Exploring barriers and enablers to primary mental health care among South Asian women in Montreal: A qualitative study

Delufa Tuz Jerin

Department of Family Medicine
McGill University, Montreal

December 2023

A thesis submitted to McGill University in partial fulfillment of the requirements of the degree of Master of Science

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ABSTRACT

Background: In Canadian health surveys, racialized groups and recent immigrants with symptoms of psychological distress report lower rates of being diagnosed and treated compared to their European white counterparts. South Asians are Canada's largest visible minority group, and lower detection may be related to difficulties expressing mental health challenges because it is considered as a taboo subject and still stigmatized for South Asians. When accessing healthcare in Canada, South Asians face the additional difficulties of expressing their mental health challenges in a second language. South Asian women in traditional households face mental health stressors because of gendered roles and expectations and they have limited agency and control over decision-making, including access to healthcare resources.

Objectives: This study seeks: 1) to understand the barriers and enablers to expressing mental health challenges and accessing care among South Asian immigrant women from different linguistic groups who receive primary healthcare services in English; and 2) to assess the acceptability and potential uptake of self-help strategies as a first step for managing their mental health challenges in a context of limited availability of psychological services.

Methods: The exploratory qualitative study used semi-structured in-depth interviews of a purposive sample of 16 South Asian immigrant women from Bangladesh, Pakistan, India, and Sri Lanka. Participants with direct or indirect experience with mental health conditions were referred from a family medicine teaching clinic serving a multicultural neighborhood. Others were recruited from a South Asian women's community centre in Montreal, Quebec. Data analysis involved an inductive-deductive thematic analysis approach, supported by the framework method.

Results: It was observed that most of the women first discussed the experiences of their close family members or friends before sharing their own lived experiences. The process migration and settlement, intergenerational stressors, intimate partner violence and financial dependency were identified as significant mental health stressors among the South Asian women. Moreover, cultural norms, language barriers, the threat of intimate partner violence emerged as major obstacles to expressing mental health challenges to the women’s primary healthcare providers. Lack of family support and the dependency on male counterparts limited for access to healthcare services A few participants reported limited knowledge about the available self-help care resources. Those who were aware of these self-help approaches mentioned the lack of cultural appropriateness as a barrier to utilizing these resources. While most participants expressed a preference for professional mental health care, they indicated a willingness to try culturally and linguistically tailored self-help approaches in situations where professional services were inaccessible.

Conclusion: South Asian immigrant women in Canada face significant mental health stressors as well as barriers to expressing psychological distress, so cultural competence in exploring mental health issues is important in primary care encounters. Providing explicit cues of psychological safety may encourage women in disclosing their personal mental health challenges. Cultural adaptation of self-help resources is promising avenue to offer mental health support to South Asian women, both in Canada and worldwide.

RÉSUMÉ

Explorer les obstacles et les facilitateurs des soins de santé mentale primaires chez les femmes sud-asiatiques de Montréal : une étude qualitative

Contexte : Des enquêtes canadiennes sur la santé, démontent un taux plus faible de diagnostics et de traitement de conditions de santé mentale dans les personnes racialisées et les immigrants récents malgré le même niveau des symptômes de détresse psychologique que Canadiens blancs européens. Dans le groupe le plus important de minorité visible au Canada, les Sud-Asiatiques, le faible taux de détection peut être lié à la difficulté d'exprimer les problèmes de santé mentale, car le sujet de santé mentale est considéré comme un sujet tabou et encore stigmatisé. En plus, les immigrants Sud-Asiatiques sont confrontés à la difficulté supplémentaire d'exprimer leurs problèmes de santé mentale dans une deuxième langue lorsqu'ils accèdent aux soins de santé. Les femmes sud-asiatiques vivant dans des foyers traditionnels sont confrontées à des facteurs de stress en matière de santé mentale en raison des rôles et des attentes sexospécifiques, et elles ont un pouvoir et un contrôle limités sur la prise de décision, y compris l'accès aux services de santé.

Objectifs : Cette étude vise à : 1) comprendre les barrières et les facilitateurs à l'expression des problèmes de santé mentale et à l'accès aux soins parmi les femmes immigrées sud-asiatiques de différents groupes linguistiques et qui reçoivent leurs services de première ligne en anglais ; et 2) évaluer l'acceptabilité et l'adoption potentielle de stratégies d'autosoin comme étape initiale de gérer des problèmes de santé mentale dans un contexte de pénurie de services psychologiques.

Méthodes : Dans cette étude qualitative exploratoire, des entretiens semi-structurés approfondis ont été menés auprès d'un échantillon raisonné de 16 femmes immigrantes d'Asie du Sud, originaires du Bangladesh, du Pakistan, de l'Inde et du Sri Lanka. Les participantes ayant une expérience directe ou indirecte des problèmes de santé mentale ont été envoyées par leur médecin de famille travaillant dans une clinique d'enseignement desservant un quartier multiculturel. D'autres ont été recrutées dans un centre communautaire pour femmes sud-asiatiques à Montréal (Québec). L'analyse des données a fait appel à une approche d'analyse thématique inductive et déductive, soutenue par *Framework Method*.

Résultats : On constate que la plupart des femmes ont d'abord parlé de l’expérience de santé mentale de leurs proches avant de partager leurs propres expériences. Des facteurs tels que les conditions de migration et d'installation, les facteurs de stress intergénérationnels, la violence du partenaire intime et la dépendance financière ont été identifiés comme des facteurs de stress importants pour la santé mentale des femmes d'Asie du Sud. Les normes culturelles, les barrières linguistiques et la menace de violence du partenaire intime sont apparues pour ces femmes comme des obstacles majeurs à l'expression des problèmes de santé mentale auprès des prestataires de soins de santé primaires. En outre, le manque de soutien familial et la dépendance à l'égard des homologues masculins sont barrières pour l'accès aux services de santé. Quelques participantes n’avaient qu'une connaissance très limitée des ressources disponibles en matière d’autosoins pour la santé mentale. Celles qui connaissaient ces approches ont mentionné le manque d'adéquation culturelle comme un obstacle à l'utilisation de ces ressources. Bien que la plupart des participants aient exprimé une préférence pour les soins professionnels de santé mentale, ils ont indiqué qu'ils étaient prêts à essayer des approches d'autosoin, compte tenu leur adaptation culturelle et linguistique, dans les situations où les services professionnels n’étaient facilement accessibles.

Conclusion : Les femmes immigrantes sud-asiatiques sont confrontées à des facteurs de stress importants en matière de santé mentale, et la compétence culturelle est donc importante pour explorer le sujet de la santé mentale dans les rencontres de soins primaires. Le fait de leur donner

des indices explicites sur leur sécurité psychologique peut les encourager à révéler leurs problèmes personnels de santé mentale. L'adaptation culturelle des approches d'autosoins est une voie prometteuse pour offrir un soutien en matière de santé mentale aux femmes sud-asiatiques, tant au Canada que dans le reste du monde.

ACKNOWLEDGMENT

I am deeply grateful and honored to express my sincere appreciation to all those who have contributed to the successful completion of my thesis.

First and foremost, I extend my heartfelt gratitude to my esteemed supervisors, Dr. Jeannie Haggerty and Dr. Alayne Mary Adams, for their invaluable guidance, unwavering support, and insightful feedback throughout this thesis journey. Their expertise and encouragement have been enormously instrumental in conceptualizing and shaping this research. Their constant support and motivation have empowered me to be confident with my capacity to contribute to scholarly literature, focusing on the significant issue of South Asian immigrant women's mental health.

I am greatly appreciative of Dr. My Lan Graziani, the physician from the Family Medicine clinic and a valued member of my thesis committee, and her generous assistance in facilitating access to participants and providing support for recruiting participants for this study. I also extend my gratitude to members of the community center for South Asian women who assisted me with participant recruitment for this study. Without their support, the recruitment of participants would not have been possible. I gratefully acknowledge my other committee members, Dr. Kimberly Munro and Dr. Sylvie Lambert, for their valuable feedback and insights on various aspects of the thesis. I am thankful to St. Mary's Research Centre and McGill Department of Family Medicine for providing me with the stipends, and to Dr. Alice Chan for granting me the multiculturalism research fellowship. These financial supports played a crucial role in conducting the research and greatly bolstered my determination to pursue my academic aspirations.

I am immensely thankful to my family for their constant support, encouragement, and motivation, which have been the driving force behind my academic journey. Their firm belief in me and the sacrifices they made enabled me to fulfill my dreams of pursuing higher studies in Canada, coming all the way from Bangladesh. Throughout this journey, my friends have also been a precious source of support and inspiration.

Lastly and most importantly, I wish to express my deepest appreciation to the South Asian immigrant women who generously participated in this research. Their willingness to share their experiences and perceptions have been a constant source of inspiration throughout my thesis journey. Their irreplaceable contributions have enriched this thesis and paved the way for future exploration in the field of mental health research.

CONTRIBUTION OF AUTHORS

Conception and design of study: Delufa Tuz Jerin (DTJ), Dr. Jeannie Haggerty (JH) and Dr. Alayne Mary Adams (AMA). Analysis and interpretation of data: DTJ, JH, AMA. Draft report preparation: DTJ. Revision of report DTJ, JH, AMA. Editing of report: DTJ, JH, AMA.

All the authors of this report have read and approved the final draft. Both of my supervisors, Dr. Haggerty and Dr. Adams have approved this version of the thesis as a final draft for the initial submission. We, the authors, and supervisors, take full responsibility for all aspects of the work and commit to addressing any queries regarding the accuracy or integrity of the study.

LIST OF ABBREVIATIONS

CBT	Cognitive Behavioral Therapy
HIC	High-Income-Country
ICF	Informed Consent Form
IRB	Institutional Review Board
LMIC	Low- and Middle-Income Country
WHO	World Health Organization

LIST OF TABLES AND FIGURES

CHAPTER 1: INTRODUCTION

Mental health challenges constitute 14% of the global burden of disease and represent a prominent cause of disability worldwide (Arias et al., 2022; GBD Mental Disorders Collaborators, 2022). Among all mental health disorders, depression and anxiety are the most common, with a global prevalence of 5-10%. More recently, the prevalence rose to 25% due to the Covid-19 pandemic and associated factors such as lockdowns, curfews, and social distancing public health measures (Kang et al., 2020; Moussavi et al., 2007; Rajkumar, 2020; Wang, Pan, Wan, Tan, Xu, Ho, et al., 2020; Wang, Pan, Wan, Tan, Xu, McIntyre, et al., 2020; World Health Organization, 2022a). Each year, approximately 15% of the Canadian population seek mental health care, with close to 5.5 million individuals accessing these services (Health Canada, 2020).

Utilization of mental health services varies across genders, with Canadian women exhibiting a 30% higher utilization rate than men (Government of Canada, 2023; Health Canada, 2020). Cultural differences are also seen in mental health utilization, with visible minority groups, such as South Asians, experiencing higher rates of undiagnosed and consequently undertreated mental health disorders compared to White Canadians (Chiu et al., 2018a; Islam et al., 2017; Public Health Agency of Canada, 2018). This difference can be linked to factors within the South Asian community, including stigma, limited awareness and understanding regarding mental health conditions, language barriers, and a lack of culturally appropriate mental health care (A. Karasz et al., 2019; Knaak et al., 2017).

In many traditional South Asian families and communities in Canada and globally, mental illness, especially depression and anxiety, is a matter of shame and stigma (Singh et al., 2019). These attitudes and beliefs pose additional challenges for women in South Asian traditional households, as cultural and gender-related constraints limit women’s agency and access to healthcare resources, and contribute to the under-treatment and underdiagnosis of mental health conditions (Fikree & Pasha, 2004). Sociocultural barriers also discourage South Asian women from expressing their needs to physicians and attaining needed services, resulting in higher rates of untreated and underestimated depression and anxiety in the primary care setting (Batsleer et al., 2003; Kudva et al., 2020).

In mental health care, stepped care is a worldwide recommended approach. This efficient and evidence-based staged strategy to mental health services organizes the order of interventions from least to most intensive care depending on least to greatest severity of needs (Ho et al., 2016a; J. A. C. Meeuwissen et al., 2019; Strauss et al., 2020). As per the model, cognitive behavioral therapy dominates the initial step for addressing mild to moderate depression and anxiety, delivered through self-help resources or professional psychological services. Indeed, given the limited availability of publicly funded psychological services in Canada, self-help resources provide an interesting alternative. To this end, a publicly available Canadian self-help resource has been developed in multiple languages, consisting of antidepressant skills workbooks, managing worry workbooks, and relaxation audio files (Dan Bilsker et al., 2008; Bilsker et al., 2012). This resource and a growing number of similar self-help tools and approaches, hold the potential to alleviate the burden of mental health in a context of limited access to publicly funded psychological services. However, in the diverse South Asian population, limited knowledge and/or awareness about mental health issues, language limitations, under-detection, and socio-cultural stigmas can hinder the understanding and utilization of these self-care resources for mental health management (Islam et al., 2017; Alison Karasz et al., 2019).

In this context of undertreated and underdiagnosed mental health concerns among culturally diverse populations in Canada, and specifically among South Asians, the first aim of this study is to generate evidence that will enhance primary care capacity to detect and manage primary mental health conditions among South Asian women by exploring cultural and gender-specific factors that hinder and facilitate their ability to express their mental health challenges, and utilize mental healthcare services. As a second aim, it seeks to enhance the range of culturally appropriate mental health care available to South Asian women in need, by exploring the potential acceptability of a self-help approach for mental health challenges in this subpopulation.

CHAPTER 2: LITERATURE REVIEW

SECTION 1 - Mental health burden in global and Canadian contexts

Global mental health burden:

Mental health challenges or conditions encompass a wider range of mental disorders including cognition-related conditions, issues with emotional regulation or behavior, psychosocial disabilities, and other mental states that are associated with considerable distress or the potential for self-harm (World Health Organization, 2022b). Mental health conditions represent a significant contributor to disability, mortality, morbidity, and quality of life on a global scale (GBD Mental Disorders Collaborators, 2022; Saarni et al., 2007; Vos et al., 2020; Walker et al., 2015). A systematic review and meta-analysis on the global prevalence of common mental disorders estimated that roughly 17.6% of participants met the criteria for common mental disorders (depression, mood, anxiety and substance use disorders) in 12 months preceding their assessment, while 29.2% reported experiencing such a disorder at some point in their lifetime (Steel et al., 2014).

Depression and anxiety are among the most common mental disorders, affecting over 970 million individuals worldwide in 2019 (GBD Mental Disorders Collaborators, 2022). According to a World Health Organization report, the prevalence of global depression in 2015 was approximately 4.4%, with an 18.4% increase in the number of people affected between 2005 and 2015 (World Health Organization, 2017). The same report says that around 3.6% of the population had anxiety disorders as per the global estimate in 2015, with approximately 264 million people affected, showing a 14.9% increase since 2005 (World Health Organization, 2017). A more recent global study conducted in 2020 investigating the prevalence of self-reported psychological distress, and related factors of depression, anxiety, and stress revealed that 50.9% of participants showed symptoms of anxiety, 57.4% showed signs of stress, and 58.6% showed the traits of depression worldwide (Shah et al., 2021), acknowledging that these figures may be higher due to Covid-19 pandemic-related stress. For example, multiple studies concur that the pandemic has increased the incidence of anxiety (Kang et al., 2020; Lima et al., 2020; Rajkumar, 2020; Wang, Pan, Wan, Tan, Xu, McIntyre, et al., 2020).

Several factors contribute to the increasing burden of mental health challenges globally. Societal changes, such as migration, globalization and rapid technological advancements have led to increased stress levels, social isolation, and decreased social support systems (Prasad et al., 2016). Additionally, economic disparities, poverty, violence, trauma, and discrimination further exacerbate the prevalence and severity of mental health challenges (Prasad et al., 2016). Epidemiologic data also shows that differences in the prevalence of depression and anxiety vary across gender, age groups, marital status as well as by ethnicity and region.

