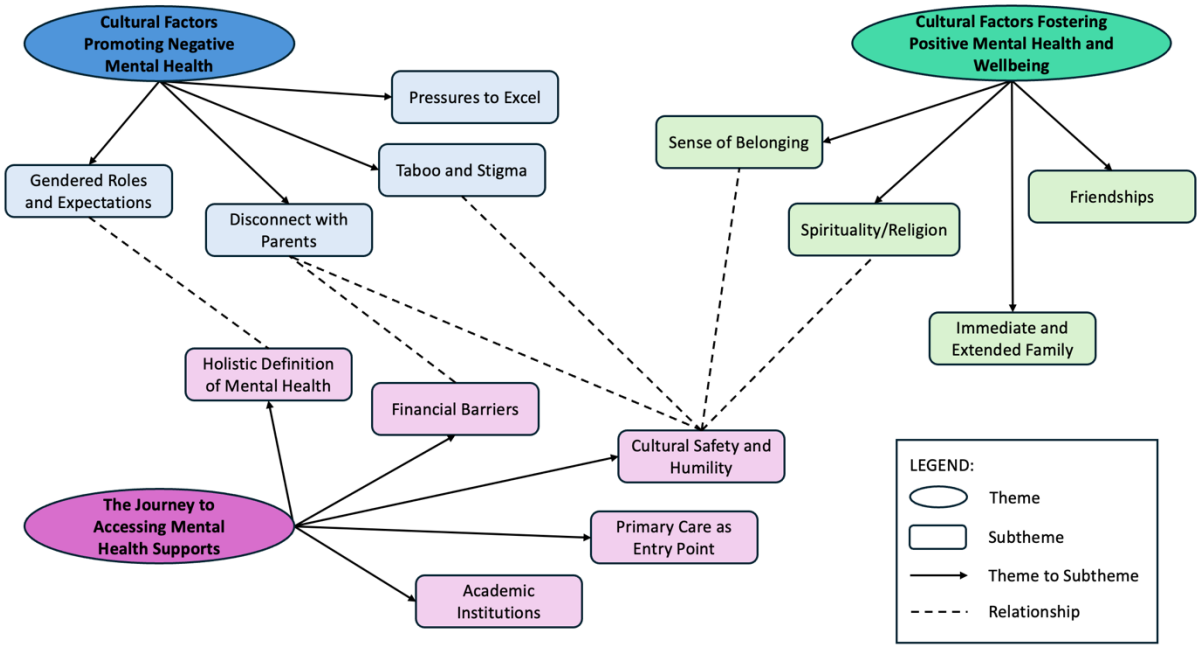
> *"To me, mental health means you being able to be emotionally available for others and for yourself more importantly and just acknowledging emotions and different states of mind and just being okay to live with the way you are mentally as a person."* (P4)

Being content with oneself, despite opinions from others, was also an indicator of positive mental health for many youth. A participant noted that *"mental health is just being satisfied with yourself despite what other people are saying."* (P12). Overall, South Asian youth define mental health very broadly which creates room for a multitude of coping strategies, supports, and ways of navigating their mental wellbeing. Often the interconnections between different dimensions of health (e.g., relationships, physical, emotional) were highlighted when referring to methods in which youth foster mental wellbeing.

The relationships between themes, subthemes, and relationships are mapped out in Figure 2. Figure 2 depicts a thematic map of the connections between each component.

Figure 2

Thematic Map of Themes, Subthemes, and Relationships Between Subthemes



Discussion for Phase I

The aim of Phase I was to explore disparities, if any, and patterns that exist in the access and utilization of MHC for South Asian youth. We found that South Asian youth had limited use of professional mental health services and most turned to their friends for mental health support. The most accessed professionals by South Asian youth were Family Doctors and Nurses/Allied Health Professionals. While the least accessed professional by South Asian youth were psychiatrists. These findings converge with other studies, such that South Asian youth will first rely on their friends for support and then often as a last resort access mental health professionals (Basri et al., 2022; Islam et al., 2023; Leung et al., 2012). Similarly, other literature also indicates that the most mentioned mental health professionals were family doctors, with some mentions of psychiatrists or other professionals (e.g., psychologists, counsellors, social workers) (Chiu et al.,

2018; Islam et al., 2017; Islam et al., 2023; Karasz et al., 2019). Limited findings on use of specific providers for MHC among South Asian youth warrants additional exploration.

We also explored the patterns of access and utilization among South Asian youth as they interact with other identities with interaction terms in logistic regression models. We found that the patterns of accessing different providers or accessing professional services did not differ between men or women, which warrants additional exploration. Previous literature emphasizes the gendered nature of mental health and expression, especially in the South Asian diaspora (Goel et al., 2023; Kulesza et al., 2014; Masood et al., 2009; Sangar & Howe, 2021; Singal & Chopra, 2023). South Asian LGBTQ2+ youth were found to have greater odds of accessing professional MHC. One study found that majority of Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, and Questioning (LGBTIQ) South Asian individuals in Southern California had access to professional MHC services, but around 30% actually used these services (Choudhury et al., 2009). Literature on the patterns of MHC access and utilization of South Asian LGBTQ2+ youth continues to be limited (Inman et al., 2014). However, perhaps our findings could be related to alienation from other forms of support that South Asian youth may rely on (e.g., religion, social) (Inman et al., 2014; Kinha, 2023).

Higher spirituality was associated with lower odds of accessing professional MHC, but the interaction with South Asian identity was not significant. Spirituality does play an important role in fostering mental wellbeing and perhaps mitigating need for professional MHC services, not only for South Asian youth (Ali et al., 2005; Karasz et al., 2019; Kent et al., 2020). When adjusted for South Asian ethnicity, immigrant youth, regardless of years since immigration, had significantly lower odds of accessing professional MHC, but there was no significant interaction with South Asian ethnicity. Immigrant populations in Canada and in USA have been found to

less likely to seek support for their mental health, perhaps indicating a reluctance to seek support due to stigma, lack of trust, cultural beliefs, or even language barriers (Gao, 2021; Mohammadifirouzeh et al., 2023). Based on our findings, we fail to reject the null hypothesis that spirituality/religion and immigration status will influence patterns of access and use of MHC among South Asian youth.

Our findings also indicated that majority of the South Asian youth that accessed professional MHC services felt that those services provided sufficient help. Contrary to this, a study done in the Peel Region of Ontario illustrated that South Asian youth who accessed support from guidance counsellors in school or elsewhere felt that the help received was not sufficient (Islam et al., 2017). Overall, South Asian individuals may have many unmet mental health needs (Karasz et al., 2019; Naeem et al., 2023).

However, we also found that South Asian youth had lower use of professional services and lower odds of indicating perceived needs for MHC. With further investigation, we found that the direct effect of South Asian ethnicity on accessing professional services appeared to be entirely mediated by perceived need for MHC services. Based on other literature, South Asian youth may be less likely to use professional MHC services due to their reliance on other supports such as friends, family, or faith-based coping (Basri et al., 2022; Karasz et al., 2019; Masood et al., 2009; Prajapati & Liebling, 2022). This may limit their help-seeking behaviours or the need they perceive to access professional MHC services (Prajapati & Liebling, 2022).

We also found that Black, Chinese, Filipino, and South Asian youth had lower odds of accessing professional mental health services (Chiu et al., 2018; Fante-Coleman & Jackson-Best, 2020; Islam et al., 2023; Martinez et al., 2020; Sato et al., 2022; Straiton et al., 2018). Based on these findings we can reject the null hypothesis that there will be no disparities in access and use

of mental health care for Black, Chinese, Filipino, and South Asian youth compared to referent groups. Black, Chinese, and South Asian youth were also found to have significantly lower odds of seeking mental health support from their family members. This could perhaps be due to strained relationships due to intergenerational clashes, stigma, and stricter parenting approaches (Beiser et al., 2014; Islam et al., 2023; Salami et al., 2022). All groups had similar odds of reaching out to their friends for mental health support. This could perhaps be attributed to feelings of social connection as well as being understood or supported (Basri et al., 2022; Fante-Coleman & Jackson-Best, 2020; Fung et al., 2022; Hilario et al., 2014; Martinez et al., 2020; Salami et al., 2022).

Strengths and Limitations from Phase I

The 2022 MHACS data utilized is a national source of mental health data, solely dedicated to collecting mental health information of the population. In Phase I, in addition to the oversampling of racialized minorities (i.e., visible minorities), adjustments for the sampling design are exhibited in the weights; the estimates are representative of the national population. These findings are generalizable to the populations included within the survey but perhaps exclude those not included in the responses (e.g., living in collective dwellings, outside of ten provinces, etc.). A strength of the data was that they collected information on both formal and informal access of mental health supports, which provides a more holistic picture of patterns of access and utilization.

There were several limitations in Phase I. The oversampling of racialized minorities was limited when it came to more narrow analyses. For example, the low cell counts were often a limitation in terms of the depth or insight that our findings had (e.g., reasons for disengagement from services). The sample size, despite oversampling from visible minorities, was not sufficient

when restricting analyses by subgroups. There are also limitations in utilizing a secondary dataset and the variables we can analyse. The PUMF did not have the "sex" variable alongside "gender" which limited analyses. Further, the "gender" category was also limited as we were unable to distinguish beyond an established binary (i.e., "men+", "women+"). Attempts to mitigate the lack of depth were done through the qualitative portion. Limitations to Phase I are also linked to oversampling of visible minorities and bootstrapping that occurs to estimate parameters, oversampling was not sufficient for more narrow analyses. Future research and similar datasets could aim to combine multiple cycles to perhaps account for the low cell count. Further, future research could also dig deeper into the role that gender may play in terms of patterns of access and utilization of MHC.

Discussion for Phase II

The aim of Phase II was to again explore what disparities, if any, and/or patterns exist in the access and utilization of MHC for South Asian youth. Specifically, how the experiences of South Asian youth with mental health care pertain to their identities such as gender, religion/spirituality, and immigration status. Cultural factors were found to contribute to both positive and negative mental health among South Asian youth, with them having unique journeys to accessing supports for their mental health.

Cultural factors that were found to foster positive mental health included friendships, family, spirituality/religion, and a sense of belonging. Youth emphasized the importance of friendships in their lives as supports for their mental health which helped them feel seen and valued. An emphasis was also placed on the importance of developing strong support networks and social connections in fostering positive mental health. This was also highlighted in the isolation felt due to the pandemic hindering development of friendships (Islam et al., 2023). They

leaned on friendships to cope instead of professional supports as their friendships helped them feel validated and supported. Friendships were especially crucial when youth experienced a lack of supportive family relationships. Findings from other studies also report that South Asian youth may rely on their friends (Islam et al., 2023; Leung et al., 2012).

Family, both immediate and extended, were described as playing a strong role in fostering positive mental health as well. Connections with family fostered a sense of safety, especially within the home. A strong relationship with siblings and parents fostered an atmosphere of open communication and support. For the purposes of this study, we included "family friends" under the categorization of family due to agreement between the author (JG) and secondary coder (AK) as well as due to the collectivistic nature of South Asian culture (Chadda & Deb, 2013; Karasz et al., 2019). Parents and family play an important role in the emotional wellbeing of South Asian youth (Islam et al., 2017; Islam et al., 2023). Youth often bridged the generation gap for their older generations (e.g., translating for grandparent appointments), which could at times add more to their already full plate (Islam et al., 2023). Participants indicated that they would also turn to cousins and family friends, as the extended family was able to understand their lives and provide meaningful support. South Asian youth place importance on the connections they have with their family, immediate and extended (Tummala-Narra et al., 2016).

