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ORIGINAL PAPER

Perceptions of mental health and utilization of mental health services among new immigrants in Canada: A qualitative study

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Abstract

The impact of immigration on individuals' overall health, including mental health, is complex. New immigrants' concepts of mental health, mental healthcare utilization, and their knowledge of existing services in Regina, Canada were explored using a hermeneutic phenomenological approach. Three focus groups were conducted with 37 participants recruited from English language classes provided by a non-governmental organization in the city. Irrespective of country of origin, participants recognized the impact of mental health on general wellbeing. Access to existing mental healthcare was hindered by language barriers, inadequate information about existing healthcare services, and individuals' perceptions about what and when services should be accessed. Despite challenges, participants viewed relocation positively and exhibited resilience when dealing with daily stress. Participants had knowledge gaps surrounding the role of family physicians in managing mental health conditions. Information on ways to access existing healthcare services should be delivered in collaboration with community organizations serving new immigrants.

Keywords New immigrants · Mental health · Mental health utilization · Barriers to mental health care

Introduction

Immigration might be undertaken for a variety of economic, social, political, and/or health reasons to improve the quality of life of oneself and one's family. Acculturative stress, stress of relocating, economic strains, loss of social networks, and changes in gender role norms can have a detrimental effect on the mental and physical health of immigrants (Bhugra & Becker, 2005; Delera, 2016; George et al., 2015; Kirmayer et al., 2011). Immigrants arrive with superior health than their Canadian-born counterparts, an effect referred to as "healthy immigrant" (Delera, 2016; Kirmayer, et al., 2011). This health advantage however is observed to deteriorate over time (Delera, 2016; Kirmayer, et al., 2011). Health decline and increased feelings of sadness, depression, isolation, and loneliness are reported with increased length of stay in Canada, particularly for women (Maio & Kemp, 2010; Salami et al., 2017). Furthermore, the risk of developing psychosis is significantly higher for immigrants and refugees compared to the host population, a risk which varies between racial groups and between age groups within the same racial group (Anderson et al., 2015; Bourque et al., 2011; Kirmayer et al., 2011). Kirmayer et al. (2011) indicated that hope and optimism experienced by immigrants upon arrival can change into disillusionment, demoralization and depression due to loss of social network, social isolation, economic instability, loss of social status and inability to meet expectations. Studies show that those experiencing obstacles during the resettlement phase, downward economic mobility, and dissatisfaction with the settlement process are more likely to experience stress, emotional trauma and are at risk for developing mental health conditions (Das-Munshi et al., 2012; Kirmayer et al, 2011; Robert & Gilkinson, 2012). Immigrants whose professional credentials are not recognized in Canada often experience unemployment, underemployment and economic instability which can lead to increased stress and mental health issues (George, et al., 2015). Individuals in the lower economic strata or living in conditions that do not meet their needs are more likely

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to experience poor mental health (Cloos et al., 2020; Das-Munshi et al., 2012; Kirmayer et al., 2011; Robert & Gilkinson, 2012). Access to, and utilization of, healthcare services differs between foreign-born and Canadian-born residents (Kirmayer et al., 2011; Xu & Borders, 2008). Under-utilization of mental health services by immigrants has been reported (Durbin et al., 2015; Fang, 2010). Education level, language barriers, stigma, cultural incompatibilities, and logistical challenges with healthcare delivery affects access to healthcare services for immigrants (Delera, 2016; Fang, 2010; Lai & Surood, 2013; Salami et al., 2019; Sumin et al., 2016). Culture and religious beliefs also influence immigrant women's perceptions of health and wellness, help-seeking behaviours, and access to healthcare services (Chaze et al., 2015; Delera, 2016; Fang, 2010; Sumin et al., 2016).