Variation of mental health burden prevalence:

In terms of gender, women globally have a higher prevalence of depression (5.1%) and anxiety (4.6%) than men (3.6% and 2.6%), with women experiencing major depressive episodes at nearly twice the rate of men (Maier et al., 1999; Moussavi et al., 2007; World Health Organization, 2017). A 2014 systematic review on global mental disorder prevalence also reported distinct gender differences in the prevalence of common mental disorders, with females exhibiting higher rates of mood (7.3% to 4.0%) and anxiety disorders (8.7% to 4.3%) over the course of the previous 12 months, while males reporting higher rates of substance use disorders (7.5% to 2.0%), aligning with patterns in lifetime prevalence (Steel et al., 2014).

With respect to global demographic and regional patterns, the WHO reported depression to be highest among older adults, while children and adolescents had lower rates, with nearly half of this population resided in the South-East Asia and Western Pacific regions (World Health Organization, 2017). Among the limited studies conducted in low- to middle-income countries, evidence of increasing depression rates with age are also noted (Bromet et al., 2005; Kessler et al., 2010). In high income countries (HICs), those who are separated or divorced have higher rates of depression than those who are currently married, while the prevalence of depression generally declines with age (Robins et al., 1981; Weissman et al., 1996). Overall, the prevalence of mental disorders appears greatest in HICs, with Europe and North America having the highest rates of diagnosed mood disorders and anxiety disorders when compared to low and middle-income countries (LMICs) (Bromet et al., 2011). Systematic reviews indicate that LMICs in sub-Saharan Africa have lower rates of diagnosed anxiety and depression over a 12-month period, aligning with patterns found in global burden of disease reviews for the region (Baxter et al., 2013; Ferrari et al., 2013). In terms of lifetime prevalence, English-speaking HICs had a higher prevalence rate of 39.7% compared to other HIC and LMIC settings, possibly due to the inclusion of older individuals who had been exposed to longer periods of risk in the study (Steel et al., 2014).

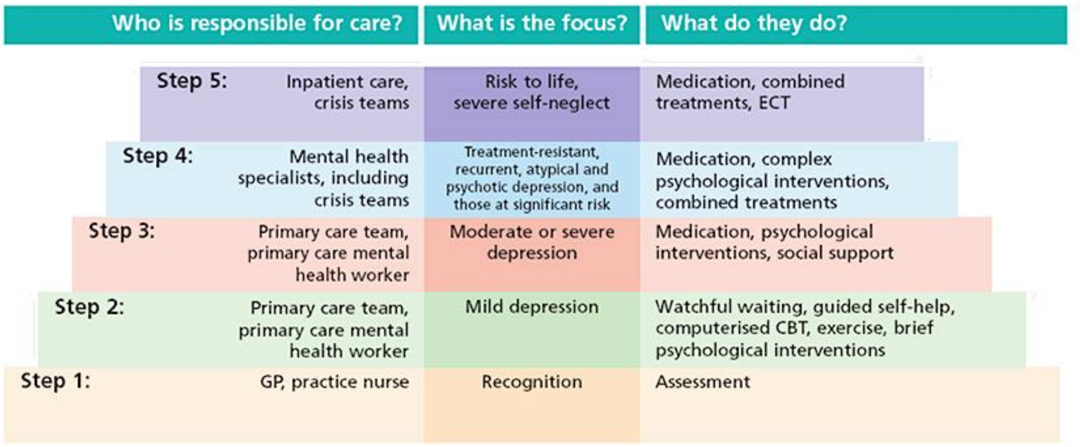
Burden of mental health in primary care in Canada:

In Canada, one in two Canadians experience a mental health condition before turning 40 (Centre for addiction and mental health, 2023). Amongst the most common, the estimated prevalence of depression and anxiety in Canada are 4.0% and 5.2%, respectively (Hannah & Roser, 2018; Hasin et al., 2018; Ruscio et al., 2017), with around half of individuals experiencing depression also having anxiety (Hasin et al., 2018; Ruscio et al., 2017). Since depression and anxiety present first in primary care, it follows that prevalence is being 3-to-5 times higher among primary care patients compared to the general population (Jeannie Haggerty et al., 2018; O'Connor et al., 2009; Olfson et al., 2016). In primary care waiting rooms in Quebec, 30.3% of patients reported high or moderate levels of psychological distress (J. Haggerty et al., 2018).

Anxiety and depression typically present first in primary care (Hasin et al., 2018; Hassin & Link, 1988). Research shows that approximately 80% of Canadians depend on their family doctors for addressing their mental health concerns, with most mental health needs being effectively assessed and treated within primary care (Moroz et al., 2020). Individuals who require specialized mental health care must first get a referral from their primary health care provider to access counseling, therapy, medication, or other information to treat mental health problems (Health Canada, 2019). In Canada, only a small fraction (about 1.5%) of the population with a mental health disorder requires access to specialized care (Moroz et al., 2020). However, the diagnosis and management of these disorders are not optimal in the primary care setting (Farid et al., 2020; Talbot et al., 2014). Primary care providers are reluctant to diagnose depression and anxiety given a percieved lack of training, resources, and time to effectively address the needs of the patients with these disorders (Clatney et al., 2008; Wener & Woodgate, 2017).

Stepped care approach to address mental health problems:

Stepped care is an evidence-based and widely recommended approach in mental health care that prioritizes a range of intermediate and effective treatment options (Middleton et al., 2005; Olfson et al., 2016; Olfson et al., 2002) that customizes service intensity to individual needs and the severity of their mental illness. It is most appropriate for the care of depression and anxiety, but is an approach that is used for many conditions except frank psychosis and acute mental health crises (Mental Health Commission of Canada, 2021). Stepped care emphasizes person-centred decision-making and offers a flexible continuum of care that can be adjusted based on regular monitoring of patient outcomes by ensuring that the right level of care is given at the appropriate time (Mental Health Commission of Canada, 2021). By varying treatment intensity according to the severity and persistence of mental health disorders, stepped care is a cost-effective intervention that results in the recovery of a majority of the patients using the least intensive approach (Ho et al., 2016b; Jolanda A. C. Meeuwissen et al., 2019).



	Who is responsible for care?	What is the focus?	What do they do?
Step 5:	Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4:	Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3:	Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2:	Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1:	GP, practice nurse	Recognition	Assessment

Figure 1: Stepped care approach diagram

Source: (Centre for Innovation in Campus Mental Health)

The initial step in stepped care is recognizing and assessing the symptoms of mental health conditions by the primary care provider. The second step is watchful waiting, with 25% of cases resolving naturally within three months (Ruscio et al., 2017). If symptoms of mild depression and/or anxiety persist among individuals, time-limited interventions grounded in Cognitive Behavioral Therapy (CBT) are recommended in the second step, with initial options such as guided self-help and exercise, followed by short-term psychological interventions with face-to-face psychotherapy as needed. In cases that persist or do not respond to initial interventions, medication with or without long-term psychotherapy is recommended in the further steps, with severe cases being referred to specialized psychiatric and psychological services including combined treatments (Mental Health Commission of Canada, 2019).

While stepped care is considered the recommended approach for mental health care, its implementation lags behind its recommendation (Hermens et al., 2014; Lorenzo-Luaces et al., 2015), with guided self-help, a recommended option for most patients, being one of the least utilized steps (Haugh et al., 2019). Primary healthcare providers often opt for a strategy of watchful waiting and then proceed directly to medication as a treatment option (step 3), without exploring the potential benefits of self-help and psychological approaches (Haugh et al., 2019; Hermens et al., 2014; van Straten et al., 2010). This reflects the insufficient capacity of mental health services including the availability of adequate behavioral and psychological support to meet the actual demand of mental health care (Ho et al., 2016a; Kosteniuk et al., 2012). One study has claimed that unmet needs for mental health care within primary care, have provoked a reliance on the acute care system, resulting in overcrowded of emergency departments across the country (Moroz et al., 2020).

The practice of depending on medication and the acute care system to address anxiety and depression is not considered the best cost-effective solution (Moroz et al., 2020). In Canada, health care, social services and income supports related to mental illness costs over $42.3 billion annually (Mental Health Commission of Canada). Moreover, mental illness-related disability leave is twice as expensive as physical illness-related leave, resulting in an estimated annual economic impact of $51 billion, encompassing healthcare expenses, decreased productivity, and diminished quality of life (Centre for addiction and mental health, 2023). On the other hand, if mental health challenges are treated in the initial stage and integrated into primary care, it could potentially lead to a 20% to 30% decrease in medical expenses (Alhawshani et al., 2019). In order to adopt a cost-effective mental health care approach, guided self-help strategy is considered as one of the potential solutions worldwide. Supported self-management as the first stage of care can lessen patients' dependency on medications and costly intensive care (Richards, 2012). A Scotland-based study used guided self-help as the primary treatment for patients, supplemented with medication and therapy as needed. Positive clinical outcomes were observed with minimal clinician interaction (2.5 hours across 4.6 sessions), resulting in over 50% savings on antidepressant medication expenses and high user satisfaction ratings (Brooks et al., 2007).

Several CBT-based self-care toolkits are used globally. However, a challenge in the effective implementation is the lack of engagement and utilization of self-help materials by individuals themselves (Fuhr et al., 2018; Gilbody et al., 2017). Guided self-help bridges this gap by offering ongoing support to promote active involvement with self-help materials and facilitate progress. Meta-analyses have reported that guided self-help is more effective compared to self-help alone (Garrido et al., 2019; Salisbury et al., 2016). Guided self-help interventions demonstrated similar outcomes to in-person therapy for depression and anxiety (Coull & Morris, 2011; Cuijpers et al., 2010; Karyotaki et al., 2018) and are also considered more cost-effective (Solomon et al., 2015).

Available in multiple languages, one such resource has been high rated for readability and by primary care practitioners for depression care (Bilsker et al., 2012). The toolkit includes core resources for managing depression symptoms and worry, relaxation audio files as well as supplementary materials on exercise and healthy eating (D. Bilsker et al., 2008; Bilsker &

Paterson, 2010). The research team at St. Mary's research centre has demonstrated in various randomized controlled trials that lay coaching to support use of these tools (Bilsker & Paterson, 2005) are more effective than the tools alone in reducing symptoms of anxiety and depression (McCusker, Cole, Yaffe, Strumpf, Sewitch, Sussman, Ciampi, Lavoie, Platt, et al., 2016). Guided self-help tools were also found to be benefiting primary care adults with chronic physical conditions and comorbid depressive symptoms (McCusker, Cole, Yaffe, Strumpf, Sewitch, Sussman, Ciampi, Lavoie, & Belzile, 2016).

Summary of burden of suffering:

Evidence has indicated that the burden of mental health conditions is a critical issue. Mental illness is a substantial contributor to disability in Canada, leading to adverse outcomes, such as decreased quality of life, overburdened the emergency care and increased healthcare expenses. Implementing stepped care is an efficient and effective way of addressing these challenges, but it is currently inadequately used. Tested self-help tools are widely available in multiple languages and guided self-help has the potential to improve the population's access to mental healthcare within the context of stepped care. Focusing on these concerns, this study will explore the acceptability of self-help resources to address the mental health challenges of South Asian women immigrants in Montreal, Quebec as a potential solution for addressing mental health issues in this community.

SECTION 2 –A review of Mental Health Challenges among South Asian Immigrants

I. Search strategy

We used a non-systematic search to investigate immigrant mental health with a focus on South Asians in global and Canadian contexts. We also looked for the gender and culture specific challenges for immigrant South Asian Women to express their mental health conditions and further elaborated the potential for self-help strategies in mental health management. The search was conducted from April 2023 to July 2023. The databases PubMed, Scopus and Google Scholar along with other grey sources (i.e., government reports, conference, thesis dissertations) were searched using the relevant subject headings. Multiple searches were conducted based on the different sections of the literature review always keeping study objectives in focus. All articles were reviewed for relevance. Final selections are referred to and referenced in this section.

Article inclusion-exclusion criteria

As the study explores South Asian women's mental health expression and preferences for care, articles that highlighted the South Asian immigrants and their mental health experiences were chosen. Articles documenting the mental health and mental health care burden in global and Canadian contexts were also identified. Articles were included if they adopted a qualitative, quantitative, or mixed methods approach. Articles were excluded if they focused on South Asian immigrants in the context of other illnesses, as opposed to mental health disorders. Considering the relevancy of information and data, articles published earlier than 30 years ago were also excluded. Articles published in languages other than English were also excluded.

II. Mental Health in South Asian immigrants to Canada and Montreal

Immigration and mental health:

The process of immigration exposes individuals to various stressors that can impact mental health. Factors such as the absence of social support, financial challenges, uncertainty, changes in social status, limited access to healthcare services, and the need to adapt to a new culture and climate have all been identified as influential stressors (Ahmad et al., 2005). Despite the various stressors associated with the process of immigration that can impact mental health, Canadian immigrants and visible ethnic minorities experience higher rates of undiagnosed depression and anxiety compared to their white counterparts (Chiu et al., 2018b; Chiu et al., 2020; Islam et al., 2018; Pahwa et al., 2012). The prevalence of major depressive episodes among South Asian, Chinese, and Southeast Asian populations in Canada was found to be 5.2%, 3.6%, and 2.9%, respectively, which is lower compared to the prevalence rate of approximately 8% reported for the general population (Tiwari & Wang, 2008). A recent study also revealed that immigrants had lower rates of mood and anxiety disorders compared to individuals born in Canada, with prevalence rates of 5.24% and 4.47% for mood and anxiety disorders, respectively, among immigrants, compared to 9.15% and 9.51% among individuals born in Canada (Nwoke et al., 2020). The lower prevalence rate among these populations may be attributed to underdiagnosis or to the "healthy immigrant effect", as studies indicate that immigrants tend to have better mental health levels upon arrival in Canada compared to their Canadian-born counterparts (Bergeron et al., 2009; Islam et al., 2014).

In addition to lower rates of diagnosis of mental health conditions, study shows that immigrant and racialized populations have lower rates of mental health service utilization than the general Canadian population services (Lesage, 2006). The same study shows that only 5.7% of South Asian, 4.8% of Southeast Asian, and 2.5% of Chinese populations in Canada seek mental health services (Lesage, 2006). Among those diagnosed with major depressive episodes, only 37.5% of South Asians, 26.9% of Southeast Asians, and 26.1% of Chinese populations utilize mental health services (Tiwari & Wang, 2008). One study found that 8% of non-Chinese immigrants in British Columbia received mental healthcare in the past year, compared to 11% among non-Chinese Canadian-born counterparts (Chen & Kazanjian, 2005). Additionally, a survey conducted in Montreal found a 5.5% rate of utilization of mental health care services among Caribbean, Vietnamese, and Filipino immigrants in Montreal, compared to 14.7% among Canadian-born counterparts (Kirmayer et al., 2007).

South Asian immigrants in Canada:

In Canada, the term "South Asian" encompasses individuals with diverse ancestral heritage, culture, language, religion, and geopolitical boundaries. It includes individuals who have ancestral origins in South Asia, encompassing a range of ethnicities such as Bangladeshi, Bengali, East Indian, Goan, Gujarati, Kashmiri, Pakistani, Punjabi, Nepali, Sinhalese, Sri Lankan, Tamil (Tran et al., 2005). The South Asian community is characterized by significant diversity in terms of ethnic or cultural backgrounds, native languages, and religious affiliations. According to the 2021 data from Statistics Canada, South Asian populations make up 7.1% of the total population in Canada, establishing them as the largest visible minority group in the country (Statistics Canada, 2023). The majority of individuals in this group were born in South Asian countries, such as India (44.3%), Pakistan (9.2%), Sri Lanka (5.4%), and Bangladesh (3.0%) (Statistics Canada, 2022).

The diversity of the South Asian community is further evident in the wide range of native languages reported in Canada’s most recent census. The most frequently mentioned languages, either individually or in combination with others, were English (36.4%), Punjabi (29.4%), Urdu (11.3%), Hindi (8.2%), Tamil (7.1%), and Gujarati (6.4%) (Statistics Canada, 2022). Lastly, the primary religions, determining most of the South Asians beliefs and lifestyles reported by South Asians include Hinduism (29.9%), Sikhism (29.6%), and Islam (23.1%). As per the population projection, Canada's South Asian population is estimated to surpass 5 million by 2041 if trends in growth continue (Statistics Canada, 2022). Despite the considerable diversity in language, religion, and other cultural aspects, the South Asian population shares gendered and cultural features, such as a strong emphasis on family unity, and social norms that perpetuate social stigma and shame regarding mental health, and challenges in accessing healthcare services (Kramer et al., 2002).