A sense of belonging manifested in the desire to fit in and feel seen. Fitting in with broader South Asian community seemed to help youth feel understood, validated in their experiences, safe, and promotes positive mental health. Feelings of belonging promoted positive mental health among participants, highlighting that it helped them feel seen. Immigrant youth expressed the difficulties associated with trying to fit into a new culture and how it fostered

feelings of alienation (Tummala-Narra & Deshpande, 2018). Participants also expressed a desire for representation of their experiences (e.g., media) (Islam et al., 2017). Further, regardless of diversity in religious affiliations, most youth emphasized the importance of spirituality/religion in helping them cope on a day-to-day basis, foster positive mental health, and develop long-term resilience. Faith-based coping and spirituality have been found to play a role in fostering mental health among South Asian youth (Islam et al., 2023; Prajapati & Liebling, 2022; Stroope et al., 2022).

Based on the current study, cultural factors such as taboo and stigma, disconnect with parents, pressures to excel, and gendered roles and expectations can contribute to negative mental health seen in South Asian youth. Despite there being a need for mental health support, these factors can also hinder the extent to which youth reach out for help. Thus, their journey when trying to access mental health supports may be unique and culturally influenced.

Our study also found that the taboo around topics of mental health in the South Asian community may play a role in the stigma, or shame, associated with mental health. The dismissal of mental health issues reported by participants was associated with an avoidance of the topic or hesitancy to bring it up. Similarly, the taboo created an expectation of what is acceptable behaviour or not, which is tied to the concept of izzat (Sangar & Howe, 2021). The shame or stigma, also known as sharam, may negatively influence mental health of youth (Gilbert et al., 2004; Sangar & Howe, 2021). Taboo or stigma relate to pressures within the community to have a "perfect" image and focus on what others in society think (Islam et al., 2023).

Pressures to perform academically can take priority over everything else in youth's lives, which often creates an association between self-worth and achievements. Youth indicated that these pressures may result in mental wellbeing being less prioritized. Pressures to succeed and

excel can cultivate competition in the community, which may hinder connection with peers. As mentioned earlier, support networks were one of the ways in which youth fostered positive mental health. As such, pressures to excel in academics or other achievements hinder the ability to form meaningful relationships with other South Asian youth without the shadows of comparison (Islam et al., 2023). Cultural expectations such as a focus on what others in society may think, result in youth putting up a front at home and in the community. Related to the concepts of izzat and sharam, this deters youth from talking about their mental health, further hindering their access to supports and promotes negative mental health (Sangar & Howe, 2021). Cultural expectations to excel, especially maintenance of image or izzat in the community, have gendered aspects (Gill & Brah, 2014; Sangar & Howe, 2021).

Women in the South Asian diaspora often shoulder the izzat of the family and have more restrictions placed on the behaviour that is considered societally acceptable for them to do (Sangar & Howe, 2021). In our study, this translated to differences in help-seeking behaviours, but also in the expression of emotion. For men, these gendered differences in emotional expression may be associated with a culture of toxic masculinity, also reported by a participant (Prajapati & Liebling, 2022). As reported by participants, for women, the expectations for emotional expression may be associated with a dismissal of their concerns. South Asian women also reported experiencing different standards in terms of the activities they're allowed to do. This limits the freedom of South Asian women and girls in homes, creating a double standard between what men and women are allowed to do (Prajapati & Liebling, 2022). All in all, this created feelings of isolation, hyper-independency, and hesitancy to reach out for help. Similar findings surrounding sex differences were found in a study by Islam and colleagues (2023) with South Asian youth in the Peel Region, Ontario. This hesitancy to seek help for aspects like

mental wellbeing were found to stem from a belief that they should be helping their family rather than seeking help or should be able to help themselves. They reported feeling selfish or that they did not recognize they needed help after dismissing their own feelings and being dismissed by others. Due to a prioritization of collectivism among South Asian families, therefore a lack of focus on the family's needs and expression of an individual view may appear selfish (Chadda & Deb, 2013). As documented in our study, eldest daughters faced additional pressures to succeed not only due to reputation of the family, but also to guide their siblings, which contributed to negative mental health. Eldest daughters may face pressures to protect their younger siblings and shoulder additional burdens (Shaligram et al., 2022).

Youth often felt that a disconnect between them and their parents contributed to negative mental health, especially for youth with immigrant parents. Parental awareness of mental health and differences in their cultural upbringing (i.e., immigrant VS. born in Canada) played a difference in the disconnect between youth and parents. Other studies indicate similar findings surrounding the importance of connection to parents (Islam et al., 2023). Participants from our study also shared that if their parents took the time to understand mental health, it would have helped them develop a relationship and feel understood. Youth discussed how their parents would silence their mental health concerns by brushing them off. This is related to the concept of taboo mentioned earlier, what is acceptable conversation or not. For youth accessing professional MHC, they may need to use parental insurance. However, if there is disconnect between them and their parent, it may further strain relationships or perhaps not even be an option. This leaves youth without the care they may need. If they do access the support, the cost or money may also be used as a form of pulling strings or power for parents over their child, which could increase strain on relationships. Unjust distribution of money as well as using money or resources to pull

strings may be common in South Asian, collectivistic families (Karasz et al., 2019). Further, pressure from parents to academically succeed or comparisons with other youth could contribute to disconnect as well (Islam et al., 2023).

Youth described that financial barriers hindered them from accessing MHC. Once youth they leave high school or graduate from post-secondary, they indicated they would not have accessible mental health resources. We found that immigrant youth especially emphasized the support they received from their high school guidance counsellors in transition or tough periods. In our study and broadly in literature, South Asian youth reach out to counsellors in their schools or universities for mental health support (Basri et al., 2022; Islam et al., 2017).

Youth holistically defined their mental health and emphasized the interconnected nature of mental health with other aspects of health. They described the importance of overall mental, emotional, and physical wellbeing. A systematic review and meta-ethnography on experiences of South Asian MHC users in the UK also indicated that South Asian communities may define mental health holistically (Prajapati & Liebling, 2022). Similarly, some youth defined positive mental health as a capacity to be there for others. This could be related to collectivist nature of South Asian families (Chadda & Deb, 2013; Karasz et al., 2019). Further, the way youth define what positive mental health means to them, may play a role in the resources they choose to use to foster positive mental health. For example, some turned to physical activity while others turned to spirituality or support networks. Physical activity, spirituality, and social connection or support networks have all been found to foster positive mental health (Arat & Wong, 2017; Karasz et al., 2019; Masood et al., 2009).

Although youth did not frequently access many professional services, one service that was often acknowledged was primary care. For those youth that had access to a primary care

physician, they described supportive experiences that allowed them to get connected with mental health resources. Often, their primary care physician was their entry point to mental health care. Participants described positive experiences associated with the longitudinal relationship they had with their primary care physician in terms of getting care they need at different phases of life. By acting as an access point to other mental health related supports, primary care providers can connect youth to services that meet their needs. South Asian youth may often turn to primary care providers for support over others and may present with physical symptoms (Islam et al., 2023; Karasz et al., 2019).

Within the context of this study, cultural safety can be further described as providers understanding of the role that power imbalances, racism, or discrimination play in how South Asian youth access or utilize MHC (Public Health Agency of Canada, 2023). Further, cultural humility requires a reflection of one's own privileges as a provider as well (Public Health Agency of Canada, 2023). In our study, South Asian youth expressed a desire for providers that acknowledge dynamics and understand their experiences. Youth expressed a desire for mental health care providers that understand their familial and cultural dynamics. In addition to safe or non-judgemental spaces, it is crucial that the burden does not fall on youth to explain their culture. South Asian youth have expressed a desire to receive culturally safe MHC (Islam et al., 2017). Thus, illustrating a need for cultural awareness and competence as well (Public Health Agency of Canada, 2023).

Often to avoid having to do the extra explaining, youth opted for providers that shared similar identities to them. Most youth expressed that providers may not have to be South Asian, but being racialized or sharing identities such as gender helps to create a stronger therapeutic relationship where they feel understood. There was an overall desire for representation in the

providers and resources available (Goel et al., 2023). Youth also expressed that mental health care providers can help bridge the disconnect we see between youth and their parents. By navigating conversations with an understanding of cultural dynamics, safety, and humility, providers can help dissuade the concerns of parents (Islam et al., 2023).

By recognizing factors that promote negative mental health and foster positive mental health, providers can tailor resources to South Asian youth. It requires an acknowledgement of broader cultural dynamics as well as imbalances in current provision of services (i.e., lack of representative services). Not every South Asian youth has the same experiences, hence illustrating the importance of a patient-centered conversation. Letting youth define their experiences, and identities is important to this. It is crucial that providers are cognizant of dynamics within general South Asian families and specific cultures, which includes the layers added to experiences by different identities (e.g., immigration, gender, birth order, stigma or taboo).

Furthermore, the first step is acknowledgement of the diversity of factors contributing to positive and negative mental health, as well as individual journeys to accessing mental health care. When we do this, we can begin to think about ways in which we can adequately meet the mental health needs of South Asian youth.

Strengths and Limitations of Phase II

The qualitative design of the study aimed to describe experiences of South Asian youth with MHC in the local context. It provided a deeper understanding of the factors that contribute to positive and negative mental health within the South Asian community. This phase allowed us to understand how different identities intersect to shape experiences of South Asian youth with MHC (e.g., gendered expectations, immigration). The theoretical flexibility of thematic analysis

allowed us to integrate a recognition of intersections between identities and how this can influence patterns of access or use of MHC (Braun & Clarke, 2021c). In addition to this, by having open conversation on mental health in the South Asian community, we can take small steps to address the taboo and stigma that exists. This allows us to generate interventions such as informational sessions for parents or providers, as well as guide providers in what cultural safety looks like in practice with the South Asian community. This phase also allowed us to obtain insight on perceived needs of South Asian youth, patterns of access and utilization, as well as helpfulness of services. The participants were also from varying groups in the South Asian diaspora, showcasing diversity even within the South Asian community.

The current study, although insightful, was limited to the local context. However, our use of thick descriptions and quotes may support the transferability or applicability of these findings to other contexts and communities (Noble & Smith, 2015). Our sample was mostly women, which could limit recognition of experiences of other genders. This has implications on South Asian LGBTQ2+ youth and men, and how their experiences may be different due to differences in intersecting identities. We also did not explore sexual orientation, which could further influence how youth interact with MHC. Similarly, youth who participated may have been more open to discussing mental health, perhaps not as affected by taboo or stigma, which could limit the representation of perspectives. In addition to this, given that financial barriers hindered use of MHC, it may have been helpful to explore differences in socioeconomic status. Another limitation is that as an insider to the community as a South Asian woman, some youth may have assumed that the author (JG) was familiar with topics (e.g., stigma). Thus, were not specific when describing their stories. The author (JG), tried to mitigate this through the rest of the interviews by letting participants know that she may be asking questions that prompt them to

explain their experiences, even though she herself is South Asian and may share similar experiences. Given the sensitive and taboo nature of the topic, some may have also experienced discomfort and underreported experiences. Further, findings may not entirely reflect the diversity within the South Asian community. Another limitation of our study is the potential for sampling bias associated with participants in Phase II. Participants opted in to participate and all except two participants were in undergraduate education, completed undergraduate program, or enrolled in a professional program. To mitigate this, we placed posters in diverse settings (e.g., restaurants, recreation facilities, campuses). This could be related to the high pressures related to academics in the South Asian community, but the pool may not be representative of the whole community. Future studies should aim to do similar deeper explorations on subgroups within the South Asian community (e.g., sects in religions, ethnicity). Given the diversity within the South Asian community, this would illustrate different ways in which mental health may influence different subgroups.