In Canada immigrants are admitted under four different categories (1) economic class inviting skilled and professionals, entrepreneurs and self-employed; (2) family class reuniting family members and (3) asylum seekers (Government of Canada). Temporary visa permits are also offered for seasonal workers and students (Government of Canada). Immigrants and refugees usually manage their own resettlement and integration into Canadian society and are primarily supported by ethno-cultural communities and community organizations (Bucklaschuk et al., 2018; Liston & Carens, 2008) Ethnocultural community organizations often are the first point of contact for many immigrants. More number of organization are found in provinces that have historically received large population of immigrants and the range of resettlement services available for immigrants differ based on where they land (Braun & Clement, 2019). However, federal and provincial governments have recognised the need to assume greater responsibility in integrating immigrants, better support ethnocultural organization already engaged in integration of immigrants and build capacity in other provinces which are now receiving more immigrants (Braun & Clement, 2019; Liston & Carens, 2008).

Although Canadian provinces such as Ontario, Quebec, and British Columbia have been preferred destinations for new immigrants, over the last 15 years the number of new immigrants settling in the province of Saskatchewan has grown considerably, from just under 1% in 2001 to 4% in 2016 (Statistic Canada, 2017). Regina is the capital city of Saskatchewan and has a population of approximately 211,000. Of these residents, approximately 36,000 are immigrants with 16,000 immigrants arriving between 2011 and 2016 (Statistic Canada, 2016). Such large-scale population movement impacts the health of individuals settling into their new communities and the healthcare system itself (MacPherson et al., 2007). Healthcare facilities in Saskatchewan are mostly concentrated in two urban centers, leading to access issues for those in rural and remote areas (Saskatchewan Advisory Panel, 2016). Population growth in recent years has created more demands on the healthcare system (Saskatchewan Advisory Panel, 2016). Currently mental health services are provided to Saskatchewan residents through inpatient care, community-based organization, child and adolescent services and mental health promotions programs. Mental health services can be accessed through family physicians and individuals can be referred to specialist and or inpatient care as needed. After hour services and crisis services can be accessed through mobile crisis services, by calling 911 or through emergency departments. Information on seeking professional mental health services is available on the provincial website (Government of Saskatchewan). Psychotherapy and counselling is not cover by provincial healthcare and must be paid for out of pocket or through additional health insurances. Further, online therapy and all psychological assessments and consultations are carried out in English creating barriers for those with low English language proficiency. Mental health needs in Canada are expected to rise significantly by 2030 and a mental health promotion and mental health prevention approach is needed to address the growing need (Robert & Grimes, 2011).

Immigrant's perspectives on mental health, cultural and religious beliefs and stigma influence mental health seeking behaviour (Chaze, et al., 2015; Gopalkrishnan, 2018).An one size fits all approach is unlikely to address mental health needs of the linguistically and ethnically diverse immigrant population in Canada. Therefore, the objective of the study was to explore immigrant women's perspective on mental health and need for services. The present study was carried out in Regina, Saskatchewan, Canada and explores the following research questions: (1) What are new immigrants' concepts of mental health?, (2) Do immigrants know about the existing mental health services in Regina, Saskatchewan and ways to access those services?, and (3) What services are required to adequately support the mental health needs of local immigrant communities?

Methods

An exploratory qualitative research design was adopted. As landed immigrants and through professional interaction with other immigrants the first three authors have developed specialised expertise and knowledge about the impacts of immigration on mental health outcomes and mental health seeking behaviours. Mental health needs of immigrant women was further emphasises during consultation with Regina Immigrant Women Centre (RIWC) a non-governmental community organization, serving new immigrants in Regina, Saskatchewan, Canada. In collaboration with RIWC a collective decision was made to systematically document immigrants women's perspective on

mental health and need for services to mobilize awareness and advocate for client-centred mental health services.