South Asian immigrants and mental health:

The existing research on depression and anxiety prevalence in South Asian communities is limited and inconsistent. Study based on the National Population Health Survey indicated lower rates of depressive symptoms and major depression (prevalence rate not reported) among South Asians (Wu et al., 2003). On the other hand, research conducted on older adults in Calgary, Canada revealed a higher prevalence of mild depression at 21%, exceeding the national average of 10% (Lai & Surood, 2008). Hierarchical regression analysis found that factors such as gender, physical and self-perceived health, and adherence to cultural values were identified as significant factors influencing depression among older South Asian adults (Lai & Surood, 2008). To date, there are no prevalence statistics for mental health outcomes of South Asian populations across Montreal, Quebec.

In terms of diagnosis and care, among various ethnic groups in Canada, South Asians with major depressive episodes had the highest prevalence rates of unmet mental healthcare needs at 48% and reported a perception of barriers to the availability of mental healthcare at a rate of 33% (Gadalla, 2010). In Toronto, Ontario, health sector workers and members of South Asian communities have identified mental health as a stigmatized and unaddressed health concern within the South Asian population (Islam, 2012).

Similar to other ethnocultural communities, South Asians often face barriers when seeking mental health care and tend to seek services only in times of crisis (Chadda & Deb, 2013; Snowden et al., 2009; Zagelbaum & Carlson, 2011). The barriers to seeking mental health care include mental health stigma, a belief in self-reliance, limited knowledge about mental health and available services, financial limitations and cultural differences in care provision (Reitmanova, 2007). Qualitative research with immigrant women and healthcare providers similarly identified barriers such as fear, stigma, limited information, lack of culturally competent mental health care, unfamiliarity with Western biomedicine, and negative perceptions of the healthcare provider-patient relationship, especially among the South Asian immigrant communities (Donnelly et al., 2011; A. Karasz et al., 2019; O'Mahony & Donnelly, 2007).

South Asian women and mental health:

Rates of depression vary considerably between South Asian men and women, with notable differences observed between certain groups such as younger married women and older adult women (Gask et al., 2011; Papp, 2011). The suicide rate, as well as the prevalence of self-harm, is reported to be higher among South Asian immigrant women than among South Asian immigrant men (Taylor et al., 2013).

Several factors contribute to these disparities in mental health morbidity and health-seeking behaviors. Many South Asian women lack a clear understanding of the importance of mental health services (Taylor et al., 2013). A Canadian study reported that for many South Asian women, mental health was a foreign topic and only became a matter of concern after immigrating (Ahmad et al., 2005). Despite having access to healthcare providers, women did not recognize healthcare encounters as opportunities to seek assistance and express their mental health challenges (Ahmad et al., 2005). Women also believed that treatment for depression would not be beneficial, and that a primary care visit, or referral to mental health services was unnecessary (Taylor et al., 2013).

Another significant factor influencing mental distress and barriers in seeking mental health care among young South Asian women was the experience of domestic violence, which is associated with mental health issues such as depression, anxiety and suicidality (E. J. Hurwitz et al., 2006; Mason et al., 2008). Women's financial dependency, stigma, family responsibility and isolation, further contribute to the gender disparity in depression and to patterns of mental health care seeking (Farah Ahmad et al., 2004; Sokoloff & Pratt, 2005). Needing to express their needs in a second language is also a barrier for immigrant South Asian women, hindering their ability to express their needs and seek support for mental and psychological issues.

In addition to second-language challenges complicating access to mainstream services, including expressing mental health issues in primary care, interventions such as therapy, complementary treatments, education, and information, are often not readily available in their native language (Kumari, 2004). When they are, self-help resources may be available in some but not all South Asian languages. Interestingly, however, a Quebec qualitative study by Lambert and colleagues found that culturally and linguistically diverse populations prefer to have self-help material in the language in which they receive their healthcare, and that they do not always understand available translations in their own language (Lambert et al., 2020).

Summary of South Asian immigrants' mental health in Canada:

Literature demonstrates that immigration can cause stressors like lack of social support, financial difficulties, and adapting to a new culture. Despite these challenges, immigrants and ethnic minorities often have higher rates of undiagnosed depression and anxiety than the white population. The prevalence of depression and anxiety, especially among South Asians in Canada is lower than the general Canadian population. Language, religion, and cultural backgrounds vary within the South Asian community, but they share attributes like family importance and stigma around mental health. Moreover, South Asian women face unique challenges related to domestic violence, language barriers, and cultural factors. Further, they often lack understanding about mental health services and tend to seek help only during crises.

Rationale for this study

In Montreal, Quebec, barriers to expressing and seeking mental health care can be particularly challenging for South Asian immigrant women due to a variety of language, and cultural reasons. In the context of Quebec and Canada’s overstretched mental healthcare services, the utilization of self-help strategies may be a potential solution for treating mild to moderate mental health challenges among lingually and culturally diverse South Asian immigrants. Therefore, it is crucial to better understand South Asian women's mental health expression and their preferences regarding the use of self-help strategies to make necessary adaptations.

To date, very little is known about the barriers and facilitators faced by South Asian women in expressing their mental health challenges to family, friends, or health care providers in Montreal. Of additional interest is whether self-help strategies constitute a feasible solution for treating mild to moderate mental health challenges among lingually and culturally diverse South Asian immigrants in Canada.

Objectives:

Given that linguistic minority patients need to receive care from their health team in English or French, the **objectives** of this study are to:

i) To understand barriers and enablers to expressing mental health needs among South Asian immigrant women from different linguistic and national groups who receive health services in English.

ii) To assess the acceptability and potential uptake of self-help strategies as a means of managing mental health challenges among South Asian women.

CHAPTER 3: METHODS

3.1 Overview

This study adopted an exploratory qualitative approach using a purposive sampling strategy for data collection to ensure maximum variation. Study participants were South Asian immigrant women originally from Bangladesh, India, Pakistan and Sri Lanka who have been living in Montreal, Quebec and receiving health care in English. Sixteen women participated in study from different Socio-cultural South Asian backgrounds. In-depth individual interviews were conducted using semi-structured interview guidelines from February 2023 to May 2023. Data analysis adopted an inductive-deductive thematic analysis approach, aiming to achieve a more comprehensive and rigorous understanding. This combination allowed for the exploration of new themes through inductive approach and the refinement of a priori themes through deductive methods, leading to a nuanced perspective on the data (Proudfoot, 2022). Comments raised from the ethics review boards concerning language proficiency led us to include an English proficiency assessment during the recruitment and sub-study on cognitive testing on the informed consent form.

This section will briefly describe the results of the cognitive test after discussing the rationale for the qualitative study design, study population and settings, sampling, recruitment, data collection, management and analysis and ethics review in details.

3.2 Rationale for study design

The qualitative research approach adopted for this study helped us to explore participant’s feelings and experiences in-depth. Qualitative data focuses on capturing the essence of the natural world through gathering individuals' personal knowledge, and their lived experiences (Polit & Beck, 2006) and emphasizes the meanings individuals attribute to these experiences, as expressed in their own words (Cruz & Tantia, 2017; Denzin & Lincoln, 2008; Miles & Huberman, 1994). Considering their effectiveness in exploring the underlying structures of beliefs and knowledge at individual level, in-depth interviews were used as the data collection method (Thorogood & Green, 2018). The focus of this study on the mental health challenges of South Asian women is a taboo subject within this community. By using in-depth individual interviews, we were successful in creating a safe place for women to consider their lived experience and express their mental health challenges and preferences for primary mental health care. The interviews facilitated an in-depth understanding due to the collection of detailed and rich data (Campbell et al., 2020). Adopting qualitative approach was thus considered an appropriate way of data collection.

3.3 Study population and setting

The target population of this study was the South Asian immigrant women worldwide and the study population was the South Asian immigrant women in Canada. The study sample focused on South Asian female immigrants who are accessing primary healthcare services in English and are at risk of mental health conditions in Montreal, Quebec.

Eligibility criteria: The eligibility criteria for the women to participate in this study were being 18 or above years of age, immigrant status, country of origin (Bangladesh, India, Pakistan and Sri Lanka), receiving health care in English, women who have had personal or indirect exposure to mental health conditions in their family members and their ability to have the interview in English. English language eligibility was determined by asking the participants two questions based on the US Census Limited English Proficiency question (Census – LEP) (Karliner et al., 2008) –

1) How well do you understand English? – i) Not well; ii) Well; iii) Very well

2) How well do you speak English? – i) Not well; ii) Well; iii) Very well.

Participants who responded less than ‘very well’ were eligible for participation with limited translation support for Bengali, Hindi and Urdu from the graduate researcher if needed. The exclusion criteria included women with no English language capacity, immigrant women from any non-South Asian community.

3.4 Sampling

This study followed a purposive sampling strategy to recruit participants from two different settings, a family medicine teaching clinic serving a multicultural neighborhood supplemented by and a South Asian women’s community organization in Montreal, Quebec. Sixteen South Asian immigrant women from Bangladesh, India, Pakistan and Sri Lanka from different linguistic groups (Bengali, Hindi, Urdu, Tamil) and life stages (age-group, married and maternal status, recency of immigration in Canada) were purposively approached and recruited from the study settings.

3.5 Recruitment

Participants with direct or indirect experience with mental health conditions were referred from the family medicine teaching clinic. Members of the care team from the clinic initially identified potentially eligible participants (South Asian, woman, receiving primary health care in English) and informed the graduate student researcher about specific days when recruitment could happen. During these days, the researcher was present in the waiting room. Recruitment for the study was also announced using a poster (Appendix I) on the television screen of the clinic to advise people to contact the researcher in the waiting room. The advertisement included a link with contact information so that people could reach out to the researcher later if interested. Other participants were recruited from a women's community centre for South Asians in Montreal, Quebec. The poster of the study was posted on the community centre and the service providers of the centre also referred the potential eligible patients to the graduate researcher.

After the initial referral, the graduate researcher briefly explained the nature of study, established eligibility, affirmed that their decision to participate would not impact on their care and finally asked them for their participation in this study. Consenting participants arranged to be interviewed at a time convenient to them, either in-person or online.

3.6 Data collection process

Data collection tool: Data collection was conducted using a semi-structured interview guideline (Appendix II). All the demographic data (such as age, country of origin, known languages, recency of immigration in Canada, marital status, number of children) were collected using close-ended questions. The rest of the interview followed the semi-structured open-ended questions and probes. The interview guideline was developed with feedback from the thesis supervisors and a family physician (one of the committee members of this thesis project) to avoid any questions that might be sensitive and cause harm to the participants. After taking the initial demographic data, participants were asked open-ended questions to explore their knowledge, beliefs, and practices regarding mental health challenges, their viewpoints on how society and family influences their utilization of mental health services, and their perceptions about the potential of self-help approaches in managing mental health challenges.

Consent and audio recording: After meeting the eligibility criteria and initial recruitment for participating in the study, participants were provided with an informed consent form to review during the interviews. The consent form outlined the purpose and methodology of the study as well as ethical safeguards regarding data protection and privacy. It was ensured that the participants completely understood the study requirements, potential risks, and voluntary nature of participation. The participants were also informed about their ability to withdraw at any time. Written informed consent were obtained from the participants before starting the interview.

Participants were asked to consent for audio recording, and a few of them expressed concern about the process of being recorded. The advantage of audio recording is to ensure that all important details are documented, and to allow the interviewer to remain focused during the conversation with the distraction of detailed note-taking (Silverman, 2000). Study participants were informed of these advantages and assured that the tape would only be listened to by the graduate researcher and used for the purposes of this research only. After explaining the audio recording process and purpose in details, participants were asked and agreed to also sign the audio recording part of the consent form (Appendix III). Although the interview would be recorded, the participants were assured that neither the tape nor the transcript would identify them in any way, and that their anonymity would be fully maintained.

Interviews: Individual in-depth interviews were conducted mostly in-person. A total of 16 women participated in the study. Interviews were conducted simultaneous to data analysis using an iterative approach, allowing the inclusion of any new topic that emerged to be included or modified in subsequent interviews (Pope et al., 2000). For example, during the first few interviews it was found that the participants were not aware of “self-help toolkits”. Instead, they kept referring to resources they find by themselves from online to manage any mental health challenges. Initially, the question in the interview guideline asked participants whether they knew what self-help toolkits were or if they ever used any of these tools. For subsequent interviews, this section was modified in the guideline to read “what are the things you do on your own informally to support your mental health”. This helped in gathering richer data in the following interviews.

Only 3 out of 16 interviews were conducted over Zoom as it was the most convenient options for the participant concerned. Interviews were approximately 45-90 minutes in duration. All the interviews were conducted in English; however, translation support was provided in some parts of the interview to four participants as they said they would be able to express themselves better in their first languages (Bengali and Hindi). Data collection continued until data saturation was achieved, indicating that no new information was being obtained on women’s barriers and facilitators to expressing their mental health problems as well as their preferences of primary mental health care.

In order to prevent discomfort or harm to the participants due to the sensitive nature of the topic, even though the study was considered low risk, the graduate student researcher underwent mental health first aid training provided by the Mental Health Commission of Canada prior the data collection. This training allowed the researcher to acquire skills for providing initial help to individuals experiencing a decline in their mental wellbeing or a mental health during the interviews. It also helped the researcher in providing participants with any potential mental health care seeking resources if required. Throughout the interviews, the interviewer observed and recorded both verbal and non-verbal cues of the participants.

3.7 Data management

As per research ethics norms, all data were kept in a password-protected computers and/or locked filing cabinets only accessible to members of the research team. All interviews were transcribed verbatim. The sections in which 4 participants responded in Bengali and Hindi rather than English were directly translated verbatim into English. During transcription, audio-recordings were anonymized, with all identifiable information removed prior to using the software analysis tool. And finally, all the audio-recordings were destroyed immediately after transcription. Full access to data files, including audio recordings, transcriptions and field notes was limited to the graduate student researcher. To maintain participant's anonymity, pseudonyms are used throughout this thesis report.

3.8 Data analysis

A thematic analysis was conducted to identify, analyze, and report patterns or themes within the data. This approach to analysis involves the careful examination of data to identify recurring ideas or concepts, which are then grouped into broader themes (Belotto, 2018; Clarke et al., 2015). The thematic analysis was supported by the Framework Method, which utilizes data matrices to facilitate the recognition of patterns and themes through summarizing codes to ensure the findings are represented across participants (Gale et al., 2013). Following the method, we employed the five key steps to our analysis - data familiarization, initial coding, theme identification, developing an analytical framework, and applying the framework to the dataset (Goldsmith, 2021). The transcripts were indexed based on key "a priori" concepts from the interview guide, as well as inductive codes that were developed through analysis.

Preliminary data analysis started after the first interview, and advanced throughout the data collection period in an iterative manner. Data was coded and organized using the data management software "Dedoose" (Huynh, 2021). The transcripts were indexed based on the key "a priori" concepts in the interview guide, as well as open or inductive codes that were developed through analysis. Following, transcripts were re-read to get familiarized with the range and content of the data (Goldsmith, 2021). Reference to the literature and research objectives also occurred simultaneously to explore patterns and emerging themes. Final codes and code definitions were developed, shared, and discussed with the thesis supervisory committee until consensus was reached (Appendix IV). Data was summarized into data matrices to enable the identification of patterns and themes for further interpretation. The thesis supervisory committee provided ongoing assistance and guidance throughout the data analysis process.

3.9 Ethics review

Primary ethics approval for this study was obtained from Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l’Île-de-Montréal (CIUSSS – ODIM) before proceeding with any data collection from the family medicine teaching clinic for this study purpose. In addition to this, another approval was obtained from the Women’s Community Centre for South Asians in Montreal to recruit participants from that institution for the data collection purpose. The Research Ethics Boards (REB) provided approval for the research protocol, English version of the consent form as well as the initial interview guideline of the study. As the first languages of the participants were other South Asian languages than English, the research ethics board expressed concern about participants’ comprehension of English for the interviews. Therefore, language proficiency assessment was included as one of the eligibility criteria during participant recruitment. A cognitive testing of the consent form was conducted as a sub-study of the research to ensure that the participants understood the form well as intended and provided informed consent in English which is briefly described in the following section.