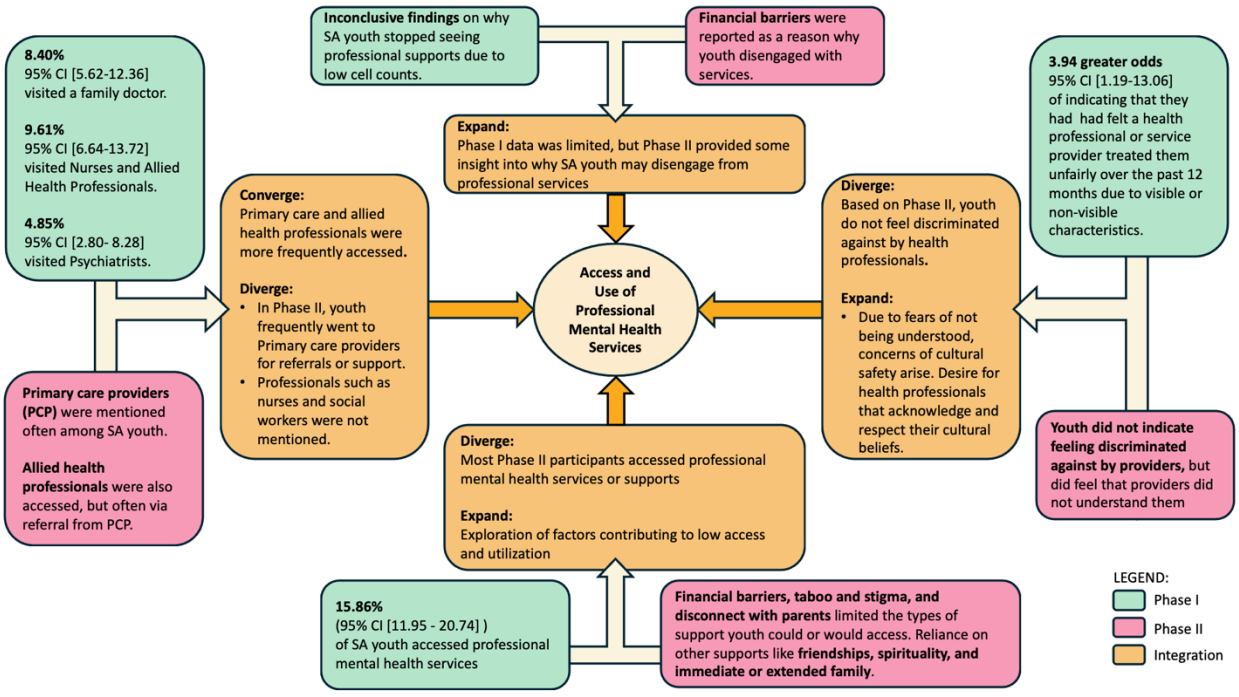
Integration of Phase I and Phase II

Following data analysis of individual phases, we integrated findings to identify key findings. Given that the current study followed a convergent mixed-methods design, the integration and interpretation involved identifying points that converged, diverged, and perhaps provided additional insight (Creswell & Plano Clark, 2018). This was done by mapping the findings from Phase I to findings from Phase II. By combining Phases I and II we were able to understand and describe experiences that South Asian youth have with MHC. The goal of integration was to see how the findings from each phase expanded on, diverged from, or converged with findings from the other phase (Creswell & Plano Clark, 2018). These findings were integrated within a joint display table (see Appendix F) and four separate visual figures.

Figure 3 provides a visual that combines both Phase I and II in a discussion of access and utilization patterns of professional MHC services among South Asian youth. As seen in Figure 3, in both Phase I and II, South Asian youth placed emphasis on primary care and Nurses/Allied Health Professionals if they received professional MHC. However, diverging from Phase I, youth in Phase II described that they frequently went to Primary Care Providers (i.e., family physicians) and did not mention Nurses or Social Workers.

Figure 3

Integration of Access and Utilization Patterns of Professional Mental Health Services among South Asian Youth



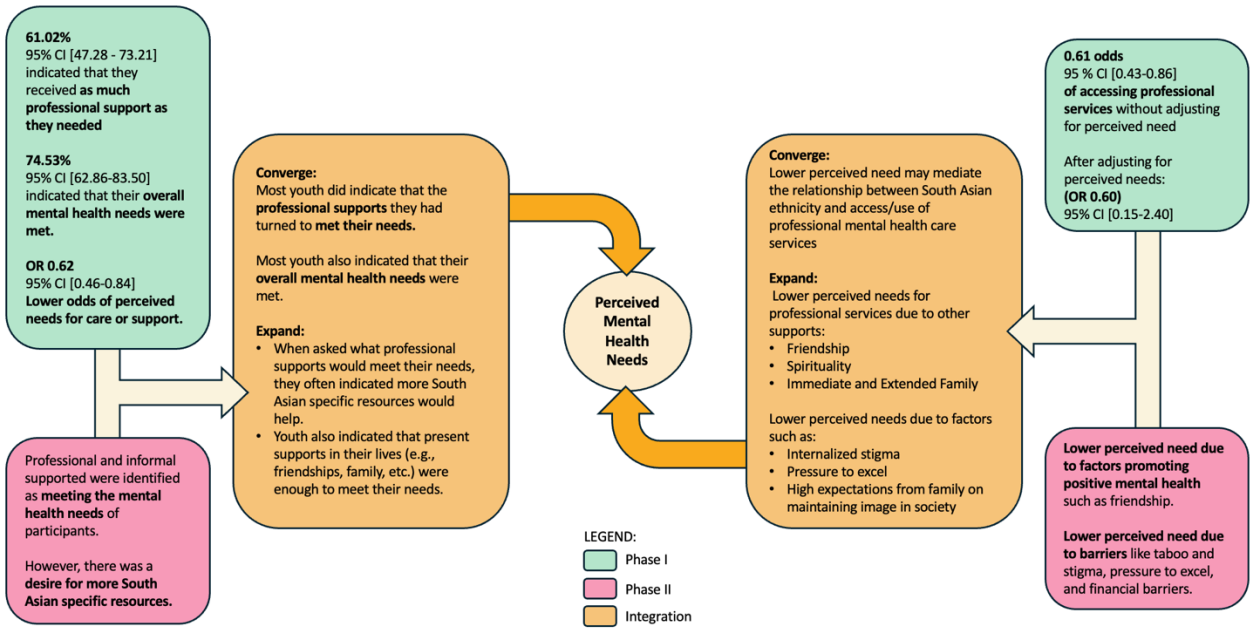
Due to low cell counts in Phase I we were unable to determine reasons for disengagement. However, seen in Figure 3, Phase II expanded on the reasons why South Asian youth may have disengaged from professional MHC services, elucidating the effect of financial barriers on access and use of MHC. Also in Figure 3, in Phase I, South Asian youth had higher odds of indicating they had been discriminated against or treated unfairly over the past 12

months due to visible or non-visible characteristics. However, these findings diverged from those in Phase II. Phase II expanded findings and provided insight that youth may be afraid of not being understood and fear a lack of cultural safety.

As seen in Figure 3, a smaller proportion of South Asian youth accessed professional MHC in Phase I. However, diverging from this, majority of participants in Phase II indicated accessing MHC in some capacity (e.g., counsellor, primary care physician, psychiatrist). Phase II expanded on Phase I and highlighted factors that could hinder or mitigate access of MHC among South Asian youth. Financial barriers, taboo or stigma, and disconnect with parents could hinder access and use of MHC. Similarly, a reliance on other supports such as friendships, spirituality, and family could perhaps mitigate need for MHC. Further, Figure 4 illustrates the integration of findings from Phase I and II regarding perceived mental health needs of South Asian youth.

Figure 4

Integration of Perceived, Met and Unmet Mental Health Needs of South Asian Youth



As depicted in Figure 4, in Phase I, South Asian youth felt they received as much support as they needed, their overall mental health needs were met, and they had lower odds of indicating

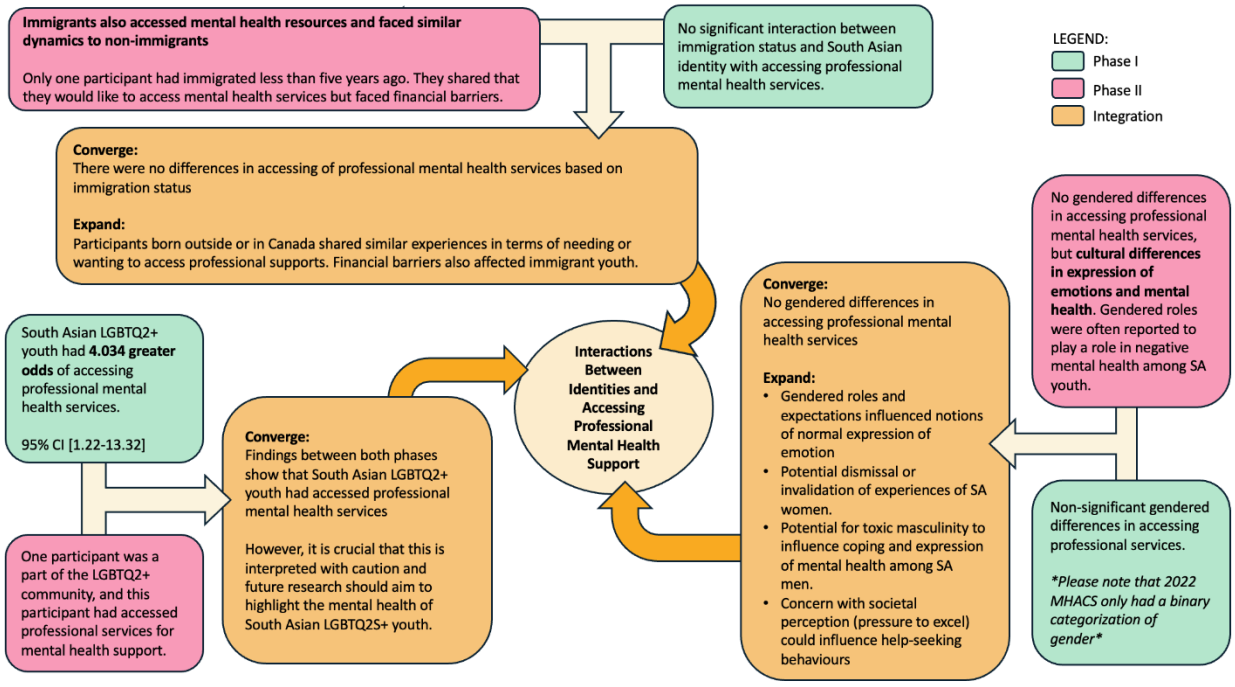
they had perceived mental health needs for care. This converged with findings from Phase II, wherein most youth indicated that their overall mental health needs were met and any professional MHC they turned to had sufficiently met their needs. Phase II also expanded on Phase I as youth indicated a desire for more South Asian specific mental health resources. Youth also emphasized that the other supports in their lives were enough to meet their mental health needs.

Phase I, as shown in Figure 4, also indicated that after adjusting for perceived needs, the lower odds for accessing professional MHC among South Asian youth were no longer significant. Phase II converged with Phase I to indicate that lower perceived needs may mediate the relationship between South Asian ethnicity and access or use of professional MHC. Phase II expanded on findings by describing that lower perceived needs could be related to a reliance on other supports such as spirituality, friendship, and family. A lower perceived need for MHC services could also be related to internalized stigma, pressures to excel, and maintain family image in the community.

Figure 5 depicts the integration between identities of South Asian youth and patterns of access or use of professional MHC services from Phase I and II. In Phase I, there was no significant interaction between immigration status and South Asian ethnicity with accessing professional MHC. Phase II converged with Phase I and indicated that there were no differences in accessing professional MHC services based on the immigration status of youth. Phase II also expanded on Phase I, such that youth born outside or in Canada shared similar experiences of needing or wanting to access professional support. Immigrant youth also reported financial barriers in accessing professional MHC services.

Figure 5

Integration of the Interactions Between Identities of South Asian Youth and Accessing Professional Mental Health Supports



South Asian LGBTQ2+ youth, as seen in Figure 5, in Phase I had greater odds of accessing professional MHC services. We had one participant that was a part of the LGBTQ2+ community who had accessed professional MHC services. Phase II converged with Phase I and showed that South Asian LGBTQ2+ youth had accessed professional MHC services. However, these findings should be interpreted with caution and future research should aim to highlight the mental health of South Asian LGBTQ2+ youth.