Ethics approval for this study was obtained from the Research Ethics Board of the former Regina Qu'Appelle Health Region, within the Saskatchewan Health Authority (REB 14-122). A hermeneutic phenomenological approach (Van Manen, 2014) was considered appropriate as this qualitative research method aims to explore individuals' subjective experiences and perceptions of an event or series of events. Analysis takes place via a two-stage interpretation process: First, through interactive discourse, the researcher attempts to gain a comprehensive perspective of the research participants' worldviews. Second, it allows researchers to become cognizant of their own perceptions and experiences of the issues under investigation. Researchers must acknowledge and actively challenge their own biases and presuppositions during all stages of the research process including interpretation (Laverty, 2003). This approach allowed the researchers to reflect on their resettlement experiences as immigrants, clinicians, and professionals and bring that lens to data interpretation. This approach also proposes that participants' perceptions and unique lived experiences can be understood by learning about their cultural and historic background that shape their beliefs and worldviews (Laverty, 2003). This approach allowed researchers to broach the sensitive topic of mental health and provided a safe space for participants to freely reflect and share their views. Employing a Canadian-born lens the last author ensured that the researchers' perspectives expanded understanding of the topic while still maintaining a strong focus on participants' perspectives. A research team led by two family physicians and a health researcher collaborated with the Executive Director (ED) of RIWC. The ED and teachers facilitating the English language classes from RIWC actively assisted the research team in finalizing research objectives, revising focus group questions, and recruiting participants.

Participants

Individuals were eligible to participate if they had been living in Canada for six years or fewer at the time of recruitment. Thirty-seven immigrants (28 women and 9 men) from 15 different countries volunteered. Participants were recruited from English language classes for new immigrant women at RIWC. Although women were the target demographic initially, there were a few male participants attending the language classes during data collection who wanted to participate, so they were also included. Participant demographics are reported in Table 1.

Data Collection

Focus group questions were distributed beforehand to allow participants to organize their thoughts. The focus groups were hosted during the English Language class at the RIWC. Each focus group was 2 h long with a refreshment break. Two family physicians, a health researcher, three undergraduate medical students, and a pre-doctoral Psychology resident served as focus group facilitators. All facilitators represented specific ethnic groups, spoke a second language and were first or second generation immigrants. Informed consent was obtained, and demographic information was gathered from participants before each focus group began. Three health related questions were also explored as literature review indicated that mental distress is often expressed as somatic symptoms by immigrants (Fang, 2010; Kirmayer et al., 2011) Three focus group sessions were held and each was attended by 11–14 participants. For each focus group session, participants were split into 3–4 sub-groups which were held concurrently. Each facilitator worked with a group of 3–4 participants. The questions were read in English and facilitators wrote all responses verbatim and read them back to the participants, ensuring their views were recorded accurately. Facilitators and participants with advanced English language proficiency translated for participants who had limited English language abilities. After each session, facilitators reviewed the salient discussion points and identified issues that warranted further exploration with participants in subsequent groups. All facilitators maintained field notes, documenting important discussion points, their perceptions of the focus group discussions, and new issues that emerged. The field notes were treated as data. During the data collection period, none of the participants received any services from the family physicians on the research team. Complementary child minding, light refreshments, and a $20 gift card to a grocery store were provided as incentives to participate. All participants received information about existing mental health services, ways to access those services and the role of family physicians in providing mental health support.

Analysis

Focus group data was coded and analysed according to the qualitative methods described by Miles et al. (2019), using QSR NVivo® 9 (© QSR International, 2010). The written responses were transcribed using a Word processing program and imported into NVivo for analysis. The transcripts were read line-by-line by the first author and broken into small meaningful chunks. Data chunks with similar meanings were organized under 132 base level codes and appropriate descriptive titles were assigned to each of them. The base codes were reviewed again and those referring to similar ideas were then grouped under

Table 1 Participants demographic description

	Female	Male
N (%)	28 (75.7%)	9 (24.3%)
Age (M,SD)	37.6 (7.9)	41.1(7.1)
Marital Status n (%)		
Married or common law	25 (89.3%)	8(88.9%)
Divorced	1 (3.6%)	1 (11.1%)
Missing	2 (7.1%)	N/A
Education n (%)		
Schooling	1 (3.6%)	1 (11.1%)
High school	5 (17.9%)	5 (55.6%)
Trades and or vocation	1 (3.6%)	1 (11.1%)
Undergraduate	18 (64.2%)	2 (22.2%)
Missing	3 (10.7%)	N/A
Number of children n (%)		
0	5 (18%)	N/A
1–3	20 (71%)	8 (88.9%)
> 3	2 (7.1%)	1 (11.1%)
Missing	1 (3.6%)	N/A
Number of individuals in the same household n (%)		
1–3	17 (60.7%)	3 (33.3%)
4–6	10 (35.7%)	3 (33.3%)
> 6	N/A	1 (11.1%)
Alone	N/A	1 (11.1%)
Missing	1 (3.6%)	1 (11.1%)
Annual household income n (%)		
0-$30,000	9 (32.1%)	1 (11.1%)
$30,000–$50,000	6 (21.4%)	2(22.2%)
$50,000–$100,000	4 (14.3%)	3 (33.3%)
Missing	9 (32.1%)	3 (33.3%)
Length of stay in Canada: Mean (*SD*)	2.8 (1.9)	3.4(.15)
Continent of origin		
Asia (*Afghanistan, China, India, Pakistan, Philippines, Russia, and South Korea*)	22	
Europe (*Hungary, Poland,Turkey and Ukraine*)	10	
Africa (Egypt, Tunisia, Eretria)	4	
South America	1	