3.10 Sub study: Cognitive testing on the informed consent form

Overview, population, sampling, and recruitment:

Cognitive testing, usually used in improving survey questions and techniques is a qualitative method that relies on evidence to determine whether survey questions are fulfilling their intended purpose by understanding how participants interpret survey questions and instructions (Collins, 2003). These tests can also be used to enhance the understanding of survey responses and improve response rates, which are frequently used in introductory lectures in courses and workshops (Willis & Artino, 2013). We did not come across any prior research that had utilized cognitive testing to enhance the clarity of the Informed Consent Forms (ICF). However, through the application of the same technique followed for survey questions, we were able to understand the level of comprehension of our potential study participants with regards to the ICF.

The cognitive test was conducted in 3 rounds, with each round incorporating an improved and more understandable version of the consent form. We used a highly pragmatic semi-qualitative approach with a goal of rapid modification of the form in each round. The first round was conducted using the initial consent form that was later revised in 2 subsequent rounds based on participants' suggestions and researcher's observations, to ensure that the information presented in the modified version of the consent form was clear and comprehensible to the participants. We recruited a total of 11 women from different age groups, levels of literacy, occupation and number of years living in Canada, by using snowball sampling within the South Asian community. Participants involved in cognitive testing were excluded from the main study. The test was conducted by the graduate student investigator who was also responsible for recruiting and interviewing the participants for the main study. Hence, it was a great opportunity for the researcher to explore people's understanding and perspectives towards the study subject. Alongside the specific questions and feedback, participants were also asked to comment on their overall thoughts on the ICF.

Results based on participants' responses and researcher's observation:

Throughout the three rounds of testing, participant's reactions to the contents of the ICF were carefully observed. At the outset, many participants expressed concerns with the length and time required to read the 6-page document. Specific sections, such as those related to the "conduct of the research project" and the distinction between "disadvantages" and "risks," posed comprehension challenges, requiring participants to re-read them multiple times. Despite initially engaging with the document, participants were seen to skim through the information from page 3 onwards. Observations, feedback and recommendations from cognitive testing were integrated at each round, leading to modifications to the initial form. Ultimately, a simplified and shorter version of the ICF was developed with a higher readability score than the original document. We used the approved consent form for the main study, however, the modified version created after cognitive testing was a supplementary document that proved valuable in clarifying confusing sections for participants during the informed consent prior interviews.

Conclusion:

As part of dissemination of the findings of this cognitive test, a detailed report was developed and shared with the research ethics committee (Appendix V). The results were also presented and discussed during a monthly meeting of the ethics committee. The committee members found the findings intriguing and recognized the importance of improving the comprehensiveness of the consent form, particularly for linguistically and culturally diverse study populations and those with low literacy levels. As a result, the ethics board decided to review the current consent form template and explore the possibility of creating a simplified version using accessible language for individuals within culturally diverse study populations besides the original version.

Positionality and reflexivity

As a South Asian international student conducting qualitative research on the mental health challenges faced by South Asian immigrant women in Montreal, my identity and positionality as a researcher and its potential influences on the research, is important to acknowledge. Firstly, my identity as a South Asian woman allowed for a certain level of cultural understanding and shared experiences with the participants. Being from the same cultural background facilitated rapport-building and enhanced trust, as participants perceived me as someone who could relate to their unique challenges and cultural contexts in Canada. This was reflected in a few interviews where women referred to their experiences as saying "As you know, everyone knows everything about each other in our community, there is no privacy. You can relate to this." Prior to the interviews, I also had informed the participants that I would be able to provide language support in Bengali, Hindi, and Urdu in certain sections of the interview if necessary. During the interviews, some participants took advantage of this opportunity to express their experiences and thoughts on mental health, which they found difficult to convey and translate in English. This facilitated the development of a trusting relationship between myself and the participant, which in turn encouraged them to respond to the interview questions. As a result, this language support was beneficial in helping the participants feel comfortable and open during the interview process.

Additionally, my academic background as a graduate researcher played a crucial role in shaping the research process. Through my research training, I developed an awareness of power dynamics and the need for cultural competence. Recognizing the potential power imbalance, especially between a researcher and participants, I approached the data collection process with sensitivity and a commitment to creating a safe and equitable environment. This awareness helped me establish a collaborative relationship with participants, valuing their voices and experiences as equal partners in the research.

Moreover, my personal experiences impacted the data collection process by allowing for a deeper connection with the participants. For some of the participants who were reluctant to share their thoughts, sharing my own experiences of navigating mental health challenges or accessing appropriate care fostered empathy and understanding. Participants perceived me as someone who could empathize with their struggles, thus facilitating more open and honest discussions during interviews. These personal connections not only enhanced the quality of data collected but also reinforced the trust between participants and myself.

CHAPTER 4: RESULTS

This chapter describes the characteristics of our study participants and identifies key themes emerging from my analysis of the in-depth interview data they provided. To illustrate the themes, I will present some excerpts from the participants' narratives. The detailed discussion of the major themes will relate to the research questions in this thesis.

Socio-demographic characteristics

In this study, we interviewed 16 women who had immigrated from different South Asian countries. The largest group of participants were from India, followed by Sri Lanka, Bangladesh, and Pakistan. With regards to the length of time spent in Canada, the majority of participants had been living in Canada for over five years, with only four of them having lived in Canada for less than five years. Out of the 16 participants, only five were employed, while three were students and the remainder were housewives. Most women in the study were married.

Table 1 presents an overview of the participants' demographics. To protect their anonymity, I will refrain from presenting each participant's demographics individually.

Table 1: Socio-demographic characteristics of participants (total n=16).

Characteristic		**Number of participants (n)**
Age-group	Young adults: 18-34 years	4
	Middle age: 35-44 years	6
	Older adults: 45-64 years	6
Country of origin (Native Language)	India (Punjabi and/or Hindi)	6
	Sri Lanka (Tamil)	4
	Pakistan (Urdu)	3
	Bangladesh (Bengali)	3
Years since immigration to Canada	Less than 5 years	4
	5 years or more	12
Highest Education Level Achieved	High school	7
	Bachelor's	5
	Graduate	4
Marital Status	Married	10
	Separated	2
	Widowed	1
	Unmarried	3
Children	Less than 2	6
	2 or more	10
Occupation	Housewife	8
	Employed	5
	Students	3

Table 1 also illustrates the diverse demographic and social backgrounds of women in the study.

Despite huge variations in age, levels of education, and employment, there were remarkable commonalities in women’s stories of after-migration to Canada, and in the challenges encountered.

The experiences and perspectives of mental health and mental health primary care among immigrant South Asian women were elicited through in-depth interviews. Systematic thematic analysis using the framework method revealed four major themes. The themes are illustrated in the following table 2 with brief descriptions.

Table 2: Theme identification

Themes	Components	Theme description
1. Emerging awareness and mental health literacy		This theme refers to low awareness of mental health knowledge prior to migration and how this gap is filled through generational changes, exposure to mental health and mental health care information sources.
2. Social stressors influencing mental health conditions	i. Immigration and intergenerational stressors	This theme refers to stressors that contribute to developing or exacerbating South Asian women's mental health conditions, including generic immigration and intergenerational stressors but also gender-specific stressors such as violence and financial dependencies in familial conditions.
	ii. Intimate partner violence	
	iii. Family responsibilities and financial dependencies	
3. Expression of mental health challenges	i. Considering mental health as a threat to the family	This theme addresses the socio-cultural factors that either inhibit or enable immigrant women in communicating their mental health issues to their own social circle people around them as well as to their primary healthcare providers.
	ii. Lingual and cultural factors impacting expression of mental health concerns to healthcare providers	
	iii. Social and familial support in recognizing mental health conditions	
	iv. Trusted relationships and confidentiality to facilitate seeking physician's help	
4. Preference and expectations around mental health care	i. Preference for professional help over self- care	This theme elaborates women's preference for professional and culturally appropriate mental health care as well as their frustration about its limited accessibility.
	ii. Potential adaptations in self-help tools	
	iii. Frustrations about accessing professional services: System and cultural prospects	

Descriptions and interpretations of these identified themes and its components are given in the following sections.

Theme 1: Emerging awareness and mental health literacy

When participants were asked to describe mental health and to identify common mental health disorders, three participants out of 16 responded that they were unfamiliar with the term and its manifestations. Aleya, an older immigrant living in Canada for over 20 years said,

> *"I do not know what it is (mental health), all I know about health is to be strong and being able to eat and walk properly, and not depending on medication to survive, unlike me (P16)."*

The other two women who did not have any mental health knowledge responded in similar ways. On further questioning, all three respondents indicated that they had not received any education on mental health matters during their upbringing, and they did not regard mental health topics to be important for discussion. It was observed that all three of them were above 55 years old.

Out of the remaining 13 participants who claimed to have knowledge about mental health, most defined it as "mental stability," "mental calmness," or simply "being happy". One participant, Karima, a middle-aged woman stated that,

> *"If I wake up in the morning feeling happy and energetic to do new things, then my mental health is good. Some days are nice and energetic, and I engage in different activities with my kids. But other days, I feel low and spend the whole day doing nothing (P10)."*

Many women interviewed attributed their limited understanding of mental health to its taboo status within the South Asian community. One-half of participants indicated that mental health is highly stigmatized within their immediate and extended families. They explained that prior to migrating to Canada, they had no knowledge about mental health or its significance. Reflecting on their experiences in their home countries, these women expressed that they were never taught anything positive about mental health during their rearing. Instead, they were instilled with the belief that discussing mental health problems would bring shame upon their families. Alisha, a young participant explains-

> *"How else would I understand when no one talks about it, not even my mom or the community?... It's always as if you are crazy as a person and doing it on purpose to humiliate yourself, your family, your country, your community. At the time, it felt so real and harsh, with mental illness being used as an insult. It was like saying, "You are the crazy one, your anxiety is not right (P6)."*

Despite living in a high resourced setting like Montreal, Aisha and several other participants highlighted that the stigma and taboo associated with mental health continue to persist within South Asian communities in Canada.

According to participants, their social connections and younger family members, particularly their children, played an important role in developing and enhancing their understanding and knowledge of mental health after they moved to Canada. Out of the 13 women who knew about mental health, three mentioned that their children's schools in Canada organized workshops on mental health, which helped them become familiar with the subject. Wasundara, a middle-aged immigrant shared her experience of learning about mental health problems and resources:

> *"I didn't know anything about mental health before coming here, it was a completely new topic for me. I learned about it when my daughter started high school here. I attended a workshop there. My daughter also teaches me how to talk to her when she is upset. I also learn new things from other parents when we talk (P12).”*

Among the five working women who were interviewed, only one mentioned learning about mental health and available resources through a workshop at her workplace, and this occurred after the COVID-19 pandemic. A few women who were housewives said that attending community gatherings and workshops organized by South Asian community organizations helped them gain knowledge and awareness about mental health and services available.

During the COVID-19 pandemic, social media platforms like Facebook and Instagram also emerged as powerful tools in raising awareness and disseminating valuable information about mental health. A few women revealed that they stumbled upon mental health-related contents and relevant services such as counselling and mental health management mobile applications through these platforms. For many younger participants, these platforms provided a critical window into the issue of mental health and the availability of resources and support for individuals grappling with mental distress. As Anita shared her personal journey, stating,

> *"I didn't have much knowledge about mental health. I became aware of it during the COVID pandemic, people were talking about it on Facebook, Instagram, and everywhere. Maybe I was feeling some things, but I didn't associate them with mental health issues. I also saw there are people who were talking and suggesting others about mental health counseling, I didn't know what it was before (P15).”*

This highlights the pivotal role of social media in raising awareness and providing much-needed support during times of adversity.

Theme 2: Sources of stressors influencing mental health conditions

The second theme acknowledges the profound impact of social stressors on the development and exacerbation of mental health conditions among South Asian immigrant women. Based on the participants' responses, three major sub-themes were identified: immigration and intergenerational stressors, intimate partner violence, and family responsibilities and financial dependencies.

Intergenerational and immigration stressors

Immigration and intergenerational stressors emerged as significant factors impacting the mental health of South Asian immigrant women. Two participants highlighted the influence of having family members with long-term mental health conditions, suggesting a generational link to their own mental health problems. For instance, Radhika shared,

> *"I'm diagnosed with PTSD and I had depression twice in my life. I realized that my anxiety comes from my grandmom and mom, it's in my DNA, and it is generational. I know my sister was going through the same thing (P7)."*

The experience of being separated from immediate family members due to immigration also contributed to mental health struggles, with participants expressing feelings of emotional and mental vulnerability. The isolation from extended family members and friends further exacerbated feelings of mental health conditions. Radhika shared her mother's experience, saying,

> *"My mom came here first. She was separated from us, her own children for 4 years, and striving to be this independent woman in an unknown country, you know? She was all alone. Sri Lanka is known for the civil war that's still happening. So that also obviously has an effect, she used to worry for us all the time, like living anxiously for 24/7 (P9)."*

Additionally, participants discussed the challenges of fitting into a new culture and country, which created additional mental stress. Some (five) participants shared their struggles to integrate fully and feel a sense of belonging, leading to self-consciousness and anxiety. In search of validation and understanding, one participant expressed that when she needed to socialize, she specifically sought out individuals who shared a similar cultural background to her. The experiences of racialization and misidentification were particularly highlighted by younger participants, who felt an identity crisis as they were often categorized as belonging to a different nationality. One participant shared her perspective, saying,

> *"I am a plus-size woman. I am a dark-skinned woman. So, all these identities come into play when I ask for help for my depression and even when I come to talk about it. How do you see South Asian representation or, you know, voices? It's usually Indian, I am from Sri Lanka, but I am always categorized as Indian. I'm not really seen as a whole person (P9)."*

These immigration-related stressors significantly impacted the mental well-being of the participants, highlighting the need for support and understanding in their new cultural context.

Intimate partner violence

Intimate partner violence was a significant challenge for South Asian immigrants in Montreal, exacerbating mental health issues within this population. Six out of 16 participants shared their own experiences or those of their relatives and neighbors relating to the deeply concerning issue of domestic abuse. They acknowledged that such violence could contribute to the development or exacerbation of depression and anxiety among women. Participants also highlighted the social factors that contribute to intimate partner violence, including women's lack of education and authority to speak for themselves, and external family member's influence on their marital life. These intertwined factors create barriers for women when expressing their mental health challenges to formal care providers, as will be discussed in a later section. Sanam expressed her sense of frustration against such violence while recounting the experience of her own sister, who had fallen victim to family violence –

> *"I am so frustrated with this (South Asian) society, and I feel ashamed. My own sister was a victim of family violence, and she once decided to leave her husband. She could not take it mentally and tried to commit suicide twice (P11)."*

Family responsibilities and financial dependencies

The role of family responsibilities and financial dependencies as factors influencing or exacerbating mental health challenges among of South Asian immigrant women was evident across many of the interviews. The majority of women expressed negative feelings related to being overwhelmed by household responsibilities and its toll on their mental well-being. Some women also shared experiences of giving up their careers upon immigrating to Canada and becoming financially dependent on their spouses. Participants noted how this shift in roles and level of dependency created significant challenges, particularly in decision-making and agency regarding their own healthcare. Some women mentioned relying on their husbands for healthcare decisions, like booking appointments and follow-ups. Rani, an immigrant young woman suffering from depression vividly described her experience,

> *"My husband works full time, so he (alone) is .. bringing the money home. So now I depend on him financially. I'm doing the woman's job, staying home. Of course, I will spend more time with my baby, but it's not the only thing I want to do in my life right now. In my last job, I was a research assistant at the university... now all of a sudden, I'm reading only children's books. I need my husband even to go see my doctor, I can only go if he says so (P13)."*

These experiences highlight the mental strain caused by the imbalanced family responsibilities and the challenges faced by women who have become dependent on financially and accessing or decision-making regarding health care after immigration. The shift from professional roles to primarily domestic ones can lead to a sense of dissatisfaction and hinder their overall mental well-being.