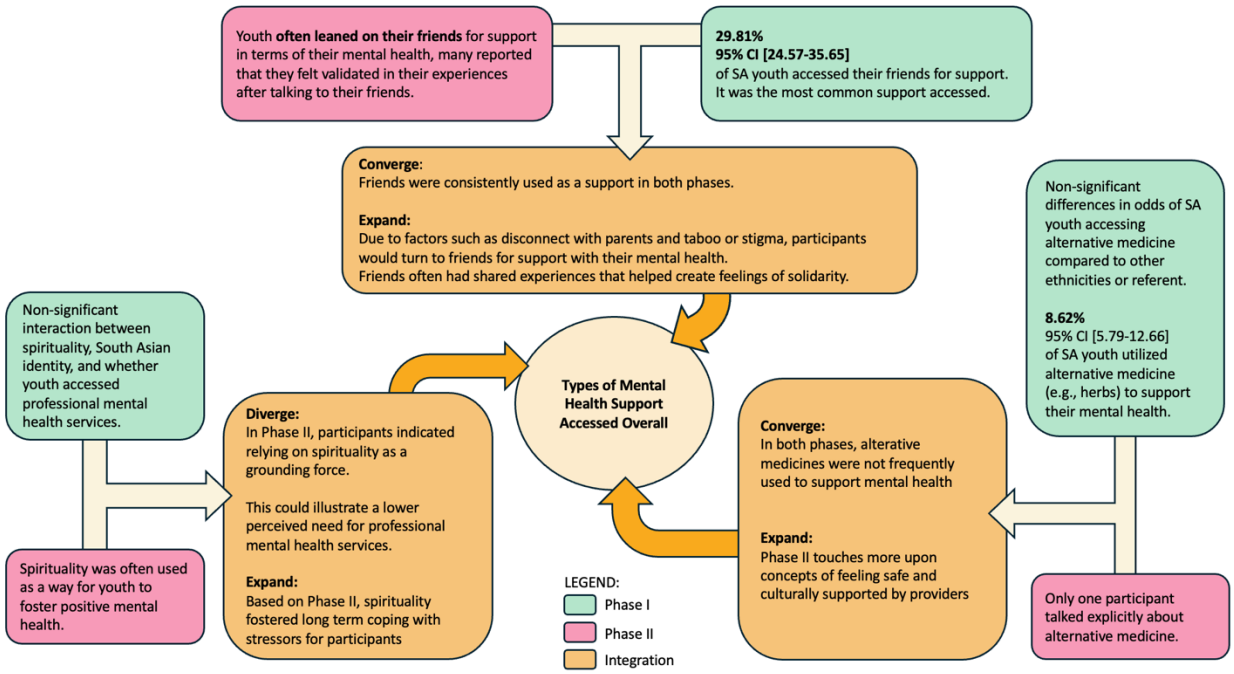
There were non-significant interactions between gender and South Asian ethnicity (i.e., only binary due to structure of variables in 2022 MHACS) in accessing professional MHC services in Phase I, as seen in Figure 5. Phase II converged with Phase I, such that there were no gendered differences (i.e., binary classification) in access or use of professional MHC services. However, findings in Phase II expanded on those from Phase I and described gendered

expectations regarding emotional expression of South Asian men and women. Additionally, emotional expression of South Asian men may be impacted by notions of masculinity while women may be dismissed or ignored. Concerns with societal perception or pressures to maintain an image in the community may differentially impact South Asian men and women.

Figure 6 illustrates the integration of types of mental health support overall among South Asian youth in both Phase I and II. Majority of South Asian youth in Phase I accessed their friends for support. This converged with Phase II as youth described leaning on their friends for mental health support. Phase II expanded on this by offering some insight as to why South Asian youth reached out to friends such as disconnect from their parents or felt solidarity.

Figure 6

Integration of Types of Informal Mental Health Support Among South Asian Youth



South Asian youth in Phase I also had non-significant differences in accessing alternative medicine for mental health support, as seen in Figure 6. Phase II converged with Phase I to illustrate that alternative medicines were not frequently used to support mental health for South

Asian youth. Phase II expanded on Phase I by touching on what they would like to see from providers when it comes to accessing different kinds of support (e.g., safety). Also in Figure 6, Phase I indicated a non-significant interaction between spirituality and South Asian identity and whether youth accessed professional MHC services. Phase II diverged from Phase I and indicated that participants relied on spirituality often to foster positive mental health. Phase II also expanded on Phase I by describing how spirituality often fostered long term coping for participants.

As shown in the figures previously described, the mixed-methods integration allowed us to obtain a broader, but also a more nuanced, understanding of the mental health of South Asian youth, access/utilization patterns, and how they pertain to different aspects of identity (e.g., gender, immigration, spirituality).

Overall Discussion

This study is the first to explore patterns of mental health care access and utilization among South Asian youth. It utilized a mixed-method design to provide a comprehensive understanding of experiences that South Asian youth have with mental health care, as well as specific factors contributing to positive or negative mental health. The study explored perceived mental health needs, as well as to what extent mental health needs were met or unmet by informal or formal resources. The key findings from integrating Phases I and II are that mental health needs of youth may be met, they often relied on primary care physicians for professional MHC support, and cultural factors can act as both barriers and supports to MHC.

Based on our study, the overall mental health needs of South Asian youth appear to be met and any professional MHC services accessed had also sufficiently met their needs. Although literature did indicate that South Asian youth had unmet mental health needs (Islam et al., 2017;

Karasz et al., 2019). Lower perceived needs for MHC services may mediate the use of professional MHC services among South Asian youth. Lower perceived needs and corresponding lower utilization of professional MHC may be due to other supports sufficiently meeting their mental health needs (e.g., family, friends, spirituality) (Leung et al., 2012; Prajapati & Liebling, 2022). On the other hand, lower perceived needs and low utilization could be related to stigma or izzat in the community (Sangar & Howe, 2021).

Our study also explored how different identities played a role in the access and utilization of MHC services among South Asian youth. Immigration status did not appear to influence access or use of professional MHC services, such that immigrant youth and Canadian-born youth may have similar experiences. South Asian LGBTQ2+ youth accessed professional MHC, but any extrapolation on the patterns or use for South Asian sexual or gender minorities requires further research (Inman et al., 2014). Phase I showed a non-significant interaction between gender, South Asian ethnicity, and access of professional MHC services. Using a binary description of gender, Phase II indicated that gendered expectations did not play a role in whether services were accessed. However, youth did report that gendered expectations did differentially influence emotional expression of South Asian men and women. Notions of izzat may manifest among South Asian men as being restrictive of their emotional expression, while women may be dismissed or ignored (Arora et al., 2016; Prajapati & Liebling, 2022; Singal & Chopra, 2023).

South Asian individuals may rely on their family doctors or primary care providers for support, especially due to their definitions of mental health focusing perhaps on more physical symptoms (Chiu et al., 2018; Islam et al., 2023; Karasz et al., 2019). Financial barriers are common for South Asian youth when trying to access professional or formal MHC services

(Basri et al., 2022). There may need to be more exploration on discrimination faced by South Asian youth when accessing professional MHC. However, within our study and others, South Asian youth did indicate a desire for MHC that feels safe, recognizes specific cultural dynamics, and understands power imbalances (Prajapati & Liebling, 2022). This emphasizes a need to develop interventions that highlight the importance of cultural safety in MHC for providers.

There were discrepancies between Phase I which had a small proportion of South Asian youth accessing professional MHC, while majority of participants in Phase II had accessed professional MHC. Literature does indicate that South Asian youth may access professional MHC at lower rates (Gadalla, 2010; Islam et al., 2023). Our study found that South Asian youth may be hindered from accessing professional MHC due to financial barriers, taboo or stigma, and disconnect with parents. These findings were also supported by other studies that highlighted that taboo or stigma, disconnection with parents, and financial barriers can hinder the access and use of MHC for South Asian youth (Basri et al., 2022; Islam et al., 2023).

Overall, aligning with other literature, our findings indicated that South Asian youth often relied on their friends for mental health support (Basri et al., 2022; Islam et al., 2023). This could perhaps be due to tensions or disconnect with family or stigma (Islam et al., 2023). Spirituality and South Asian ethnicity had non-significant interactions when it comes to access or use of professional MHC services. However, in general, higher spirituality was associated with lower odds of accessing professional MHC. Further, youth indicated that spirituality fostered long-term coping and positive mental health.

Furthermore, this mixed-methods study found that many factors play a role in the patterns of access and utilization of MHC we see among South Asian youth. From our findings, we were

able to understand the importance of cultural factors in both promoting and hindering mental health.

Strengths and Limitations

Our study captured a wide range of data but also explored deeper into details of experiences that South Asian youth have with MHC in the local context and across the country. This allowed us to quantify broader patterns using the cross-sectional nature of Phase I and then supplement it with the qualitative nature of Phase II to recognize the importance of context or lived experiences. Given that mental health can be influenced by a multitude of factors, using the mixed methods design we were able to highlight potential reasons for why certain trends (i.e., low use, low unmet mental health needs) may have been seen in Phase I. The results from our findings in Phase I provided specific direction in recognizing gaps in patterns of access and use, with Phase II we provided context or stories to aforementioned gaps, both of which can be applied to targeted interventions that can meaningfully support South Asian youth mental health. Another strength of our study was the integration component of mixed methods, which combined descriptive statistics with personal experiences to provide additional insight that expanded our understanding and provided a comprehensive outcome. Overall, within the context of a convergent mixed methods design, the integration allowed us to also confirm or validate our findings (Creswell & Plano Clark, 2018).

One limitation of our mixed methods study was that Phase I did not directly involve the same participants who were then interviewed in Phase II. However, by limiting it to a similar age range and focusing on identity (i.e., South Asian), they may have shared similar experiences. This approach with two different pools could mitigate biases. For example, our approach could potentially have mitigated the social desirability bias (i.e., giving responses that participants feel

are more desirable) in both phases (Braun & Clarke, 2013). If we used the same pools, participants may not have been comfortable in honestly sharing their experiences and repeating this in both phases. Similarly, a response bias based on answers in one phase could have influenced responses in the other. Thus, having two different pools of participants may have allowed us to gather a diverse representation of experiences for nationwide and local contexts. Further, using two different pools may limit attrition, especially with mixed-methods studies that can be more time-consuming.

Future Directions

Mixed methods research can provide deeper meanings or understandings of the complex phenomena, like access or use of MHC among South Asian populations, to stakeholders of the findings (McKim, 2015). Future studies should do deeper exploration into individual factors (e.g., spirituality, izzat, gendered expectations) and how they influence mental health. The use of mixed methods studies with the same pool of participants could be valuable by allowing participants to provide accounts of experiences that supplement statistical findings in a more direct manner. Similar mixed methods research should be done with other racialized minorities such as Black, Chinese, or Filipino populations as it provides deeper insight of their mental health needs. It can highlight cultural factors that promote negative or positive mental health, which can support generation of targeted interventions (e.g., community-based outreach, training for providers). In Chapter 3, we also discuss and propose future directions.

Contribution to the Field of Mixed Methods Research

Our study findings contribute to the field of mixed methods research, specifically in the context of mental health research in racialized populations. The study generated a comprehensive understanding of patterns of access and use of MHC with mixed methods research. The field of

mixed methods is growing and is valuable in exploring complex phenomena such as mental health (McKim, 2015; World Health Organization, 2022). The current study generated visual displays in addition to joint-display tables in order to foster comprehension of findings in an accessible format. Joint displays are helpful in assisting researchers with integration of their data, regardless of what stage it is occurring at (i.e., data collection, results) (McCrudden et al., 2021). Mixed methods research does not have one specific way of presenting findings and there are limited examples of what constitutes a joint display for mixed methods research (McCrudden et al., 2021). Our representation adds to the creative ways in which we can use visuals to represent findings (McCrudden et al., 2021).