18 intermediate codes (Miles et al., 2019). A summary statement and a title representing the intermediate codes were developed. Pictures and diagrams were used to further group intermediate codes under five main themes and to illustrate the relationships between main themes. Facilitators' field notes were consulted to ensure that the relationship diagram linking these intermediate categories to the main themes was inclusive of all the salient points identified by other facilitators. The diagram and data analysis were reviewed by all the authors and final adjustments were made by consensus (Miles et al., 2019). The diagram was also reviewed by the ED at RIWC for confirmation about the conclusions drawn from the study.

Results

Five main themes were identified: concept of health, stressors, coping strategies, Mental health knowledge and attitudes, and barriers to accessing mental health services. The interaction between stressors, coping mechanism and barriers to accessing mental healthcare services and associated intermediate codes are illustrated in Fig. 1.

Concept of health

All participants indicated that a balance between physical, mental, social, and spiritual health was essential for overall wellbeing. Maintaining a balanced diet and regular exercise

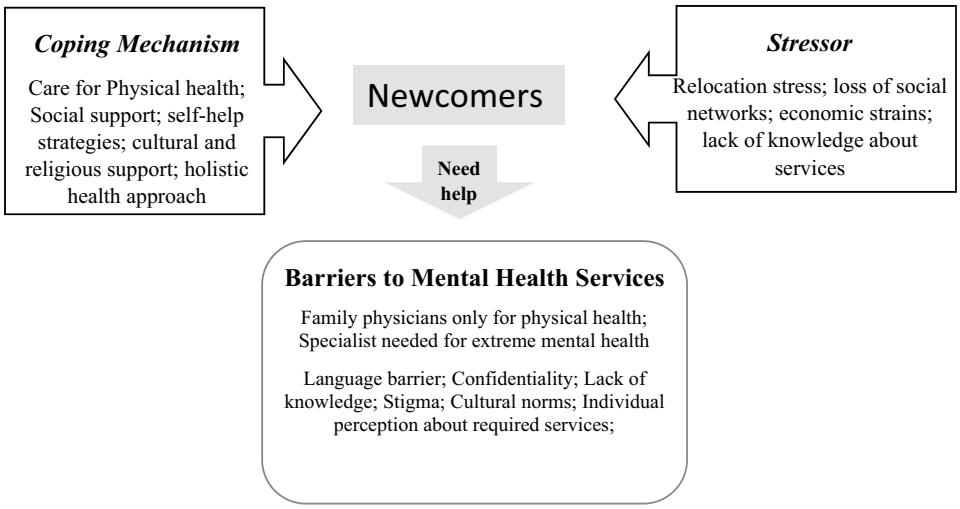

Fig. 1 Interaction of new immigrants' coping mechanism with, stress and barriers to mental health utilization