Theme 3: Expression of mental health challenges and seeking help

This theme highlights the stressors, fear, and potential repercussions that South Asian immigrant women face in expressing their mental health conditions. The combination of societal judgment, stigma, and the threat of intimate partner violence creates a challenging environment where women feel compelled to prioritize the preservation of family reputation and their own safety over their mental well-being. However, while exploring women's mental health concerns and stressors, it was observed that many women initially felt more at ease expressing their family members' or friends' mental health conditions rather than their own.

This theme also draws attention to the influence of linguistic and cultural elements on the communication of mental health issues. It highlights the presence of language barriers and cultural differences faced by women in the South Asian immigrant community and how those elements impact the way women communicate their mental health concerns to their health care providers. Within the context of accessing primary mental health care, these factors present considerable challenges, impeding the ability of effectively expressing the mental health concerns when interacting with healthcare providers. However, in contrast to these barriers, social and familial support emerge as facilitators in enabling South Asian women to express their mental health conditions to others. Additionally, the establishment of trust and assurance of confidentiality with healthcare providers serve as motivating factors for women to openly communicate their mental health issues and seek care from the physicians. In the subsequent sections, a comprehensive discussion of these barriers and facilitating factors is presented, complemented by the excerpts mentioned by the participants.

Risk in expressing mental health vulnerability to health care providers

The findings of this study demonstrate that the perception of mental health as a threat to the family is a substantial barrier for South Asian immigrant women when it comes to expressing their mental health challenges and seeking help. A few women indicated their concerns about the potential consequences of disclosing their mental health problems, fearing that the news would spread throughout the community, leading to negative judgments and social exclusion. A number of women noted that this fear of societal judgment and stigma prevented them from openly discussing their mental health challenges, causing them to suffer in silence. Alisha, a young participant who has recently been married, highlighted the intense societal pressure and fear of social consequences she feels when considering whether to disclose her mental health struggles with her family,

> *"If I talked to my parents about my depression, my mom might brush it off. It's like they deny the fact that I have anxiety. It is a pressure from the society because they (South Asian community) will say this family is crazy. It was worse when I was unmarried. Because no one would marry me if they knew that I have mental issues. So, my family tried to keep it a secret all the time, denied it. It only got better when I got married (P6)."*

Study findings also highlight the fear that women experiencing intimate partner violence face when it comes to sharing their mental health conditions with friends, family, and healthcare professionals. Participants who disclosed experiencing or witnessing violence within their friends or family members, expressed that women are afraid to seek help for mental health concerns as they fear it may anger their partners and escalate the violence they already suffer. Women also worried that seeking mental health care could potentially reveal their abusive partners, leading to legal repercussions that could negatively impact their financial and immigration status. And thus, Mitu, a victim of domestic abuse shared that remaining silent felt to be more secure for herself and her family rather than risk the potential consequences of expressing or seeking help for her mental health concerns. Sanam shared a similar story about one of her family members who was experiencing violence and therefore hesitant to express that she was having mental distress and needed help. As Sanam said,

> *"Once my sister was saying she has been feeling to give up on her life.... her husband tortures her every day, he even beats her with whatever he finds at hand. I asked her to talk to me or to her doctor about this. But she said no. She is afraid that if people come to know all this, she will*

> *feel embarrassed in front everyone. Her husband will also get mad at her. Also, if the police gets to know about this, they will take away her children to child protection care and everyone will blame her (P11).”*

Women also shared that in South Asian communities, societal expectations often pressure women to be strong in their roles as caregivers for their families, and that disclosing mental health issues would brand them as “weak.” Reflecting on Rani’s discussion regarding the barriers she confronts in expressing her mental health needs, this stigma prevents women expressing their mental health problems, as they fear judgment, isolation, and a loss of social standing.

Limited expression of mental health concerns to health care providers

The expression of mental health concerns to healthcare providers are also influenced South Asian linguistic and cultural factors. Women immigrants shared experiences of having to rehearse even their physical health-related questions before seeing a doctor. Consequently, when it comes to discussing mental distress, one woman doubted her ability to engage, particularly if the GP raises any follow up questions given her limited knowledge about what mental health is and how to express this in a non-native language. This difficulty in communication due to language barriers leads them to avoid talking about mental health problems altogether.

Referring to other women who need language supports during medical appointments, a few women said that the presence of an interpreter could pose a confidentiality concern for them. Additionally, women shared that if the interpreter belongs to the same community or cultural background, they may be more hesitant to share their mental health struggles with the physician as keeping confidentiality is a big concern in the South Asian community. As noted by Radhika,

> *"I fear to share anything with anyone. I mean if I tell someone that I have anxiety issues, the next day everyone will get to know about it. As you know, everyone knows everything about each other in our community, there is no privacy…(P 9)."*

The fear of their personal information being disclosed within their community adds another layer of complexity to their already challenging situation, further impeding their ability to express their mental health concerns.

Cultural differences between healthcare providers and women patients from South Asia also present obstacles to expressing mental distress in the clinical encounter. Two out of the three student participants shared that they often find it difficult to effectively communicate their experiences to healthcare professionals due to a lack of shared understanding and familiarity with the South Asian cultural context. Anita, a Pakistani immigrant living in Montreal for the past 7 years explained that she was fearful of being judged by her physician if she shared her cultural context in regard to mental health. She also mentioned that healthcare providers sometimes provided oversimplified solutions for mental distress,

> *"She (health care provider) once suggested me to live alone for a while when I was having terrible family issues. I know it's not her fault to suggest something like that, it is normal for a lot of people here. But I couldn't tell her that this is not the usual parental norms within South Asian families for a South Asian girl (P15)."*

Participants shared how their cultural upbringing influences their ability to explain their mental health situation to their physicians. Several (four) young women highlighted the embarrassment they felt in discussing the cultural restrictions imposed by their parents, such as having male friends or returning home before evening. As Esha explains,

> *"My parents will never think out of their cultural box. Once I had a really hard time just explaining my mental health situation to my doctor, because you have to share everything in the background, right? I found it really difficult to explain why my parents are not accepting me having a boyfriend, why they won't allow me to date someone. This is just a cultural thing; our parents don't allow us to be in relationships before marriage. I felt embarrassed to share that with her, so I stopped explaining (P7)."*

Another barrier to expressing mental health concerns is a lack of knowledge and understanding about mental health. Participants who mentioned having little to no knowledge expressed the belief that mental health is not an issue to be concerned about, nor discussed with others.

The importance of social and familial support in recognizing mental health conditions

Social and familial support was identified as important factor influencing the recognition and expression of mental health conditions among South Asian women. When women have a strong support system of friends and family, they are more likely to receive validation for their own mental health conditions, motivating them to express them with others. The. majority of study participants (nine) shared that they feel encouraged to seek help when they find their friends and parents listen to them without any judgment, and preferable, in their own language. Emphasizing on the importance of familial support, Wasundara said,

> **"***If I share my problems with them (family), they are open to listening and always available to support me. I can call them anytime. Sometimes, when I discuss my problems, I find solutions along the way. They provide me with multiple options to try, or they suggest taking a break and relaxing if I'm not feeling okay. Their love and care for me help me to seek help and stay healthy (P12)."*

Some participants mentioned that witnessing someone else openly addressing and seeking mental health care encourages them to talk about their own mental health problems and possible management strategies. For instance, one participant mentioned feeling motivated to seek mental health care after observing a friend consult a mental health counsellor during the pandemic. Another woman expressed that normalizing mental health disorders in the South Asian community will help her and a lot of other women discuss their concerns more openly. Participants with children expressed their desire to prioritize their mental well-being knowing its importance in effective care giving. They emphasized that if they recognized their own mental health issues were impacting their children's upbringing, they would openly discuss their conditions and even teach this topic to their children.

Trust and confidentiality facilitate seeking physician's help

A last finding under the expression of mental health challenges theme is the importance of trust and confidentiality in facilitating South Asian women's willingness to seek help from physicians for their mental health concerns. Karima observed that she would feel much more confident and comfortable sharing her mental health problems with a physician who was welcoming and gentle in their clinical approach. Some women also emphasized the importance of trusting their healthcare providers when it comes to sharing their mental health problems. Two participants who had the same general practitioner (GP) as their parents indicated their discomfort and lack of safety in discussing their mental health conditions with a GP who is familiar with their family members. These concerns were primarily rooted in concerns that disclosure of their mental health problems could create family problems. Quoting Esha,

> *"I wanted my mental health separate from my family and school. I had a negative experience when I got a call at my home number for my appointment instead of my cell phone. It made me hesitant to share anything else with my doctors. Even though she might not disclose anything, I just felt uncomfortable (P7)."*

Theme 4: Preferences and expectations around self-care

How women view and prioritize their mental health needs, as well as their expectations and preferences concerning the types of care, they want has an impact on their mental health help-seeking behaviors. In this section I describe participants' preferences and expectations around mental health care and how that shapes their experiences when seeking support for their mental well-being.

Preference for professional help over self- help: Limited knowledge and time to utilize self-care approach

The majority of the women interviewed had limited knowledge of self-help strategies for managing mental health conditions. A few participants (four) who did possess knowledge of self-help strategies expressed a preference for professional support over self-care for mental health management. They emphasized the need for someone to listen to them and provide direct assistance when they require mental health care. These women found paper-based tools or navigating online resources on their own to be challenging and complicated, particularly when they were experiencing mental distress. Quoting one participant,

> *"If those are basically some papers instructing me to do certain things by myself, then I may not be using those because it's too much (P9)."*

Issues of time and feasibility emerged as additional factors influencing the preference for professional help over self-care. One participant highlighted that the daily responsibilities of being a parent and spouse left little time for self-care. On further reflection she noted that she prioritized the demands of taking care of others over attending to her own well-being. This perspective was echoed by another participant, who concurred that time constraints and responsibilities towards others, especially among women with children, made it difficult to implement self-help practices consistently. As Anita explains,

> *"For someone who has children and is married, the way their day is structured, there's no time. I can talk about my mom, there's no time in her day (P15)."*

Some of the women interviewed expressed concerns about the effectiveness of self-help approaches for women experiencing long-term mental health conditions. One participant who tried these tools before said that they were not helpful as her mental health needs were serious and long-term and needed more advanced care. While some women acknowledged the potential benefit of self-help in the absence of available professional help, they were uncertain about its effectiveness in addressing everyone's mental health issues. As Preet mentioned,

> *"I think it depends on what the tool is and what it is that I'm dealing with. If it's something that I feel like I've been dealing with for a long time and I really need help, but I find no professional to help me, then maybe I will be OK with using it, but I I'm not sure (P4)."*

Potential adaptations for utilization and popularization of self-help tools

Women who were knowledgeable about self-help strategies expressed difficulties in using available self-help resources and mentioned that these materials are not adapted for South Asian cultural backgrounds. They indicated a need for resources that are specifically tailored to South Asian cultural beliefs and languages. Suggestions included the translation of self-help materials into every South Asian language and drawing on culturally relevant examples and illustrations.

One participant highlighted her unfamiliarity with self-help resources and highlighted her children’s potential role in increasing her mental health knowledge if self-help strategies were introduced in the schools and academic curriculum. She also emphasized the utility of self-help tools for children themselves and the importance of ensuring the mental well-being of future generations. A few women similarly discussed the lessons they learn from their own children and believed that children can teach adults about these tools within their families and within the community as well. As Khushi explains,

> *“I don't know, in school also if they talk about it, students will learn more about these from the younger age. Children play a big role. I mean understanding that for as a child age, when you were young that's also help, it will change the society. I learn a lot of things from my kids every day, they can teach us about these too (P2).”*

Frustrations about accessing professional services: System and cultural aspects

Among study participants, six women who have been experiencing mental health challenges expressed their concern about the waiting period for accessing mental health services. One participant shared her ordeal of waiting for a year to see a mental health professional, during which she relapsed and was unable to help herself:

> *"I was going through this (depression) for 2 years, initially I did not know what this feeling is. Then my son forced me to talk to my doctor about it. But then I was waiting to see my therapist for once whole year. I think my condition got worse at that time (P4)."*

Additionally, some women (two) mentioned difficulties in navigating online resources when they tried to access these services. They discussed the lack of South Asian mental health professionals as well as their lack of independence in choosing their own mental health providers. A young participant named Alisha, who has been diagnosed with anxiety disorder, stated,

> *"If I know that my therapist shares the same background as me, it is easier to engage in conversation. But this is a problem. Most of the time we do not have doctors who match our profile. I don't know if it's possible to fix though. Or if it's too much to ask for. I am speaking for myself (P6)."*

One woman highlighted the need for education and awareness about mental health in her community, suggesting that it should be integrated into primary healthcare discussions even if the patient is not currently experiencing mental distress:

> *"Make us more familiar to words like "depression", "counselling", "therapist" even when we go to see a doctor with stomach-ache. Because we don't know enough about this topic. We need to get used to these before knowing that it important to share our mental problems (P2)."*

In summary, women participants expressed their frustrations around the long wait periods for mental health services and challenges in accessing appropriate online resources. They also highlighted that having mental health professionals who share their cultural background and language, would enhance their comfort and communication.

CHAPTER 5: DISCUSSION AND LIMITATIONS

This qualitative study of South Asian women receiving English primary care services in Montreal revealed the important influence of immigration experience on mental health – both as a stressor and as an opportunity for increased knowledge and awareness of mental health issues. Findings indicate that culturally-located mental health stressors such as gendered family responsibilities, dependency on male family authorities and the threat of intimate partner violence, combined with limited English proficiency and concerns about confidentiality, impede the expression and treatment of psychological distress. Culturally appropriate care by primary care providers can encourage disclosure of mental health issues. Further, while the South Asian women in our study expressed a clear preference for professional help over self-help resources, culturally-adapted self-help resources present a promising initial care step for identified mental health issues. These key findings are discussed here in detail.

Immigration as a stressor as well as an opportunity for enhanced mental health literacy

Immigration and integration are the significant stressors impacting the mental health South Asian women in Montreal, and the literature concurs that immigration is a mental health stressor. Immigration experience is a key social determinant of health influencing the health and wellbeing of the Canadian population (Raphael et al., 2020). But for South Asian women, the immigration experience introduces a distinct set of gendered challenges, including increased family responsibilities, adapting to a new social and cultural environment, and greater dependency on their male counterparts especially among those who left jobs in their country of origin. Other studies confirm that South Asian immigrant women face strong socialization pressures to prioritize family needs and maintain "cultural continuity", (Mahalingam, 2013;

Masood et al., 2009) which exacerbates mental distress for many women (Inman et al., 2001). These factors combine to create a complex and unique struggle for immigrant women in managing their mental well-being.

Nonetheless, the immigration experience also presents opportunities to raise awareness and destigmatize mental health discussions within the community. The majority of the women participants said they had never received education on mental health due to prevailing stigma and taboo within their families and community. This limited mental health knowledge aligns with other research indicating common knowledge gaps due to stigma, social, financial and other immigration stressors among South Asian immigrants and other ethnic minorities in Canada (F. Ahmad et al., 2004; Islam et al., 2014; A. Karasz et al., 2019). However, many women participants claimed that their understanding of mental health increased after immigrating to Canada, supported by resources such as social media, workshops, exposure to community programs, as well as learning from school-going and healthcare providers. Consistent with this finding, another Canadian study highlighted that mental health was a relatively unfamiliar subject for many South Asian women that only gained significance as a concern after they migrated to Canada (Ahmad et al., 2005). Similarly, research conducted in the United States revealed that the South Asian community experienced a decrease in depression stigma, alongside improved mental health literacy and depression management after immigration due to increased awareness and exposure to mental health knowledge (Sharma et al., 2020; Virupaksha et al., 2014).

Understanding immigration as both stressor and opportunity has implications for supporting the integration process of South Asian women. First, recognizing the role of children as agents for promoting mental health awareness and resources is important. Aligning with these findings, previous studies have indicated crucial role of children in reducing familial mental health stigma and enhancing their parents' help-seeking abilities through education and motivation regarding the need for treatment (Ong et al., 2021; Riebschleger et al., 2017; Samari et al., 2022). The findings also emphasize the importance of primary care clinicians actively referring immigrant women to community centres, as these centres can serve as a vital source of information or assistance regarding available resources for mental health education and support. Our study also underlines the importance of community services. Other studies have shown that community outreach, such as cultural interventions, educational programs, workshops, and youth-focused activities and clubs, along with religious gatherings organized by community organizations can help destigmatize mental health issues and foster a stronger sense of integrated identity among South Asian and other immigrant communities (Lai & Hynie, 2010; Sharma et al., 2020). Study results strongly support the need for more community engagement in enhancing mental health literacy among the South Asian immigrant population in Montreal.