Conclusion

Our findings illustrated complexities of South Asian youth mental health and how factors may influence access or use of MHC in Canada and local context. South Asian youth may access primary care providers (e.g., primary care physicians) prior to being connected with specialized providers for MHC. South Asian youth may rely on their support networks such as immediate/extended family and friends to foster positive mental health. These factors that promote mental wellbeing could contribute to a low need for formal MHC services. Cultural factors such as stigma, gendered expectations, pressures to excel, and disconnect with parents could be related to the low utilization of MHC. Findings generated a comprehensive understanding of factors impacting access and use of MHC among South Asian youth so that we can support populations in a meaningful manner. The next chapter will discuss and extend key findings to interventions or initiatives to foster mental health of South Asian youth.

Chapter 3

Introduction

Chapter 1 defined key topics such as CRT, intersectionality, cultural safety, and mental health of racialized populations. We discussed the breadth of the South Asian diaspora and mental health both in the Canadian and diasporic context. Limited research has examined the needs of South Asian youth and patterns of access and use of specific MHC services. Further, there are gaps in the literature regarding how the intersections of multiple identities may impact access or use of MHC among South Asian youth. Thus, a study that aimed to understand patterns of access and use of MHC, both quantitatively and qualitatively, is novel to the field and has implications on how we understand mental health in the South Asian population. We described our methodological and theoretical foundations for the study, while also discussing objectives for the study.

In our second Chapter, we described the study. The study was a mixed-methods design which explored patterns of access and use of MHC among South Asian youth. Phase I was a quantitative, descriptive analysis on nationwide cross-sectional data (2022 MHACS). Phase II involved semi-structured interviews based on a QD methodology with South Asian youth in the local context. Following analysis in both phases, the findings were integrated to create a comprehensive understanding. The key findings from our study were that South Asian youth often turned to friends, family, or informal supports (e.g., spirituality). This may have mediated low access or utilization of services along with the negative factors. Cultural factors such as stigma or taboo, pressure to excel, disconnect with parents, and gendered expectations hindered access to and use of MHC for South Asian youth. There were gendered differences (i.e., binary) in cultural expressions of mental health, but not within access or use of MHC. Youth had holistic

definitions of mental health, which influenced what they felt best supported them. If they reached out to a professional, the primary care physician was most frequently reported. Lastly, youth placed an emphasis on cultural safety in MHC.

The current chapter discusses how we can implement findings to different levels of interventions to support the mental health of South Asian youth in the local context. The findings from our study illustrated that the mental health of South Asian youth is impacted by factors that range from individual to community levels. This included helping youth take charge of their own mental health through educational initiatives in school curriculums, reducing interpersonal disconnect with parents, increasing and cultural safety training for providers.

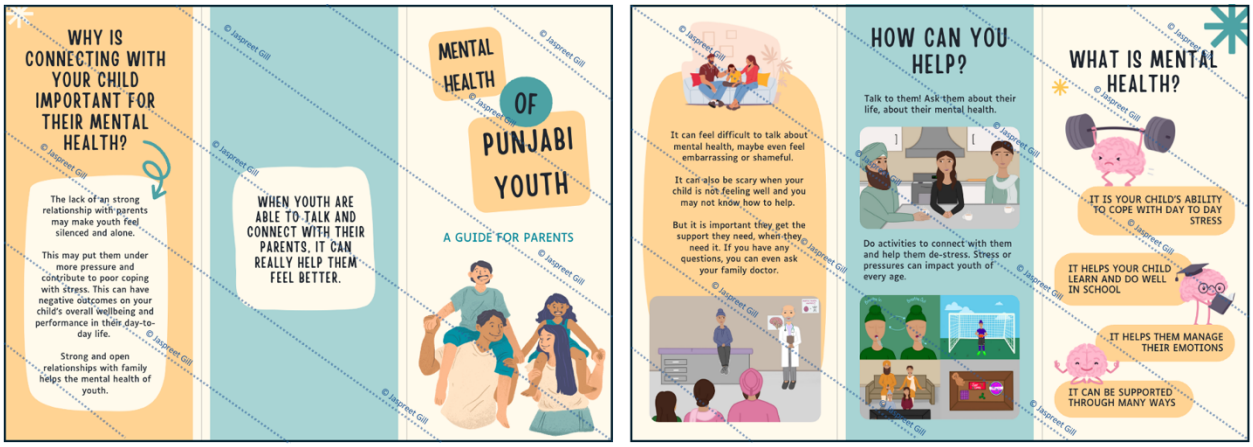
Implications for Access to Mental Health Care for South Asian Youth: Parents

Our study had found that a disconnect with parents, perhaps due to other cultural factors like izzat or taboo and stigma, contributes to negative mental health for youth. A qualitative study by Islam and colleagues (2017) also found that parents play an important role in youth mental health. Our study also found when providers took time to work with parents in explaining information, it fostered a relationship between the parent and an understanding of what mental health is. Thus, the results provide ideas for some steps we can take to better the mental health of youth. In this case, we designed brochures for parents in how to support their child. These brochures could be placed in primary care clinics in regions with larger South Asian populations, in schools, or even in recreation facilities. The English version of this brochure is depicted in Figure 7. We would like to emphasize that every South Asian subgroup has slightly different practices or dynamics due to differences in ethnic groups, language, or even religion. Thus, these figures are solely an example of how we can address this in one community, the Punjabi community.

For instance, South Asian Punjabi families, especially Punjabi men, may have a higher prevalence of substance use issues which can also be perpetuated by a lack of communication in homes (Kunz & Giesbrecht, 1999). Other concerns such as migratory trauma (e.g., partition of Punjab, attacks on religious minorities), acculturative stress, and other stressors could be contributing to the differences seen between the Punjabi community and other South Asian subgroups (Puri et al., 2020). Other subgroups within the South Asian population may not face these issues or may face different ones due to factors such as varying religion or spirituality, or language. By focusing on subgroups, we can ensure that the interventions or mental health promotion strategies are culturally safe and meaningful.

Figure 7

Mental Health of Punjabi Youth: A Guide for Parents (English Version)



A. Outside of brochure

B. Inside of brochure

Note. Designed on "Canva", therefore some graphics utilized from "Canva". Graphics on "*How Can You Help*?" and at the bottom left of Figure 7B. are illustrated by the author (JG).

These brochures touch on key aspects of defining mental health in simple, accessible terminology. It touches on components of the results of our study where stigma or sharam may hinder support for mental health. Figure 8 takes into consideration the potential language barriers

and attempts to translate mental health into the Punjabi language to facilitate understanding among families who may solely be communicating in Punjabi.

Figure 8

Mental Health of Punjabi Youth: A Guide for Parents (Punjabi Version)

A. Outside of brochure

B. Inside of brochure

Note. Designed on "Canva," therefore, some graphics utilized from "Canva." Graphics under *"ਤੁਸੀਂ ਕਿਵੇਂ ਮਦਦ ਕਰ ਸਕਦੇ ਹੋ?"* and at the bottom left of Figure 8B. are illustrated by the author (JG).

The goals of the brochure can be connected to the findings from our study that indicated youth wanted to increase mental health awareness among parents as it would foster connection and conversation. As a part of the Punjabi community, the author (JG) was able to connect pieces of the findings to present them in cohesive manner. Similar interventions or mental health promotion strategies should be implemented in other South Asian ethnic subgroups depending on religious affiliation, language, and other (Puri et al., 2020). By doing so, this recognizes the heterogeneity and diversity even within the South Asian community and ultimately aims to empower wellbeing of subgroups by meeting communities where they are at.

Implications for Access to Mental Health Care for South Asian Youth: Academic Institutions

Youth in our study indicated a desire to have increased integration of mental health into curriculums, for the local context this is the Alberta Education curriculum. The curriculum is developed by the Government of Alberta; however, we have developed some suggestions for what one segment of it could look like (Calgary Board of Education, 2023). Figure 9 is a sample of our proposed integration of mental health into the curriculum.

Figure 9

Sample Organization of Mental Health Integration into Curriculum

Physical & Psychological Wellbeing: Sample Proposed Curriculum

Organizing idea: Developing skills to foster mental health can promote long term mental wellbeing and resilience among South Asian youth.

Guiding question: How can cultural factors support promotion of mental health in South Asian populations?

Learning Outcome: Students analyze mental health and the importance on their day-to-day lives

Knowledge	Understanding	Skills & Procedures
Many factors contribute to mental health, this can depend on the cultural background of youth. For example, South Asian youth may ascribe importance to their relationships (e.g., friends, family) or to faith-based coping.	Mental health is crucial to helping students perform well in school. Setting this foundation of habits in fostering their mental health can support them in their future.	Describe aspects of their day-to-day that help them feel better in the moment. Describe aspects of their lives that help them feel supports and able to cope with stressors. Recognize existing mental health supports in lives and add new ones where necessary.

The current curriculum has a subject called “Physical Education and Wellness”, we believe mental health promotion initiatives and curricula would fit well. The “Physical Education and Wellness” subject is defined as aiming to promote holistic development of student wellness through multiple dimensions (e.g., physical, social, emotional, spiritual, etc.) (LearnAlberta, 2022). Although mental health is mentioned briefly, it could be worth adding a separate section

(LearnAlberta, 2022). Broadly and within our study, youth expressed a desire for more mental health education integrated into their school curriculums, this would help reduce stigma through promotion of conversation as well as promote healthy coping habits (Islam et al., 2017).

As seen in Figure 9, this curriculum would engage youth in understanding what contributes to their mental wellbeing. This would be a reflective process and is broken down into the general knowledge, understanding, and skills/procedures needed to meet the organizing idea. This addition to the curriculum would address common factors we saw in our study such as faith-based coping, importance of relationships, and even the desire from youth to see mental health integrated into curriculum. It is important to note that this could be tailored to other populations as well, it would be crucial to look at the demographics of the students in the schools. Further, implementation may be difficult due to procedural barriers to complexity in knowing who to contact. However, contacting individual schools (i.e., public, private, separate) may be a feasible starting point. Partnering with community organizations (e.g., South Asian Youth Mental Health, Punjabi Community Health Services, etc.) may also foster relationship-building and support implementation.

Implications for Access to Mental Health Care for South Asian Youth: Medical Learners and Physicians

Our study found that South Asian youth often turned to their primary care physician for mental health support. Primary care was found to service as an entry point in accessing other specialized mental health services (e.g., psychiatrists, counsellors, psychologists, etc.). Youth also indicated the importance of cultural safety and receiving care that feels safe, non-judgemental, and respectful. Given this, we should be integrating aspects of cultural safety with respect to different populations into different stages of medical education. This education starts at

the beginning of medical school, wherein students are often taught about social determinants of health and other topics. We propose that this could even be done through a seminar offered for continuing professional development purposes. This could be implemented through partnerships and reaching out to medical education programs. Seen in Figure 10, we created a structure for what this professional development seminar could look like.

The objectives for the professional development seminar were based on our findings. Medical learners would be taught the difference between cultural safety and humility. There would be a reflexivity exercise where students would walk through their own, biases and reflect on their privilege. The goal is that through learning the process of cultural humility, medical learners can in the future build trust with their patients. It would be helpful to integrate current research and literature on understanding the South Asian population so that examples can be used to support the seminar. The current study would also inform objectives 3-6. Finally, to create a meaningful learning experience, we would recruit a South Asian youth and their parent who have experiences with the MHC system to share their experiences during the seminar. This is referred to as “Human Libraries”, learning via conversation from people from different walks of life and engaging in discussion based on their personal experiences (Human Library Organization, 2025b). Originating in Copenhagen, this approach aims to challenge stereotypes and prejudices around topics (Human Library Organization, 2025a). It can be used as a teaching method for increasing cultural safety, humility, and competence among medical learners (Pope et al., 2023). Opportunities for reflection would also occur after the discussion with Human Libraries.

Figure 10

Proposed Professional Development Seminar for Medical Learners

Professional Development Seminar

Lecture: Cultural Safety and Understanding Mental Health for South Asian youth in Primary Care

Objectives:

1. Defining key terms such as ***"cultural safety"*** and ***"cultural humility"***
2. Walking through your positionality, biases, and reflection to understand cultural humility as a medical learner.
3. Understand social and structural determinants that contribute to mental health of South Asian youth.
4. Understand cultural factors that contribute to power imbalances within South Asian communities and as a result contribute to experiences with mental health care systems.
5. Understand cultural factors that can promote positive mental health for South Asian youth.
6. Engage in a discussion with patient and family speakers

Continuing with our findings, primary care physicians or family physicians played a very important role for the participants in our findings. For South Asian youth in our study, primary care often served as an entry point to receiving further specialized mental health care support. We suggest that these findings be shared as a part of a Grand Rounds presentation, as shown in Figure 11. Grand Rounds can be a great way to disseminate and learn about work of others in your department, as well as inform development for faculty (Department of Family Medicine, 2025). Given that the previous seminar in Figure 10 focused on learners, this could disseminate findings of our study to faculty and other staff. This Grand Round presentation would focus on sharing our findings on promoting positive mental health among South Asian youth, as well as discussing key aspects such cultural safety and humility. Integrated into the rounds presentation would be an activity of learning how to reflect on one's own privileges, power, and understand cultural humility as it pertains to clinical practice. Like the professional development seminar for

medical learners, we would bring in a South Asian youth and their parent to share their stories with MHC access or utilization in primary care settings.

Figure 11

Grand Rounds Presentation for Family Medicine

Department of Family Medicine - Grand Rounds

Title: Cultural Safety and Understanding Mental Health for South Asian Youth in Primary Care

Description: This presentation will cover how to navigate mental health among South Asian youth patients and their families. We will address the application of cultural safety to common patient encounters that physicians may have. We will highlight cultural factors that can support physicians in bridging the gap that South Asian youth experience with mental health care. We will be bringing in a patient and their parent to share their experiences with navigating primary mental health care.

Objectives:

1. Defining key terms such as "cultural safety" and "cultural humility"
2. Walking through your positionality, biases, and reflection to understand cultural humility as a provider.
3. Understand cultural factors that contribute to power imbalances within South Asian communities and broader context to contribute to experiences of South Asian youth with mental health care systems.
4. Understand cultural factors that can promote positive mental health for South Asian youth.

Furthermore, these proposed initiatives based on our findings aim to foster understanding around cultural safety and address barriers to mental health care experienced by South Asian youth. Given that Phase I also described other patterns of access and use of MHC among other racialized minorities, we propose similar types of future research be done with populations to gain deeper understandings of specific mental health needs.

Addressing Limitations of Phase I: 2022 MHACS

In Phase I, we described many limitations. For example, in the future, the oversampling from racialized populations could be greater to allow for more narrow analyses. The descriptions or "gender" variables should also account for genders beyond the binary. For example, questions about gender in which individuals can self-identify broadly (e.g., non-binary, transgender

woman, etc.) should be used and recruitment should aim to oversample from SGMs in order to have more power in narrow analyses. However, with more iterations of the MHACS, multiple cycles could be combined to obtain larger samples. In the context of specific questions, in Figure 12, we proposed some questions that could be added to the MHACS in order to obtain greater detail about mental health and access to care in the Canadian population.

Figure 12

Additional Questions for the MHACS

MHACS Questionnaire – Additional Questions

- What is your ethnicity?
  - If South Asian, what country of origin does your family come from?
  - If South Asian, what ethnic subgroup (if any) do you identify with?
- In the past 12 months, has stigma in your community prevented you from reaching out for support for your mental health?
- In the past 12 months, have you had open-conversations with your parent(s)/guardians about your mental health?
  - Do you feel that the conversations with your parent(s)/guardians meet your mental health needs?
- In the past 12 months, have you spoken to a sibling(s) about your mental health?
  - Do you feel that the conversations with your sibling(s) meets your mental health needs?
- In the past 12 months, have you reached out to an extended family member for support for your mental health?
  - Do you feel that talking to your extended family member(s) meets your mental health needs?

For South Asian ethnicity, the questions could account for diversity within the South Asian population. Stigma is also a common barrier to mental health, it would be imperative to add a question to the survey that could assist in assessing the role of stigma (Knaak et al., 2017). Similarly, the survey question could be expanded beyond whether individuals turned to family members to support. It could further breakdown and specify which family members (i.e., parent(s)/guardians, sibling(s), grandparents, extended family). These are also illustrated in the questions shown in Figure 12. Overall, the MHACS could have obtained a more specific

understanding, but these questions would need to go through the qualitative testing and pilot stages (Statistics Canada, 2023c). However, this could prove to be quite a lengthy process and would perhaps be more feasible to create a survey and explore psychometric properties, prior to engaging Statistics Canada.

Addressing Limitations of Phase II

There were several limitations to the second phase. First, the sample was mostly women, so was not able to provide perhaps more nuanced perspectives from other gender identities. Given the gendered nature of emotional expression and cultural expectations in the South Asian diaspora, it would be important for future research to expand on this. Similar studies within the South Asian community could be conducted with different gender identities to assess the role of gender with mental health of South Asian youth. Specifically, engaging South Asian youth of diverse genders as partners in future research could help recruitment but also facilitation of interviews to ensure comfort of participants. Specifically, given that men face different cultural pressures and the dearth of literature on South Asian men's mental health, it may also be useful to do similar studies with just men. Based on our study, men in South Asian communities may face pressure from their families to limit their emotional expression due to standards of masculinity. Further, it is important to understand how men may experience cultural pressures differently and what factors may differentially contribute to their mental health.

Exploring how South Asian LGBTQ2+ youth experience their mental health may be insightful as well. For example, South Asian gay men felt that while maintaining their family's izzat was important, they felt very shamed by their family for their LGBT identity ((Khan et al., 2020). This concept of izzat contributed to experiences with honour-based violence, hindering mental health of South Asian gay men (Khan et al., 2020). The current study was limited due to

the lack of exploring SGMs in the South Asian youth community as sexual and gender identity could relate to other factors, we found such as stigma as promoting negative mental health or sense of belonging as promoting positive mental health. Depending on sexual or gender identity it could contribute to alienation experienced, and deter LGBTIQ South Asian individuals from seeking formal health services (Choudhury et al., 2009). Further, both Chapter 1 and 2 illustrated how complex mental health is and some of the factors associated with identity that can contribute to both positive and negative mental health. This study provided a deeper understanding of the experiences that South Asian youth have with MHC and how we can begin to address the mental health needs of a growing population in both the local and national context.

Future Directions and Research

Our study highlighted the need to further understand the relationship between mental health needs of South Asian youth and access or utilization of MHC. We found that mental health needs may mediate the relationship between South Asian identity and access of formal mental health services. We addressed factors that may contribute to mental health needs of South Asian youth, the intersections with some identities, and how these needs may be met.

Medical education should consider incorporation of cultural safety and value of lived experiences in highlighting what responsive care looks like for different populations due to varying cultural expectations. However, it should be acknowledged that the South Asian community in Canada has been the target of increasing hate rhetoric and historical trauma within the Canadian context (Government of Canada, 2024a). This was illustrated in Chapter 1. Our study found that cultural factors such as a reliance on immediate/extended family for support, spirituality/religion, and sense of belonging played a role in fostering positive mental health for South Asian youth. Given that these factors align with the collectivistic nature of the South Asian

diaspora, by decolonizing or decentering Western narratives around mental health, we can support youth in a responsive manner (Millner et al., 2021). Future research should aim to understand past and ongoing effects of colonization, as well as the role of historical trauma on mental health of South Asian youth.

Further, similar research should be done with other racialized minorities or populations and equity-denied groups. Our study did find that South Asian youth often differed significantly on outcomes where other racialized minorities did not. However, it is still imperative that a more comprehensive understanding of what shapes mental health needs and corresponding access or utilization of mental health services is also done with other racialized populations. These future studies should aim to address the role of colonization, spirituality or religion as a support, sexual and gender identities, as well as the potential mediating relationship between mental health needs and formal service utilization.

Given that our study found relationships with parents played such a crucial role in the mental health of South Asian youth, future studies could explore parent-child dyads to understand how mental health or experiences manifest between both and how identities of the child or parent may influence this dynamic.

Conclusion

Embedding cultural safety in education for mental health professionals including primary care physicians could foster a space in which racialized minorities feel safe when receiving care. Integrating mental health education into curriculum for youth could empower them with information to foster their own mental wellbeing, as expressed by our participants. Further, leaning on and leveraging existing supports to foster mental health of South Asian youth could

advance mental health of the South Asian diaspora. These findings could benefit not only South Asian youth, but also other youth regarding the decolonization of mental health and wellbeing.

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Appendix A. Convergent Mixed Method Study Design

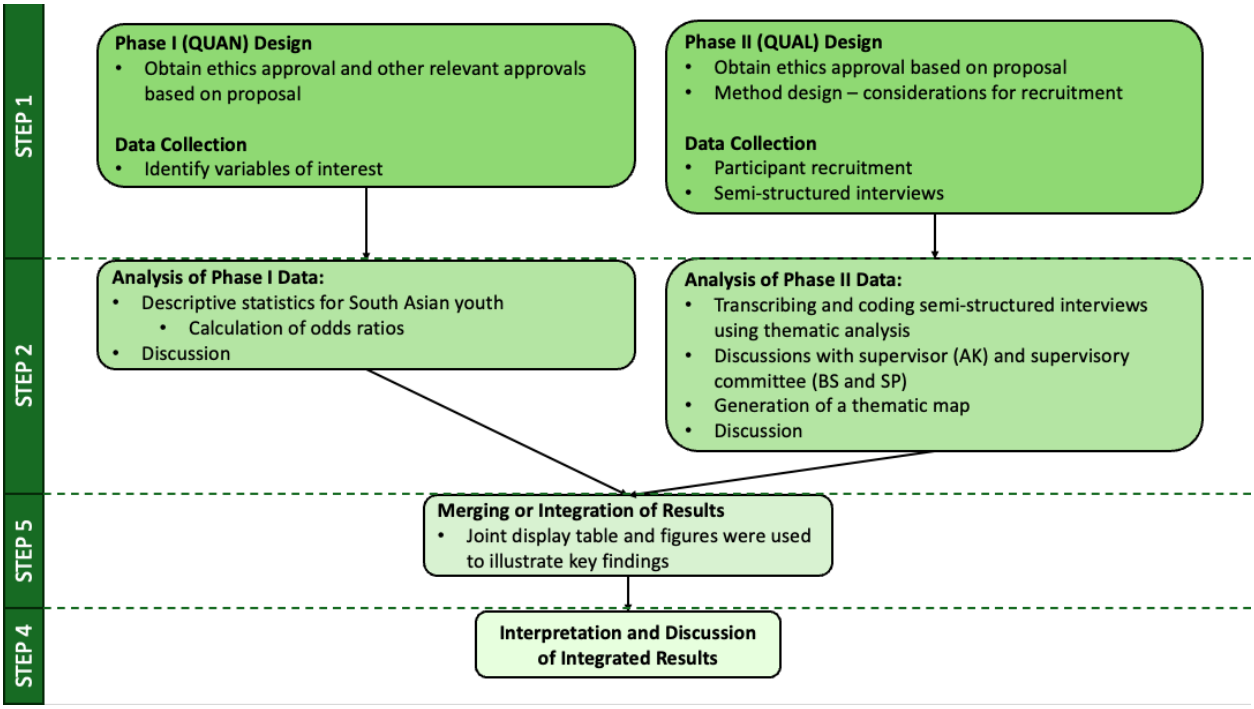

Figure 1. *Phases of the Study*

Appendix B. Interview Guide for Phase II

UNIVERSITY OF CALGARY

INTERVIEW GUIDE

Project Name: Exploring Disparities in Access and Utilization of Mental Health Care Among South Asian Youth: A Mixed-Methods Study

Ethics ID: REB24-0488 (Conjoint Health Research Ethics Board)

Investigators:
Principal Investigator: Dr. Aliya Kassam
Co-Investigators: Dr. Scott Patten and Dr. Bukola Salami
Student Co-Investigator: Jaspreet Gill

Preamble to participant:
Hi [participant name], thank you for being here with me today! My name is Jaspreet and I am a graduate student conducting research at the Cumming School of Medicine. My work focuses on understanding experiences of South Asian youth with mental health care.