Culturally-located stressors and challenges to expressing mental health issues

The heightened recognition of mental health problems may lead to a greater understanding of challenges linked to culture. In addition to immigration, study participants mentioned stressors that are particularly relevant for women, because of their familial and socio-cultural responsibilities. These include an increase in family responsibilities accompanying immigration, combined with reduced familial and social support, and greater dependence on their male counterparts. Experiences such as physical and emotional abuse as well as controlling behaviors by partners had adverse effects on the mental well-being of the women, leading to feelings of fear and distress. Previous studies have also revealed that intimate partner violence is a common factor for developing depression and anxiety in women (Lee & Hadeed, 2009; Santos & Monteiro, 2018).

In our study, intimate partner violence was identified as a gender-specific mental health stressor in immigrant South Asian women, and a significant barrier to women openly communicating their mental health concerns to healthcare providers. Among South Asian women experiencing partner abuse that compromised physical and mental health (E. J. H. Hurwitz et al., 2006; Raj et al., 2005), the likelihood of spontaneously disclosing their mental health concerns or abuse to a healthcare provider is dampened due to fear, stigma and shame (Yoshioka et al., 2003). In our study, many women believed that expressing mental distress and receiving a mental health diagnosis could also risk their social, financial, and immigration status and make them even more vulnerable to intimate partner violence.

Barriers in expressing their mental health problems to a healthcare provider are also related to women's dependency on their husbands and their limited agency in seeking mental health care. Some women said they needed their husband's permission to visit their doctors or in making any healthcare decision. This was evident during the participant recruitment process for this study, when some women declined to participate because of concerns that their husbands might disapprove of their participation in a mental health-related study. This finding aligns with existing research that highlights prevailing male dominance in South Asian communities. This patriarchal culture can restrict women's decision-making power, even when it comes to matters concerning their own health (Kandiyoti, 1988; Parr et al., 2011). For many women, these dynamics persist even after immigration (Grewal et al., 2005). For instance, in a study that examined women's autonomy in South Asia, it was reported that the majority of decisions concerning women's health care in South Asian households occurred without the active participation of women (Senarath & Nalika Sepali, 2009). This pattern was similarly observed among South Asian immigrant women living in the US (Ikram et al., 2023; Mann et al., 2017).

The importance of culturally-appropriate mental health care

The threat of intimate partner violence and women's limited healthcare autonomy underscores the importance of cultural competence in addressing the issue of the mental health in immigrant South Asian women. Healthcare providers can play a crucial role. A study conducted among South Asian immigrant women in Toronto found that women first disclosed their mental health concerns in response to a specific inquiry by their family physician or in the hospital emergency department. In these cases,, frequent contacts with family physicians for mental health issues tended to follow (Ahmad et al., 2009). Another key factor recommended to improve immigrant mental health care in a previous study is that clinicians make efforts to improve service accessibility, by considering culture, and recognizing broader social determinants of health when providing care (Rousseau & Frounfelker, 2019). Healthcare providers in Montreal should be especially vigilant about asking questions or pursuing cues regarding intimate partner violence when attending to South Asian immigrant women as asking can legitimize its discussion in the primary care setting. Healthcare providers should also recognize that the presence of intimate partner violence even in relatives or neighbors can cause women to feel psychologically unsafe at home, as indicated by our study participants. Women in our study also expressed fears in exposing intimate partner abuse due to potential immigration and legal consequences. Efforts to address intimate partner violence in the primary care setting should be cognisant of these indirect consequences for women and their families.

Lastly, confidentiality emerged as a major concern for South Asian women in getting healthcare. It is crucial for providers to maintain absolute discretion and confidentiality. Healthcare providers need to explicitly state their commitment to confidentiality, especially when women require assistance from interpreters to overcome language barriers. The importance of confidentiality when managing any mental health condition, especially in cases where intimate partner violence is a threat is also suggested in another study (Mahapatra & Murugan, 2023).

Implications for clinical practice

In response to study findings, the family physician on our thesis committee reflected on ways in which healthcare providers can more effectively discuss mental health matters with South Asian women in primary care interactions. Foremost, is importance of both ensuring and explicitly informing women that their privacy and confidentiality concerning mental health discussions will be rigorously maintained. Women worry about facing isolation or judgment from their families and community if diagnosed with mental health conditions. Therefore, it is critical that both providers and interpreters are bound by confidentiality, and that confidentiality be explained to women in ways that can be understood and trusted (Chew-Graham et al., 2002; Fernando & Keating, 2008; Kirmayer et al., 2011).

Providing explicit cues that assure psychological safety, including confidentiality, becomes paramount in fostering an environment where women feel comfortable disclosing their personal mental health challenges. Given the high likelihood of intimate partner violence in South Asian women, family physicians can adopt an approach similar to the context of prenatal care, where the questions about intimate partner violence are posed as being routine for the prenatal standard of care. This not only normalizes the issue but also legitimizes it as a concern to be raised with the family physician.

To address concerns related to social consequences linked to receiving a mental health diagnosis for South Asian women, healthcare providers should adopt compassionate and non-stigmatizing approaches to mental health care. This approach involves actively engaging women in the decision-making process of their treatment and attentively listening to their preferences for managing their mental health, taking into consideration their family and societal circumstances. By demonstrating understanding and respect for their cultural backgrounds, healthcare providers can establish trust, which is essential for effective communication about mental health concerns. Additionally, tailored mental health care is essential to address and manage depression and anxiety stemming from the immigration experience in the primary healthcare setting.

In light of limited autonomy for healthcare decision-making among many South Asian immigrant women, family physicians can play a critical role in legitimizing access to regular follow-up care and helping them feel empowered regarding their mental health and well-being. Similarly, other studies indicate the need for healthcare professionals serving South Asian population to be aware of potential gender role expectations that influence decisions around mental health care for South Asian immigrant women (Chew-Graham et al., 2002; Rastogi et al., 2014).

Self-help strategies for greater mental health care

In terms of culturally-appropriate mental health care options, our results suggest that South Asian women in Montreal prefer mental health care from professionals rather than using self-help resources. At the same time, they are reluctant to share their challenges due to concerns about trusting healthcare providers that include worries about confidentiality and cultural competence. This pattern of preference and hesitation is observed not only among South Asian women in Montreal but also among other South Asian immigrants in different countries. For example, a systematic review and another study on accessing mental health services by South Asian immigrants in the UK showed that the service users valued culturally-sensitive approaches, which included an explicit commitment to confidentiality, respect for their ethnic and cultural identity, and showing genuine interest in understanding their distress and faith (Prajapati & Liebling, 2022; Thomson et al., 2015). Despite the longstanding and widespread recommendation for culturally-adapted mental health care for South Asian immigrants (Islam et al., 2017; Naeem et al., 2023; Naeem et al., 2019), our study participants indicate that resources remain largely inaccessible or insufficient. Culturally appropriate primary healthcare is therefore a crucial first step in filling gaps in South Asian immigrants' mental health services.

In our study, most women demonstrated limited awareness of self-help tools or strategies. This lack of awareness and knowledge gap hindered a thorough exploration of self-help resources, highlighting the unfamiliarity of the self-help tools within this community. Nevertheless, as both the literature review and study finding suggest, in the context of limited mental health services and resources, self-help tools could serve as a valuable initial recommendation from clinicians to address mental health concerns. Self-help strategies could provide a wide range of accessible resources that can empower South Asian immigrant women to take proactive steps towards improving their mental well-being.

Considering the utilization of self-help strategies, among the women in our study who were aware of self-help resources, their capacity to utilize such strategies was constrained by factors such as knowledge gaps, language barriers, cultural issues, and time constraints. These factors have been identified in other studies related to South Asian women's utilization of mental health care in Canada (Beiser et al., 2003; Naeem et al., 2019). Women in our study emphasized their prioritization of roles as mothers and wives, left little room for utilizing self-help strategies as family responsibilities take precedence. In these circumstances, women might find it challenging to use self-help tools independently. However, with guidance, utilizing these tools could be highly beneficial. This implication is supported by the randomized trials conducted in Montreal, which examined a depression self-care toolkit (Bilsker & Paterson, 2005) with guided help. Results revealed that the guided self-help toolkit, in comparison to the self-help toolkit used alone, led to improved adherence among participants (McCusker et al., 2015). It was also effective in improving clinical outcomes for adults with chronic physical conditions and comorbid depressive symptoms in primary care (McCusker, Cole, Yaffe, Strumpf, Sewitch, Sussman, Ciampi, Lavoie, Platt, et al., 2016). Support for the adaptation of self-help tools and their promotion in primary care settings is a crutial area for work and advocacy.

To increase familiarity with self-help tools and strategies, community organizations can play a vital role in facilitating access to culturally adapted self-help tools. By marketing these culturally adapted tools through community centres, their effectiveness and utilization can be promoted. Collaborating and referring patients to these organizations can enable clinicians to offer more resources and culturally sensitive mental health care and support to this vulnerable community. Moreover, incorporating self-help tools into mental health interventions can lead to greater empowerment and resilience within South Asian communities, ultimately contributing to improved mental health and overall well-being.

Limitations

Due to time and resource constraints, one limitation of this study was the need to restrict the scope of data collection to two settings: a family medicine clinic and a community center. While South Asian women from these settings offered valuable insights into the mental health challenges and care preferences in Montreal, the diversity of experience in this population might not be fully represented in the study. Thus, study findings may not fully encompass the breadth and complexity of mental health expression and care preferences among South Asian women in Montreal. The challenge of recruiting participants due to existing taboos and cultural barriers presented another limitation. The reluctance to discuss personal details, especially with a stranger, might also have affected the openness of some participants during the data collection phase. Hence, important information might have remained undisclosed, potentially impacting the depth and accuracy of the data obtained.

There are also a few limitations of my positionality and reflexivity during the data collection phase. Despite shared cultural backgrounds, there are important variations within the South Asian community, related to language, traditional and regional customs, family structures and socioeconomic backgrounds. These variations might have influenced the perspectives and experiences of the participants, despite efforts to account for this diversity during data analysis. Additionally, besides the participants, my own limited knowledge and experience with self-help tools or guidance may have limited my capacity to explore this dimension more deeply.

My exclusive focus on women in this research is a further limitation. Future studies could benefit from exploring the perceptions and behaviors of men in relation to mental health among South Asian immigrant women, as well as their own experiences with mental health conditions and their management. Such inclusion could provide a more comprehensive understanding of the topic, considering the potential influence of gender dynamics and the interplay of different gendered perspectives within the community.

Nevertheless, the strength of this study remains its focus on women’s expression and acceptance to self-care for primary management of mental health conditions. Some of the insights gleaned from this study hold relevance for similar populations, and our findings can provide valuable guidance for future research exploring the intricate cultural, social, and structural factors influencing mental health expression and care among immigrant communities in Canada. In our study, the influence of age and popular culture on mental health knowledge and expression is apparent with younger individuals showing more knowledge and awareness than the older aged participants. Further research can be conducted to delve deeper into these aspects.

CHAPTER 6: CONCLUSION

The findings of this study shed light on the significant mental health challenges faced by South Asian immigrant women in Canada. Mental health stressors related to language barriers, stigma, intimate partner violence, and family responsibilities act also impede women’s ability to express their psychological distress openly. Providers can help by understanding the mental health challenges and access barriers faced by South Asian immigrant women in Canada and by providing cues that indicate their concern for psychological safety, and commitment to confidentiality. At the same time, exposure to mental health resources through children, community, and media, contributes positively to South Asian immigrant women’s knowledge and sensitivity to mental health challenges. By leveraging this growing awareness, primary health care providers can enhance mental health awareness and promote resilience and empowerment among South Asian immigrant women, fostering a more inclusive and holistic approach to mental health care in Canada.

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APPENDIX I (Recruitment Poster)

Are you a South Asian woman like me?

What will you be asked to do?

I will ask you to discuss what we understand about mental health in South Asia and what services can be helpful for us to tackle these challenges.

Who can participate in this study?

If you are:

- A Bangladeshi, Indian, Pakistani or SriLankan
- 18 years or above,
- Receiving health care in English

Enjoy $20 gift card for your participation.

Contact me:

Mobile:

Email: delufa.jerin@mail.mcgill.ca

APPENDIX II (Interview guideline)

In-depth interview guideline

Participant's name:

Nickname:

Interviewer:

Date of interview:

Duration (to be written after completion of the interview):

Theme	Probing questions
Warm-up and socio-demographic	
Socio demographic characteristics	Before we start, can you please give me the following information about yourself? • Age • County of origin • Language • Education • Occupation • Marital status • Number of kids • Number of years living in Canada/Montreal
Diagnosis and treatment	
Mental health challenges	• Probe: issues with sleeping, anxiety, depression, feeling sad, lonely, isolated • Probe: whether these issues were diagnosed and/or treated.
Knowledge about mental health and mental health services	

Knowledge of mental health disorders	• Probe: knowledge, source of information (internet, family members, neighbors, and physicians) • Probe: feelings about sharing mental health problems with others • Probe: perspectives on seeking help for mental health issues
Knowledge about mental health services	
Barriers and enablers	
Barriers to expressing mental health problems and seeking care	• Probe: perceptions of barriers to sharing mental health needs with others? • Probe: challenges experienced in seeking mental health care?
Enablers of expressing mental health problems and seeking care	• Probe: perceptions of things that make it easier to express feelings or mental health needs • Probe: factors motivating use of mental health services for depression and anxiety
Culture and gender	
Challenges in expressing mental health problems and availing services as a South Asian woman	• Probe: factors accelerating/provoking mental health issues? (Family barriers, societal support etc.) • Probe: factors specific to your culture? • Probe: factors specific to being a woman?
Motivating factors in expressing mental health problems and availing services as a South Asian woman	• Probe: factors that help them express mental health needs to others? (Family support, societal support, friends, relatives) • Probe: factors motivating use of services?

Knowledge and utilization of self-help strategies	
Knowledge of self-help strategies	- Probe: familiarity with self -help tools or strategies for mental health management? How do they work?
Utilization of self-help strategies	- Probe: what are the things you do on your own informally to support your mental health? - Probe: perceptions about self-help approaches
Recommendation	
Suggestions regarding self-help tools or other primary mental health services	- Probe: Any suggestions /preferences for ways to support people experiencing mental health issues/problem? Suggestions about how to make self-heath tools better.

APPENDIX III (Informed consent form & ethics approval)

INFORMATION AND CONSENT FORM

Title of the research project:	Exploring barriers and enablers to primary mental health care among South Asian women in Montreal: A qualitative exploratory study
Principal investigator:	Jeannie Haggerty
Co-researcher(s):	Dr. Alayne Mary Adams, Dr. Sylvie Lambert, Dr. Kimberly Munro, Delufa Tuz Jerin
Sponsor or granting agency:	NA
Protocol number:	2023 - 672

1. Introduction

We invite you to participate in a research project. However, before agreeing to participate in this project and signing this information and consent form, please take the time to read, understand and carefully consider the following information.

This form may contain words you do not understand. We invite you to ask any questions that you may have to the researcher in charge of this project or to a member of its research staff and to ask them to explain anything that is not clear.

2. Nature and objectives of the research project

The purpose of this research is to understand the barriers and enablers to expressing mental health challenges among South Asian women. It also aims to explore your thoughts about using the self-management services as part of mental health care. To achieve this goal, we plan to recruit 16-20 South Asian women aged 18 years and above to ask them a few questions in a 40–60-minute semi-structured individual interview. The findings from this study will help to develop an accessible and equitable primary mental health care service for South Asian women living in Montreal.

3. Conduct of the research project

3.1 Location of the research project, duration and number of visits

This research project will take place at CLSC Parc Extension and St. Mary's Hospital and your participation in this project will include only one visit for a 40-60 minute longer in-person individual interview. The time and location will be chosen based on your comfort and convenience.