Before we begin, I would like to share details about the interview and research process. The purpose of the study is to learn from your experiences as a South Asian youth. The insights you share will contribute to our understanding of factors that impact access and utilization of mental health care in the local area and that impact your journey, which may help the researchers learn more about how mental health care can best support South Asian youth. This study will identify barriers and factors that influence access to mental health care for South Asian youth. It will highlight voices of youth to inform culturally-specific resources in the community.

The interview will last approximately 30 minutes. This is a safe space, anything you say will be kept confidential. However, if you feel uncomfortable at any point we can stop and you are free to skip any questions. Your participation is entirely voluntary and you have the right to withdraw from the study at any point. If you do choose to withdraw, any data you have provided will be deleted. The interview will be recorded on Zoom, you can choose to keep your camera on or off. This recording and any transcript material will be securely handled and stored in password protected folders. To maintain confidentiality and anonymity, any information you provide will be kept safe and your

responses will be anonymized. Any identifying details will be removed or changed. If you have any questions now or at any point during the interview, please do not hesitate to ask. Please take your time to consider this information. Following consideration if you agree to participate in this study, we can proceed with the interview. We are grateful for the opportunity to learn from your experiences.

Would you be able to repeat back to me your interpretation of the study, along with any risks and benefits of your participation?

Do you consent to participating in this study?

Q1. Please tell me a little about yourself. What gender do you identify with and what are your pronouns?

Q2. Were you born in Canada or outside of Canada?

- Probe 1: Please tell me more about your experience during and after immigration.
- Probe 2: What year did you immigrate to Canada?

Q3. What ethnic subgroup or country do you identify your South Asian background to connect to? This includes countries such as Pakistan, India, Bangladesh, Afghanistan, Bhutan, Nepal, and others. This can also include ethnic groups such as Punjabi, Sindhi, Gujarati, Tamil, and others.

Q4. Please tell me what mental health means to you (can ask about perceived needs here too).

Probe 1: What does positive mental health mean to you?
Probe 2: What does negative mental health mean to you?

Q5. Please think of a time when your experienced positive mental health.

Q6. Please think of a time when you experienced negative mental health.

Q7. Please think about supports that help your mental health.

- Probe 1: What kind of support, if any, do you think you would like?
- Probe 2: What kind of support do you think would meet your mental health needs?
- Probe 3: Do you think talking to your friends met your mental health needs?
- Probe 4: Do you think talking to your family met your mental health needs?

Q5: Please tell me about your experiences regarding how you found information about mental health services.

Q6: Please tell me about your experiences regarding how you found information about South Asian specific mental health services.

Q7: Please tell me about a time you overcame a mental health challenge.

- Probe 1: What specific strategies did you turn to in order to cope?

Q8: Please tell me if you identify with any religion or faith?

- Probe 1: Can you describe your experience with spirituality and faith?
- Probe 2: How would you describe the importance of spirituality and faith in your life?

Q9. Please tell me about your experiences with accessing or using mental health care.

- Probe 1: Have you ever consulted a provider(s) for mental health care, this includes your family doctor, a psychologist, psychiatrist, nurse, or a counsellor? Other? If so please specify.
- Probe 2: Would you be able to tell me more about what type of health provider(s) you consulted?

Q10. (if they have consulted a provider) Please tell me about your experience when accessing mental health services with [insert provider type].

- Probe 1: Do you feel like your expectations were met? Why or why not?
- Probe 2: Are you still getting support from this provider?
- Probe 3: (if not getting support from provider) Why did you stop seeing this provider?

Q11. (if they have talked to a provider) When accessing mental health services, have you ever felt that a provider treated you differently based on your race, ethnicity, religion, or culture? If so, how?

Thank you for taking the time to speak with me today.

Appendix C. Participant Recruitment for Phase II (Qualitative)

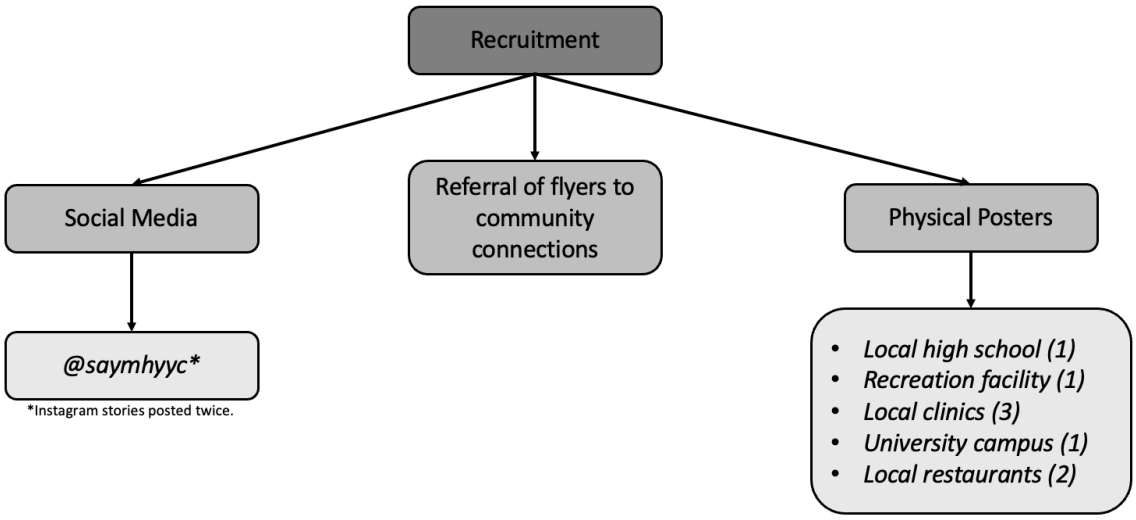

Figure 1. *General Recruitment*

Appendix D. Recruitment Survey for Phase II

UNIVERSITY OF CALGARY

RECRUITMENT QUALTRICS SURVEY

Project Name: Exploring Disparities in Access and Utilization of Mental Health Care Among South Asian Youth: A Mixed-Methods Study

Ethics ID: REB24-0488 (Conjoint Health Research Ethics Board)

Investigators:
Principal Investigator: Dr. Aliya Kassam
Co-Investigators: Dr. Scott Patten and Dr. Bukola Salami
Student Co-Investigator: Jaspreet Gill

The **purpose of the study** is to understand the experiences of South Asian youth. It will focus on access to and use of mental health care in Calgary. This will be done through virtual interviews. These virtual interviews will be an hour in length.

If you are South Asian and between the ages of 15 and 24, you are eligible to participate in this research. Your participation in this research study is voluntary.

There will be no direct benefit to you from participating in this study. However, this study may help the researchers learn more about how mental health care can best support South Asian youth.

Q1. Are you willing to participate in the study described above?
☐ Yes
☐ No

Q2. What is the best way to get in touch with you?
☐ Phone
☐ Email

Q3. Please type your preferred phone number. (If answered “Phone” to Q2)
[type answer here]

Q4. What time and days are best to call you? Write with as much detail as you want. (If answered “Phone” to Q2)
[type answer here]

Q5. Please type your preferred email.
[type answer here]

Q6. When is your birthday (day, month, year)?
[type answer here]

Q7. Are you South Asian?
☐ Yes
☐ No

Q8. If yes (to Q7), what country would you identify your background to be associated with?
☐ India
☐ Bhutan
☐ Pakistan
☐ Bangladesh
☐ The Maldives
☐ Nepal
☐ Sri Lanka
☐ Guyana
☐ United Kingdom
☐ Fiji
☐ Kenya
☐ Uganda
☐ Trinidad and Tobago
☐ United Republic of Tanzania
☐ Afghanistan
☐ Other [type answer here]

Q9. What ethnic group do you most identify with?
☐ Punjabi
☐ Sindhi
☐ Gujarati
☐ Tamil
☐ Other [type answer here]

End of Survey:

We thank you for your time spent taking this survey.

Your response has been recorded.

Appendix E. Qualitative Rigor

The following aspects will be considered in bolstering the qualitative rigor of the current study:

1. ***Credibility:*** Credibility refers to the quality of the work or internal validity (Lincoln & Guba, 1985; Noble & Smith, 2015). Member checking (respondent validation), sending cleaned transcripts back to participants, was utilized to ensure the transcripts represent what the participant intended (Denzin, 2018; Lincoln & Guba, 1985; Noble & Smith, 2015). Reflexivity and reflection was utilized to enhance credibility (Noble & Smith, 2015). The discussion of themes and data with a secondary coder (AK) may add to credibility of results (Noble & Smith, 2015). Further, at the end, data from Phase I and Phase II was triangulated, which enhanced credibility (Noble & Smith, 2015).
2. ***Transferability:*** Transferability entails the range of contexts in which the information can be understood, this can be referred to as external validity (Lincoln & Guba, 1985; Noble & Smith, 2015). Thick descriptions of data (e.g., context, participant identity) were utilized to ensure transferability of data (Lincoln & Guba, 1985; Noble & Smith, 2015).
3. ***Confirmability:*** Confirmability refers to consistency and neutrality of work, such that the findings account for how methods and reflexivity may influence findings (Noble & Smith, 2015). A trail of the research process was kept alongside the reflexivity journal (Noble & Smith, 2015).
4. ***Dependability:*** Dependability, at times referred to as reliability entails how predictable and consistent findings and processes were. For the purposes of the current study, the supervisory committee of the student reviewed the process of the study from start to finish (Lincoln & Guba, 1985; Noble & Smith, 2015).

Appendix F. Joint Display Table for Integration

Table 1. Integration of Phase I (Quantitative) and II (Qualitative)

Concept	**Quantitative Data**		**Qualitative Data**	**Converge, Diverge, and/or Expand**
	Estimate	**95% CI**		
Accessing Professional Mental Health Support	**15.86%** accessed professional mental health services	[11.95 - 20.74]	Financial barriers, taboo or stigma, and disconnect with parents limited types of support youth could or would access. *"They [South Asian youth] want to access that help. The one thing that also stops them is not only the taboo, but also the financial constraints. Because sometimes I remember when I was researching trying to get mental health support, it would be like, pay $200 for the first session…"* (P13) *"I really did want to get help and stuff, but it's like, A) I don't know how to tell my parents that. B) I didn't have my job back then, so I didn't know where I would get the money to pay for sessions."* (P14) *"I feel like I want to access services when I have way more free time. […] I feel like right now it's more just I'm at my parents' house. I'm kind of just chilling here, so I don't really want to*	**Diverge:** • Around half of all Phase II participants accessed professional mental health services or supports ***Expand:*** • Based on Phase II, potential negative factors that influence the low access/utilization include ○ Financial barriers ○ Taboo and Stigma ○ Disconnect with Parents • Based on Phase II, potential positive factors could also include reliance on other resources. ○ Friendships ○ Spirituality ○ Immediate and extended family

			do anything I know they'd be against if I'm in their house and I don't want them to be aware of it." (P12)	
Perceived Mental Health Needs and Whether Youth Got Enough Professional Support	**61.02%** indicated that they received as much professional support as they needed **74.53%** indicated that their overall mental health needs were met. Lower odds of perceived needs for care or support. (OR = **0.62**)	[47.28 - 73.21] [62.86-83.50] [0.46-0.84]	The following responses were from participants were asked whether their current supports meet their needs: *"yeah, it [friends as a support] definitely does [meet mental health needs]. When I first came here, I had some friends, but we weren't that close initially. Over time, though, we grew closer, and they started opening up and sharing things about their mental health."* (P11) *"Yeah, I think so […] I think when you talk to your friends, your friends kind of experience similar things to you."* (P12) *"Yeah, they [family] definitely [meet mental health needs], I think when they're very nonjudgmental about everything, even school, as long as you're trying, it's good. So I don't feel any issues talking to them."* (P15) There was a desire for more resources, especially South Asian specific mental health resources.	***Converge:*** • Most youth did indicate that the professional supports they had turned to met their needs. • Most youth also indicated that their mental health needs were met. ***Expand:*** • When asked what professional supports would meet their needs, they often indicated more South Asian specific resources would help. • Youth also indicated that present supports in their lives (e.g., friendships, family, etc.) were enough to meet their needs. • Other factors influence whether youth perceive a need for professional mental health supports (see "Perceived Needs as a Mediator to Accessing Care")

			"I guess having information about South Asian kind of resources to reach out to would be really nice to know about. So I can consider that if I ever really need to." (P10) *"...actually I've never seen [mental health resources] just specific to South Asian. It's mainly dances and celebrations that way it's never mental health related."* (P14) *"...there's no representation. It's like everyone looks like me, but they really don't. Right. So it's hard to validate your feelings and how you feel if you don't see any other exposure of it online."* (P1)	
Gender and Accessing Professional Mental Health Services	No gendered differences in accessing professional services. **Please note that 2022 MHACS only had a binary categorization of gender**	-	No gendered differences in accessing professional mental health services, but cultural differences in expression of emotions and mental health. Gendered roles were often reported to play a role in negative mental health among South Asian youth. *"In our [South Asian/Pakistani] society, if a boy cries, he's often shamed with comments like, 'Are you a girl?'—which is sexist. It creates this stigma that showing emotions makes you less masculine. This kind*	**Converge:** • Between the one participant that identified as a man and participants that identified as women, descriptions of accessing services were similar. • No gendered differences in accessing professional mental health services **Expand:**

			of messaging is harmful. When boys are denied a safe space to express their feelings as children, it often manifests later as anger or aggression because they've never learned healthier ways to process emotions." (P11) *"…as a South Asian girl especially, maybe if I was a boy, I might've had chance to be more open towards my parents, but I guess as a girl, it's kind of in my culture, it's like, 'oh, every girl goes through difficulties. Every girl will not be happy in life. Every girl will feel this feel bad though'. It's being able to break out of that system seems so impossible"* (P14) *"There's one big thing I forgot to mention which affects my mental health: my gender. Being a South Asian girl feels so different from being a South Asian boy. I've always felt pressure to fit into traditional roles—I'm expected to cook, clean, and focus on family way more than my brothers."* (P10)	• Gendered roles and expectations influenced notions of normal expression • Potential dismissal or invalidation of experiences of South Asian women. • Potential for toxic masculinity to influence coping and expression of mental health among South Asian men. • Gender norms and roles may place more pressure on women to excel, contributing to negative mental health. ○ Concern with societal perception (pressure to excel) could influence help-seeking behaviours
South Asian and LGBTQ2+ youth.	South Asian LGBTQ2+ youth had **4.034** greater odds of accessing	[1.22-13.32]	One participant was a part of the LGBTQ2+ community and this participant had accessed professional services for mental health support.	**Converge:** • Findings between both phases show that South Asian LGBTQ2+ youth had

	professional mental health services.			accessed professional mental health services • However, n=1 (Phase II)
Disengagement with Professional Services	Inconclusive results on why South Asian youth stopped seeing supports.		For participants that stopped using services, they reported financial barriers as a reason. *"I stopped because the coverage ran out."* (P6) *"…my parents would take me out of therapy or would guilt me about how much it cost."* (P9) *"I decided to another counselor because it was all online. And the good thing was for the fees, that was the one thing. It was always the fees. That was the reason why I couldn't access mental health support."* (P13)	**Expand:** • Due to limited cell counts, this data was inconclusive from Phase I • However, based on Phase II, the reason youth disengaged form professional services is financial barriers
Type of Support Accessed (Overall)	The most commonly accessed support among South Asian youth was friends. **29.81%** of South Asian youth accessed their friends for support.	[24.57-35.65]	Youth often leaned on their friends for support in terms of their mental health, many reported that they felt validated in their experiences after talking to their friends. *"I feel like to improve my mental health, I don't really seek out mental health services. I usually just seek out my friends…"* (P12)	**Converge:** • Friends were consistently used as a support in both phases. **Expand** • Due to factors such as disconnect with parents and taboo or stigma, participants would turn to friends for support with their mental health.

			"I do have a friend that has gone through loss, so I did definitely lean on her a lot, and so that definitely helped." (P4) *"When I first came here, I had some friends, but we weren't that close initially. Over time, though, we grew closer, and they started opening up and sharing things about their mental health. That deepened our connection, and I'd say that being closer to them now has had a positive impact on my own mental health."* (P11)	• Friends often had shared experiences that helped create feelings of solidarity.
Types of Professional Support Accessed	**8.40%** saw family doctors	[5.62-12.36]	Primary care physicians were mentioned often amongst participants when asked if or how they accessed professional mental health services. *"Yeah, so the first person was definitely my family doctor and we had a talk about mental health and stuff and resources, and then eventually she referred me to a psychologist who is still my now psychologist, and so he diagnosed me with everything and yeah, those are the only two."* (P8)	**Converge:** • Primary care and Allied Health Professionals were more frequently accessed • Psychiatrists were not frequently accessed **Expand** • Primary care physicians could provide support or referrals • Primary care physicians were the most reported professional service accessed for mental health • Psychologist/Counsellors were mentioned, but other

			"…but there have been points in my life where I do get pretty depressed to the point where I need to take medication for a little bit. And my family doctor is really supportive about making sure with dosage and making sure I'm on track" (P2) *"…there was a time where I went to my family doctor about something and she recommended some resources."* (P7)	professionals such as Nurses or Social Workers were not
	9.61% saw Nurses and Allied Health Professionals	[6.64-13.72]	As seen in the previous quote as well, allied health professionals like psychologists and counsellors were also mentioned as being accessed by participants. *"So I did end up getting help, but it was just a little bit later. I connected to a counselor through my mom had access through her work, so I did counseling, but it was over the phone"* (P6) *"My counselor that I have, she is really nice. I mean she does helps me a lot of time…"* (P5) *"I decided to [see] another counselor because it was all online.*	

	4.85% saw Psychiatrists	[2.80- 8.28]	*And the good thing was the fees, that was the one thing. It was always the fees…"* (P13) *"I saw a registered psychologist and then she would also meet with my parents, and then I think we also did family therapy at some point."* (P9) Psychiatrists were only mentioned by one participant. *"I guess experimenting with different psychiatrists and therapists, just kind of see what works for me…"* (P2)	
Perceived Needs as a Mediator to Accessing Care	**0.61** greater odds of accessing professional services without adjusting for perceived need After adjusting for perceived needs: **(OR = 0.60)**	[0.43-0.86] [0.15-2.40]	Lower perceived need due to factors promoting positive mental health such as friendship or spirituality. Lower perceived need due to barriers like taboo and stigma, pressure to excel, and financial barriers. *"...because I feel like there's also negative connotation towards extra resources for mental health, and since I grew up in that environment, I feel like I'm more, I don't want to get the help, if that makes sense."* (P7)	**Converge:** Lower perceived need may mediate the relationship between South Asian ethnicity and access/use of professional mental health care services **Expand:** This mediation could be due to factors influencing lower need that decrease help-seeking behaviours Lower perceived needs for professional services due to other supports:

			"Before counselling, it was tough to make that decision because it felt selfish, and that I should be capable of helping myself in time of need as I did for others." (P1) *"They're [South Asian youth] not able to openly have a conversation about it. So I just feel like there is a need for that [conversation], even though more and more people are starting to talk about it. I haven't seen a lot within the South Asian community."* (P13)	• Friendship • Spirituality • Immediate and Extended Family Lower perceived needs due to factors such as: • Internalized stigma • Pressure to excel • High expectations from family on maintaining image in society
Discrimination when Accessing Services	South Asian youth were found to have **3.94** greater odds of indicating that they had felt a health professional or service provider treated them unfairly over the past 12 months due to visible or non-visible characteristics.	[1.19-13.06]	Youth did not indicate feeling discriminated against, but did feel like providers did or may not understand them. *"I think it's not even from a place of, it's malicious on their part, just there's a gap in culture, and so there's a lack of understanding, but they've tried to bridge it. It's just bridging the gap is like it's work."* (P6) *"... when I think about a therapist or a psychologist, I guess a white person just comes into my mind. So I'm like, 'okay, they're not going to*	**Diverge:** • Based on Phase II, youth do not feel discriminated against by health professionals. **Expand:** • Based on Phase II, youth expressed fears of not being understood by providers. • Concerns of cultural safety come into play based on experiences of youth wanting mental health professionals that acknowledge and respect

			understand my cultural background. They're not going to understand my religious background.'" (P2) *"Frankly, you're in therapy to work through things, not necessarily to be giving cultural heritage lessons."* (P9)	their cultural beliefs, but also of cultural competence
Immigration and Accessing Professional Mental Health Support	No significant interaction between immigration status and South Asian identity with accessing professional mental health services.	-	Immigrants also accessed mental health resources and faced similar dynamics to non-immigrants. *"...we still have it at my new school as well, is this counselor kind of, and she would help refugees or immigrants coming from different countries. And I had that at my old school and I was meeting with her and I'm pretty sure we have it at my new school as well, so that definitely helped as well."* (P8) Only one participant had immigrated less than five years ago. They shared that they would like to access mental health services but faced financial barriers. *"I would say I did look into therapists and stuff, but it would cost money here. I don't know why. So maybe, I mean, not a proper*	**Converge:** • There were no differences in accessing of professional mental health services based on immigration status **Expand**: • Based on Phase II, participants born outside of Canada shared similar experiences in terms of needing or wanting to access professional supports. • Financial barriers also affect immigrant youth. • For immigrant youth joining high school, there are resources available.

			therapist, but a mentor you can talk to or somebody like that. I mean, free of cost." (P11) Taboo and stigma were mentioned by youth often. *"Because it's not considered good in Indian society to see a mental health professional."* (P5)	
Use of Alternative Medicine for Mental Health	Non-significant differences in odds of South Asian youth accessing alternative medicine compared to other ethnicities or referent. **8.62%** of South Asian youth utilized alternative medicine (e.g., herbs) to support their mental health.	[5.79-12.66]	Only one participant talked explicitly about alternative medicine. *"... there's a lot of home remedies or natural remedies that come up when talking about health, so she'll [physician] always go back to, oh, if you want to try this though first, because she knows medicinal benefits of something."* (P7)	**Converge:** • In both phases, alterative medicines were not frequently used to support mental health **Expand** • Phase II touches more upon concepts of feeling safe and culturally supported by providers
Spirituality and Mental Health	Non-significant interaction between spirituality, South Asian identity, and whether youth accessed	-	Spirituality was often used as a way for youth to foster positive mental health. Religious diversity can be seen in Table 8. *"I think it keeps you really grounded and it takes you back to the bigger*	**Diverge:** • In Phase II, participants indicated relying on spirituality as a grounding force. • This could illustrate a lower perceived need for

	professional mental health services.		*picture. At least for me, your life here is not everything, so there is still so much else out there. You shouldn't be focusing on small things. That's me. I'm an overthinker, so I'll focus on the littlest of things and then going back to spirituality, it takes me back to everything else that's out there and beyond."* (P7) *"…the strategies that I used to cope was probably engaging in prayers, making sure I was spiritually staying grounded and connected, and that really helped me overcome the mental stress."* (P4) *"And when you take that time to yourself, whether it's through prayer, meditation, anything, making these decisions become a little bit easier."* (P13)	professional mental health services. **Expand:** • Based on Phase II, spirituality fostered long term coping with stressors for participants