3.2 Nature of your participation

If you agree to participate in this study, you will be asked to participate in a semi-structured individual interview. The interview will range in length from 40-60 minutes, depending on how much information you would like to share. It will be conducted by me (Delufa Tuz Jerin), a graduate student at the Department of Family Medicine at McGill University. The interview will be conducted fully in English according to your convenient time and location. During the interview, you will be asked questions about your barriers and enablers of expressing the mental health needs and accessing adequate mental health services as a South Asian woman. If you provide consent, your interview will be audio recorded for transcription purposes. Your interview will be anonymized during transcription and after transcription, all recordings will be securely destroyed. No identifying information will be included in the transcript or in research reports, presentations, or publications.

4. Disadvantages associated with the research project

This study anticipates of having no intended physical or psychological disadvantages to participate. However, if you feel any psychological discomfort such as anxiety, nervousness, boredom, embarrassment, or exacerbation of a psychological condition, we will stop the interview right away and ensure your wellbeing first.

5. Risks associated with the research project

It is anticipated that this study would not pose any additional physical risk to the participants. The interview guideline is developed after a discussion with a family physician (one of the committee members of this thesis project) to avoid any potential questions that might be sensitive and cause harm to the participants. However, if you still feel any discomfort to share any information with the researcher, we will not proceed with the interview anymore. Moreover, to ensure their psychological safety, you will be referred to the physician with your consent.

6. Benefits associated with the research project

You will receive no personal benefit from your participation in this research project. However, we hope the results obtained will contribute to the advancement of scientific knowledge in mental health research focusing on South Asian women.

7. Voluntary participation and possibility of withdrawal

Your participation in this research study is voluntary. Therefore, you may refuse to participate. You may also withdraw at any time, without giving any reasons, by informing the member of the research team.

Your decision of not to participate in the study, or to withdraw from it, will have no impact on the quality of care and services to which you are otherwise entitled, or on your relationship with the teams providing them.

The doctor in charge of this research study, or the Research Ethics Board may put an end to your participation without your consent. This may happen if new findings or information indicate that participation in this research study is no longer in your best interests, if you do not follow study instructions, or if there are administrative reasons to terminate the study.

You have the right to modulate your withdrawal from the study at any time, by withdrawing from the study completely.

If you withdraw or are withdrawn from the study, no further data or samples will be collected. The information and audio recordings already collected for the study will be destroyed by the research team to ensure your withdrawal.

Any new findings acquired during the course of the study that could influence your decision to continue your participation will be shared with you quickly.

8. Confidentiality

During your participation in this study, the researcher in charge of the study and the research team will collect, in a study file, the information about you needed to meet the scientific objectives of the study.

The study file may include information from your medical charts including your identity, such as your name, date of birth, ethnicity, past and present health status, lifestyle, and your responses to questions of interview guideline.

All study data collected during this research study including personal information will remain confidential to the extent provided by law. You will be identified by a code number only. The key to the code linking your name to your study file will be kept by the researcher in charge of this research study.

The researcher in charge of this research study will forward your coded data to the other research team members.

Study data will be stored for 7 years as per the CIUSSS policy following the end of the study by the researcher in charge of this research study.

The study data may be published or shared at scientific meetings; however, it will not be possible to identify you.

You have the right to consult your study file in order to verify the information gathered, and to have it corrected if necessary.

11. Compensation

You will receive a gift card worth $20 per visit as compensation for costs incurred during your participation in this research study.

Your expenses for travel and parking related to your participation in this research study will be reimbursed upon presentation of receipts which will be given to you after the completion of the interview.

12. Should you suffer any harm

Should you suffer any discomfort due to the procedure related to this research study, you will receive all the care and services required by your state of health.

By agreeing to participate in this research study, you are not waiving any of your rights of receiving your health care.

13. Contact information

If you have any questions or if you have a problem, you think might be related to your participation in this research study, or if you would like to withdraw, you may communicate with the researcher in charge (Delufa Tuz Jerin) of this research study at the following number: (Phone).

14. Complaints

For any questions regarding your rights as a research participant in this study, or if you have comments or wish to file a complaint, you may communicate with:

Commissioner for Complaints and Quality Services CIUSSS de l'Ouest-de-l'Île-de-Montréal at 1-844-630-5125 or by email at commissariat.plaintes.comtl@ssss.gouv.qc.ca.

15. Declaration of interests

The principal investigator states that she has no personal interest that could conflict with his/her role as a researcher.

16. Monitoring of the ethical aspects of the research project

The Research Ethics Board of the CIUSSS de l'Ouest-de-l'île-de-Montréal has given ethics approval to this research study and is responsible for monitoring the study at all participating institutions in the health and social services network in Quebec.

Additional consent options:

Audio recording

Do you accept to be audio recorded during interviews? The audio recordings (either stored in digital files or audio tapes) will be included in your research file and be kept for a maximum period of 7 years after the end of the study by the researcher responsible for this research project. Content of the tape(s) may be published or scientifically discussed, but it will not be possible to identify you.

☐ Yes ☐ No

Declaration of Consent

Title of research project: Exploring barriers and enablers to primary mental health care among South Asian women in Montreal: A qualitative exploratory study

Signature of participant

I have reviewed the Informed Consent Form. Both the research study and the Informed Consent Form were explained to me. My questions were answered, and I was given sufficient time to decide. After reflection, I consent to participate in this research study in accordance with the conditions stated above, including the use of all personal data and information collected.

Name and signature of participant Date

Signature of the person obtaining consent

I have explained the research study and the terms of this Informed Consent Form to the research participant, and I answered all questions asked.

Name and signature of the person obtaining consent Date

Commitment of the Principal Investigator

I certify that this Informed Consent Form was explained to the research participant, and that the participant's questions were answered.

I undertake, together with the research team, to respect what was agreed upon in the Informed Consent Form, and to give a signed and dated copy of this form to the research participant.

Name and signature of the Principal Investigator Date

APPENDIX IV (Codebook and definitions)

Codebook with definitions

Parent codes:

1. Knowledge
2. Factors accelerating mental health challenges
3. Expressing mental health challenges
4. Mental health primary care
5. Self-help tools

1. Parent code: Mental health knowledge

Sub-codes: Knowledge of mental health challenges (and sources of mental health knowledge),, diagnosis, knowledge of available services and treatments (and sources of mental health treatment/services knowledge).

Definition: Mental health knowledge includes the capacity to identify mental health problems (depression, anxiety, sleeping disorders etc.), understanding the causes and professional help available, attitudes that promote recognition, and appropriate mental health help-seeking behaviors.

When to use: Apply code to all references of participants perspectives about mental health, acknowledgement of their personal and/or family member's mental health problems, available services, their sources of knowledge.

When not to use: Do not code where participants refer to experiencing any physical health issues or seeking care that is not relevant to mental health.

Example: "I went through the same and I saw my friends and other relatives. Many times, I used to feel frustrated when, let's say I have a friend I wanted to go and visit her, but I have to get permission from my parents, chacha (uncles), dadi (grandmother)." (Page 3, line 60-62, P1).

2. Parent code: Accelerating factors

Sub-codes: Family responsibilities, Domestic violence (husband's dominance), financial dependency, isolation from families, immigration stressors

Definition: Factors accelerating mental health challenges refer to any individual, familial, or societal conditions that increase the likelihood or severity of mental health issues (stress, depression, anxiety etc.).

When to use: Apply code to all references of present family conditions, perceived loneliness, cultural shock, language barriers, settling down as an immigrant, feeling of not belonging, prioritizing other's feelings over own, presence of comorbidity.

When not to use: Do not code when participants are refereeing to factors accelerating physical health challenges or social challenges that are not relevant to mental health.

Example: "We live for our kids. They make us happy. If I do not have my family, if I cannot keep my family happy then why am I living for?... I feel bad making him (husband) work at home. He earns the money. He wakes up early morning, goes to office and come back home in the evening. It is very tiring for him. So, I do all the household chores for everyone (page 5, line 164-171, P3)."

3. <u>Parent code: Expressing mental health problems</u>

Sub-codes: Barriers (language, gender, family upbringing, societal stigma and culture, extended family influence, financial dependency, lack of knowledge as a community), Duration of stay in Canada, Enablers (family support, community awareness, children's influence.

Definition: Expressing mental health challenges refers to the act of communicating participants' own or any female friends/family member's mental health problems with the physicians or others. It involves barriers and facilitators to sharing thoughts, emotions, and experiences related to their mental health conditions as well as seeking help and suggestions for those.

When to use: Apply code to all references to the participant's challenges (individual, familial, societal) to talk to about mental health, factors that motivates (listening without judging, valuing the feelings etc.) to talk about those challenges.

When not to use: Do not code when participants talk about expressing physical health issues only or explaining the challenges of settling down after immigration.

Example: "I never felt that they were open enough to have a conversation like that…. I have no idea why actually, but it's just that I never exactly felt comfortable with them…Sometimes they (parents) just look at it and look at it as me being weak (page 2-3, line 58-72, P4)".

4. Parent code: Formal mental health services

Sub-codes: Availability, accessibility to mental health services, integrated mental health service for long-term physical health care, services for the family members with mental health patients, lack of appropriate resources for the South Asian community.

Definition: This refers to the initial point of contact for women seeking help for mental health challenges in primary care setting. This includes family physicians, community services, counselling services, online resources in the primary care setting.

When to use: Apply code to references where participants talk about relevant mental health services in Montreal, recommendations, cues, approaches of physicians, discontinuity of care, use of medication, communication barrier.

When not to use: Patients describing mental health services outside Canada

Example: "One thing that I would say is there's not a lot of South Asian therapists available. My friend went to therapy to a white person, and it was really hard for her to explain it to the therapist that why her mother wouldn't accept someone she is dating. And with different language and expressing in our own language is hard and then if you have to explain it in English, that's even harder (page 7, line 194-206, P4)".

5. Parent code: Self-management of mental health challenges

Sub-codes: Knowledge, perspectives on utilizing self-help strategies, experiences of using self-help strategies, recommendations.

Definition: The knowledge, unawareness, underutilization, strategies, and techniques to use and tailor the tools for South Asian women.

When to use: Apply code to references where participants share their understanding and knowledge about the tools, talk about their preferences to utilizing those. May include the recommendation regarding tailoring the tools if needed.

When not to use: Patients referring to seeking private mental health care, therapy or counselling

Example: "I think it depends on what the tool is and what it is that I'm dealing with. If it's something that I feel like I've been dealing with for a long time and I really need help then maybe I will be OK with using it, but I I'm not really sure (page 7, line 185-191, P4)."

APPENDIX V (Cognitive test report)

Demographics

To make our Informed Consent Form (ICF) adequately understandable to our participants as intended, we conducted three rounds of cognitive test among 9 South Asian and two non-South Asian women. There were four participants in the first round and four in second round and three in the third round. In the first round, among the women aging 26, 29, 37 and 42 years old, two were employed and the other two were housewives. Three of them completed graduation (bachelor's) and were fluent in English language whereas the other person completed only high school but has fluent reading and communication skills as she has been living in Canada for the past 15 years.

In round 2, we had four more participants where only two of them were under 35 years old, one was 41 years, and another person was 44 years old. Most participants had moderate fluency in both speaking and reading in English. One of them was recently migrated in Canada whereas the other three have been living here for over 5 years.

Among the three participants in round 3, one was in her 20s, one in her 40s and one was in her 30s. The first two participants were native English speaker whereas the last one was non-native English speaker and South Asian. She is an immigrant here and a housewife with high school degree.

The test was conducted by me, a graduate student from McGill University Department of Family Medicine who will also be responsible for recruiting and interviewing the patients for this project. Hence, it was a great opportunity to be able to explore people's understanding and perspectives towards the study subject. Alongside the specific questions and feedback, the participants were also asked to comment on their overall thought on the ICF.

Overall reflection of the researcher

I thoroughly observed the participants reactions towards the ICF contents throughout the test in all 3 rounds. Noticeably, many of the participants expressed concerns regarding the length and time required to read the entire document at their first glance. The participants had difficulty understanding some sections and were observed to re-read those parts sometimes, such as section

3 (conduct of the research project), section 4 and section 5 (disadvantages risks associated with the research project). Overall, most of the participants were observed to be engaged in reading the document thoroughly until page 2, but from page 3 to onward, they were found to be quickly skimming through the information. This report breaks down the findings and proposed modifications in the following sections.

Findings: Findings from our cognitive test are documented section by section in the following:

Title of the research project: Exploring barriers and enablers to primary mental health care among South Asian women in Montreal: A qualitative exploratory study

Findings: *Most of the participants in both rounds were observed to read the title more than once and commented that it was very lengthy. In second round when specifically asked about the title, they said using simpler language would facilitate having clearer idea about the study at the onset. Additionally, it was observed that most participants were spending a significant amount of time reading the names of all the co-researchers and sponsoring agencies rather moving forward to the introduction of the study.*

*All the participants in round 2 and 3 preferred the alternative title "**How South Asian Women in Montreal talk about mental health and their preferences of getting care"**. We also observed the participants spending a lot of time reading the researchers name and other information in this section. However, as we cannot change this format in this section for the standard format, we do not propose any modification here other than the title.*

1. Introduction

We invite you to participate in a research project. However, before agreeing to participate in this project and signing this information and consent form, please take the time to read, understand and carefully consider the following information.

This form may contain words you do not understand. We invite you to ask any questions that you may have to the researcher in charge of this project or to a member of its research staff and to ask them to explain anything that is not clear.

***Findings:** During the initial round of interviews, two participants queried if there is going to be more than one person conducting the interviews as the introduction started with "we invite you". Based on the feedback received from participants regarding the pronouns used in the form, we recommended that the use of "we" not be employed in this section. We also anticipate that by reducing the length of the introduction, it will likely lead to increased attention and engagement from participants when reading all sections of the document without skipping over any. However, participants in round 3 commented that they found both the older and proposed version to be the same for this section. Moreover, as the introduction already stated that this form may contain words they do not understand, participants seemed concerned about the contents of the study being out of their knowledge.*

2. Nature and objectives of the research project

The purpose of this research is to understand the barriers and enablers to expressing mental health challenges among South Asian women. It also aims to explore your thoughts about using the self-management services as part of mental health care. To achieve this goal, we plan to recruit 16-20 South Asian women aged 18 years and above to ask them a few questions in a 40–60-minute semi-structured individual interview. The findings from this study will help to develop an accessible and equitable primary mental health care service for South Asian women living in Montreal.

***Findings:** Similar to the title, this section employs technical language, such as "barriers and enablers," which are not frequently utilized in non-academic contexts and was unclear to the participants in round 1. Moreover, one participant specifically noted that the information presented in this section is also repeatedly covered in sections 3.1 and 3.2. Following the revisions made after round 1, most participants appeared to comprehend the objective of the study in round 2. One participant (South Asian) in round 3 pointed that they are not clear what a "semi-structured interview" is. After showing the proposed modified version, she stated that the modified version was better to understand. However, she was also concerned that the modified simpler version might have missed some information that the participants may need to know about this study (referring to the interviews"). As mentioning the word "semi-structured" confused most of the participants and not using it on the ICF is not risky/harmful for the participants, we propose not to use it and modify this part.*

3. Conduct of the research project

Findings and proposed modifications of section 3.1 and 3.2 are provided together after section 3.2.

3.1 Location of the research project, duration and number of visits

This research project will take place at CLSC Parc Extension and St. Mary's Hospital and your participation in this project will include only one visit for a 40-60 minute longer in-person individual interview. The time and location will be chosen based on your comfort and convenience.

3.2 Nature of your participation

If you agree to participate in this study, you will be asked to participate in a semi-structured individual interview. The interview will range in length from 40-60 minutes, depending on how much information you would like to share. It will be conducted by me (Delufa Tuz Jerin), a graduate student at the Department of Family Medicine at McGill University. The interview will be conducted fully in English according to your convenient time and location. During the interview, you will be asked questions about your barriers and enablers of expressing the mental health needs and accessing adequate mental health services as a South Asian woman. If you provide consent, your interview will be audio recorded for transcription purposes. Your interview will be anonymized during transcription and after transcription, all recordings will be securely destroyed. No identifying information will be included in the transcript or in research reports, presentations, or publications.

Findings: *As mentioned in the earlier, there was a redundancy of information present in sections 3.1 and 3.2, which resulted in an inefficient use of participant's time and a decline in their concentration. Based on observations from the first round, these sections were consolidated and revised. In the second round, participants were specifically prompted to explain the meaning of the section in their own words, and it was found that nearly all four participants were able to effectively articulate their understanding as per the study purpose. In the third round, participants were asked to describe what this modified section means to them in their own words where all of them could explain it back clearly and preferred the modified version over the old one.*

4. Disadvantages associated with the research project

This study anticipates of having no intended physical or psychological disadvantages to participate. However, if you feel any psychological discomfort such as anxiety, nervousness, boredom, embarrassment, or exacerbation of a psychological condition, we will stop the interview right away and ensure your wellbeing first.

Findings: *The only individual who thoroughly read the document in round 1 was observed to be confused about the phrases "psychological disadvantage" and "psychological discomfort". She read the section multiple times and specifically queried the meaning of exacerbation of a psychological condition and expressed her concerns about the types of questions that will be posed during the interviews. Based on the question to differentiate between "disadvantages" and "risks", we found that participants did not find section 4 and 5 to be different, rather they thought section 5 is the elaborated part of section 4.*

5. Risks associated with the research project

It is anticipated that this study would not pose any additional physical risk to the participants. The interview guideline is developed after a discussion with a family physician (one of the committee members of this thesis project) to avoid any potential questions that might be sensitive and cause harm to the participants. However, if you still feel any discomfort to share any information with the researcher, we will not proceed with the interview anymore. Moreover, to ensure their psychological safety, you will be referred to the physician with your consent.

Findings: *In the first round, the participant was observed to understand this section well. However, she asked if it was an explanation for the previous section (disadvantages associated with the project). Due to this concern, the participants in the second round were specifically asked if they knew the differences between 'disadvantages' and 'risks' discussed in sections 4 and 5. None of the participants were able to distinguish between these two terms and most of them believed they had the same meaning. However, one participant in round 2 stated that the words anxiety, nervousness, boredom, harm etc. gave her a negative perception and made her hesitant to take part in the research. However, after showing the modified version to all three participants in round 3, two of them mentioned that acknowledging some of the risks or disadvantages (i.e., feeling shy, anxious or nervous) will make the participants aware of any* *unexpected situations beforehand and help them to be prepared for that. We also want to mention to provide a list of resources to avail mental health first aid if they want.*

Hence, firstly to make it less confusing to the participants, we propose to combine section 4 and 5 together and provide less detailed information that imposes negative perceptions about the study among the participants. We suggest the modifications together as section 4 (Disadvantages and risks associated with the research project).

6. Benefits associated with the research project

You will receive no personal benefit from your participation in this research project. However, we hope the results obtained will contribute to the advancement of scientific knowledge in mental health research focusing on South Asian women.

Findings: *Participants did not have any concern or specific questions about this part in round 1. However, in the second round they were asked what they understood by the benefits associated with the project. Two of them responded to understand that they will not be getting paid or receiving any direct health care service for participating in this study. Based on the responses, we propose to specifically mention that participating in this study will not ensure getting any direct health care services for the participants. Statement regarding not getting any direct financial benefits is also mentioned in section 11 (compensation). When we showed both the old and modified sections to the participants in round 3 and asked them to describe it in their own words, all of them seem to explain the modified version clearly to us.*

. Voluntary participation and possibility of withdrawal

Your participation in this research study is voluntary. Therefore, you may refuse to participate. You may also withdraw at any time, without giving any reasons, by informing the member of the research team.

Your decision of not to participate in the study, or to withdraw from it, will have no impact on the quality of care and services to which you are otherwise entitled, or on your relationship with the teams providing them.

The doctor in charge of this research study, or the Research Ethics Board may put an end to your participation without your consent. This may happen if new findings or information indicate that participation in this research study is no longer in your best interests, if you do not follow study instructions, or if there are administrative reasons to terminate the study.

You have the right to modulate your withdrawal from the study at any time, by withdrawing from the study completely.

If you withdraw or are withdrawn from the study, no further data or samples will be collected. The information and audio recordings already collected for the study will be destroyed by the research team to ensure your withdrawal.

Any new findings acquired during the course of the study that could influence your decision to continue your participation will be shared with you quickly.

Findings: *This section were found to be very long by almost all the participants in round 2. However, one participant specifically was concerned about having the doctor involved in this study saying, "the doctor in charge of this research study, or the Research Ethics Board may put an end to your participation without your consent." It posed a concern that it might hamper their relationship with the doctor or the hospital even though we mentioned it earlier in section 4 and 5. Based on the participants responses about the length and their concerns regarding the terms used, we propose to shorten this section and use the term "researcher in charge" everywhere instead of using "doctor in charge". However, after asking the participants to notice any difference between the older and proposed version in round 3, they said they found it almost similar and no vital information was missing in the proposed version.*

8. Confidentiality

During your participation in this study, the researcher in charge of the study and the research team will collect, in a study file, the information about you needed to meet the scientific objectives of the study.

The study file may include information from your medical charts including your identity, such as your name, date of birth, ethnicity, past and present health status, lifestyle, and your responses to questions of interview guideline.

All study data collected during this research study including personal information will remain confidential to the extent provided by law. You will be identified by a code number only. The key to the code linking your name to your study file will be kept by the researcher in charge of this research study.

The researcher in charge of this research study will forward your coded data to the other research team members.

Study data will be stored for 7 years as per the CIUSSS policy following the end of the study by the researcher in charge of this research study.

The study data may be published or shared at scientific meetings; however, it will not be possible to identify you.

You have the right to consult your study file in order to verify the information gathered, and to have it corrected if necessary.

Findings: *The term data "confidentiality" was not clear by some of the participants both in round 1 and 2. Moreover, participants got concerned after seeing that the study file may include information from their medical charts. As we are not collecting any medical data from the chart, we propose to remove this section in the modified version. One participant in round 1 was also noticed to be re-reading the section to understand how the data will be managed and protected from being published. However, participants seemed to be better understand it when we said "management of your data" in the next round. Whereas, in round 3 all the participants responded that using the word "data confidentiality" is better than "management of your data" as confidentiality somehow represents the term "privacy" which is important for the research participants. Based on their responses, we propose to modify this section as follows.*

9. Compensation

You will receive a gift card worth $20 per visit as compensation for costs incurred during your participation in this research study.

Your expenses for travel and parking related to your participation in this research study will be reimbursed upon presentation of receipts which will be given to you after the completion of the interview.

Findings: *To make it clear that the participants will not be financially benefited for participating in this study, we propose the following modification. This following modified section was clear to almost every participant in all the rounds.*

10. Should you suffer any harm

Should you suffer any discomfort due to the procedure related to this research study, you will receive all the care and services required by your state of health.

By agreeing to participate in this research study, you are not waiving any of your rights of receiving your health care.

Findings: *When participants were asked in the second round and third rounds to express what they understood in this section, most of them seemed to be concerned about what type of procedure will be conducted in this study. As we are not conducting any medical procedure in this research, we would like to sincerely ask the review committee if the first part of this section can be removed in our consent form. Hence, the modification will be as following.*

11. Contact information

If you have any questions or if you have a problem, you think might be related to your participation in this research study, or if you would like to withdraw, you may communicate with the researcher in charge (Delufa Tuz Jerin) at the following number (Phone number).

Findings: *The interviews in this study will be conducted by the graduate student researcher instead of the researcher in charge. Hence, we propose to modify the section as following.*

12. Complaints

For any questions regarding your rights as a research participant in this study, or if you have comments or wish to file a complaint, you may communicate with:

Commissioner for Complaints and Quality Services CIUSSS de l'Ouest-de-l'Île-de-Montréal at 1-844-630-5125 or by email at: commissariat.plaintes.comtl@ssss.gouv.qc.ca.

Findings: *Explained after section 16.*

13. Declaration of interests

The principal investigator states that she has no personal interest that could conflict with her role as a researcher.

Findings: *Explained after section 16.*

14. Monitoring of the ethical aspects of the research project

The Research Ethics Board of the CIUSSS de l'Ouest-de-l'île-de-Montréal has given ethics approval to this research study and is responsible for monitoring the study at all participating institutions in the health and social services network in Quebec.

Findings: *(Section 14, 15 and 16) Participants in did not have any question in section 14, 15 and 16 and said that it is well understood in all the rounds. Hence, we do not propose any further modifications in these sections.*

Additional consent options:

Audio recording

Do you accept to be audio recorded during interviews? The audio recordings (either stored in digital files or audio tapes) will be included in your research file and be kept for a maximum period of 7 years after the end of the study by the researcher responsible for this research project. Content of the tape(s) may be published or scientifically discussed, but it will not be possible to identify you.

☐ Yes ☐ No

Declaration of Consent

Title of research project:	*How South Asian Women in Montreal talk about mental health and their preferences of getting care*

Signature of participant

I have reviewed the Informed Consent Form. Both the research study and the Informed Consent Form were explained to me. My questions were answered, and I was given sufficient time to decide. After reflection, I consent to participate in this research study in accordance with the conditions stated above, including the use of all personal data and information collected.

Name and signature of participant Date

Signature of the person obtaining consent

I have explained the research study and the terms of this Informed Consent Form to the research participant, and I answered all questions asked.

Name and signature of the person obtaining consent Date

Commitment of the Principal Investigator

I certify that this Informed Consent Form was explained to the research participant, and that the participant’s questions were answered.

I undertake, together with the research team, to respect what was agreed upon in the Informed Consent Form, and to give a signed and dated copy of this form to the research participant.

Name and signature of the Principal Investigator Date

Findings: *All the participants were clear about the audio recording and consenting part and found to understand they are supposed to sign on this form to participate in the study.*

Readability statistics of the old and proposed informed consent form

Readability statistics of the old and proposed modification in the informed consent was compared using the Microsoft word processor. The data is shared in the following sections along with the reference scale.

Flesch reading ease (reference scale):

Score	School level (US)	Notes
80.0–70.0	7th grade	Fairly easy to read.
60.0–50.0	10th to 12th grade	Fairly difficult to read.
50.0–30.0	College	Difficult to read.

Source: Moraine Park Technical College (April 19th, 2021)

The table illustrates an enhanced reading ease of the modified sections in the proposed consent form.

Overall Flesch reading (grade level) scale:

Sections	**Flesch- Kincaid grade level**	
	Proposed ICF	**Original ICF**
Study Title	63.6	8.3
1. Introduction	54.5	10.8
2. Nature and objectives of the research project	52	11.3
3. Conduct of the research project	44.7	13.1
4. Disadvantages associated with the research project	42.6	13.2
5. Risks associated with the research project		
6. Benefits associated with the research project	40.6	12.3
7. Voluntary participation and possibility of withdrawal	45.8	12
8. Confidentiality	49.9	10.3
9. Compensation	47.3	12.3
10. Should you suffer any harm	59.6	9.9
11. Contact information	45.9	11.3
12. Complaints		
13. Declaration of interests	46.9	11.6
14. Monitoring of the ethical aspects of the research project	21.2	10.1
Audio recording	44.1	12.8
Declaration of Consent		

Proposed Consent form

INFORMATION AND CONSENT FORM

Title of the research project:	How South Asian Women in Montreal talk about mental health and their preferences of getting care
Principal investigator:	Jeannie Haggerty
Co-researcher(s):	Dr. Alayne Mary Adams, Dr. Sylvie Lambert, Dr. My Lan Graziani, Dr. Kimberly Munro, Delufa Tuz Jerin
Sponsor or granting agency:	NA
Protocol number:	2023 - 672

1. Introduction

You are invited to participate in this research project. Please take your time to read, understand and carefully consider the following information before agreeing to participate in this research and signing this consent form.

If you do not understand anything in the form, please feel free to ask me any questions so that I can clearly explain it to you.

2. Nature and objectives of the research project

This study is to understand how South Asian women talk about mental health and what are their preferences of using self-help tools for mental health care. This is a study for a master's project in the Department of Family Medicine at McGill University. The findings from this study will help to provide better primary mental health care service for South Asian women living in Montreal.

3. Nature and location of your participation

If you agree to participate in this study, we will do a 40-60-minute interview in English at the time and location you choose. During the interview, you will be asked questions like how you talk about your mental health needs to others and what kind of health care services you prefer to manage those challenges. If you provide consent, your interview will be audio recorded for the analysis, but all recordings will be deleted after the study. Your participation will not be revealed to your provider and your identity will not appear anywhere in reports or presentations.

4. Disadvantages and risks associated with the project

As the interview guideline does not contain any sensitive questions, we anticipate that there are no risk or disadvantages associated with the interviews. If you feel any discomfort to share any information, we will not proceed with the interview anymore to ensure your wellbeing first.

5. Benefits associated with the research project

Participating in the interview will not provide you with any direct health care services as your personal benefit. However, we hope the results will contribute to providing scientific knowledge to improve mental health care for South Asian women.

. Voluntary participation and possibility of withdrawal

Your participation in this study is voluntary. You can withdraw at any time before, during, or after the study without any explanations. Even if you decide to withdraw after the interview is completed, you can do it by contacting me (phone number and email address given below). Your decision of not to participate in the study, or to withdraw from it, will not affect the quality of care and services you are receiving at this health Centre.

The researcher in charge of this study may put an end to your participation without your consent. This may happen if new findings or information indicate that participation in this research study is no longer in your best interests, if you do not follow study instructions, or if there are administrative reasons to terminate the study.

If you withdraw or are withdrawn from the study, no further data will be collected. All the information and audio recordings already collected will be deleted by the research team to ensure your withdrawal.

7. Management of your data

All the information collected during this study will be stored in a safe, secure, and locked location. You will be identified by a code number only. All the information, audio recordings and notes will be stored on password-protected computers. No identifying information will be included in the reports or presentations.

Study data will be stored for 7 years as per the CIUSSS policy following the end of the study by the researcher in charge of this research study.

You have the right to consult your study file to verify the information we collected, and to correct it if necessary.

8. Compensation

You will not be paid to participate in this study but will receive a $20 gift card as an appreciation for your participation.

Your expenses for travel and parking related to your participation in this research study will be reimbursed if you provide us the receipt.

9. Should you suffer any harm

By agreeing to participate in this study, you are not waiving any of your rights of receiving your health care.

10. Contact information

If you have any questions or if you have a problem, you think might be related to your participation in this study, or if you would like to withdraw, you may communicate with me, Delufa Tuz Jerin on behalf of the researcher in charge of this study. Phone:

11. Complaints

For any questions regarding your rights as a research participant in this study, or if you have comments or wish to file a complaint, you may communicate with:

Commissioner for Complaints and Quality Services CIUSSS de l’Ouest-de-l’Île-de-Montréal at 1-844-630-5125 or by email at: commissariat.plaintes.comtl@ssss.gouv.qc.ca.

12. Declaration of interests

The principal investigator states that she has no personal interest that could conflict with her role as a researcher.

13. Monitoring of the ethical aspects of the research project

The Research Ethics Board of the CIUSSS de l’Ouest-de-l’île-de-Montréal has given ethics approval to this research study and is responsible for monitoring the study at all participating institutions in the health and social services network in Quebec.

Additional consent options:

Audio recording

Do you accept to be audio recorded during interviews? The audio recordings (either stored in digital files or audio tapes) will be included in your research file and be kept for a maximum period of 7 years after the end of the study by the researcher responsible for this research project. Content of the tape(s) may be published or scientifically discussed, but it will not be possible to identify you.

☐ Yes ☐ No

Declaration of Consent

Title of research project: How South Asian Women in Montreal talk about mental health and their preferences of getting care

Signature of participant

I have reviewed the Informed Consent Form. Both the research study and the Informed Consent Form were explained to me. My questions were answered, and I was given sufficient time to decide. After reflection, I consent to participate in this research study in accordance with the conditions stated above, including the use of all personal data and information collected.

Name and signature of participant Date

Signature of the person obtaining consent

I have explained the research study and the terms of this Informed Consent Form to the research participant, and I answered all questions asked.

Name and signature of the person obtaining consent Date

Commitment of the Principal Investigator

I certify that this Informed Consent Form was explained to the research participant, and that the participant's questions were answered.

I undertake, together with the research team, to respect what was agreed upon in the Informed Consent Form, and to give a signed and dated copy of this form to the research participant.

Name and signature of the Principal Investigator   Date