Table 2 Current health status

	Female	Male	Total
How is your health?			
Good	18 (64.3%)	6 (66.7%)	24 (64.9%)
Alright	10 (35.7%)	3 (33.3%)	13 (35.1%)
Bad	N/A	N/A	
Do you have problems falling asleep?			
Yes	18 (64.3%)	4 (44.4%)	22 (59.5%)
Sometimes	7 (25%)	3 (33.3%)	10 (27%)
No	3 (10.7%)	2 (22.2%)	5 (13.5%)

were considered important for physical health. Participants indicated that access to familiar traditional foods was limited at times and maintaining an active lifestyle was challenging during cold Canadian winters. Due to language barriers, participants' social circles were often limited to family members and other families from their own ethnic group. All participants recognized the importance of mental health and its impact on general wellbeing; as one participant mentioned, "if mind is happy all is good." Spiritual health was mentioned primarily by women. Many engaged in daily prayers and traditional ceremonies to stay connected with their culture. A few women echoed the sentiments of one woman: "I pray every day and read my religious books to stay in touch with my culture." Most participants positively rated their current health status, although 22 participants (59%) mentioned experiencing sleep problems most of the time or always as shown in Table 2.

Stressors

Most participants were in the resettling phase, navigating through various systems to find jobs, housing, childcare, healthcare, and other essential services. Language proficiency was a major barrier to finding information and services in all resettlement areas. One participant succinctly explained that "no English, no job, no friends, no nothing." The burden of stress was more pronounced for individuals without family or friends in Canada or who had not formed new social networks. Loss of cultural and social support from extended families often resulted in social isolation, leading to cumulative stress for many participants. As one participant explained: "I have large family back in my country. I miss my family at home."

Coping strategies

Irrespective of the challenges faced, participants viewed relocation positively and exhibited considerable resilience dealing with daily stress, as one participant expressed: "my husband say it is good for my children and family here [Canada], but sometimes hard for me." Women employed a variety of coping strategies such as positive thinking, mindfulness, meditation, and exercise to manage stress. Technology such as Skype™, telephone calls, and social media were utilized to connect regularly with extended family in their country of origin for mental and emotional support. One woman explained: "I talk to my mom and older sister on Skype, when I am worried and sometimes every day." Engagement in household activities, child care, and managing the family also helped fill their days meaningfully. Women mentioned developing new social circles in their ethnic communities and received peer support during the resettlement phase. One participant mentioned, "I have a good friend she helps me all the time." Many participants viewed the English language classes as a means to develop new social networks, share their stories of struggles with others, and seek support and advice. Some participants found kinship and comfort knowing that others faced similar challenges during the resettlement phase: "I come here

[English Classes] and see that people from many countries do not know English like me and they all have the same problems, I am not the only one."

Women engaged in spiritual care through participation in cultural activities at local religious organizations, regular prayers, and spiritual readings. As was mentioned by a participant:

> I pray 5 times a day. Only God can help when in trouble …. I pray when I get sad, feel bad, when in trouble ask God for help always. When I am sad, I pray and then after I feel good. When you do not pray you feel bad.

Some women mentioned that referring to religious scriptures helped them deal with life challenges. Male participants discussed fewer coping strategies and mainly connected with other families, consulted older males and sought support from co-workers in their ethnic groups. The views of a few participants are reflected in this comment made by a participant: "when there is lot of stress or pressure, I need to take time off and take rest and then I get better, when under serious stress I call my sister to talk."

Mental health knowledge and attitudes:

All participants were familiar with words like depression, anxiety, tension, and stress. Participants agreed that stress and tension were part of daily living. Some participants from war-torn countries indicated they were compelled to self-manage stress on a daily basis, due to the dire state of life in their country. As one participant stated:

> We do not go to doctors for mental health. In my home country, everyone is having a tough life, everyone is sad and stressed. If I go to my doctor and say I am stressed they tell me don't worry everyone is stressed. People in my country die very young and there is lot of trouble. So no one talks about the stress. It is better here [Canada].

Relationship problems, daily stress, and tensions were managed with support from extended family members and friends, without professional help, as was mentioned by a few women. As one described, "if there is problem with husband or wife you ask other older family members, they can explain and help you understand the problem and solve it".

Most participants indicated that psychiatrists were only consulted for severe mental health conditions in their country of origin. Participants mentioned that mild conditions are usually managed with family support and/or herbal or traditional medicines, and rarely discussed with outsiders in order to maintain privacy and avoid stigma:

> When I get worried, I take a tablet I got from home. It is natural medicine. It is not available here [Canada]… Too much of other [western] medicine is not good; you should use natural medicine first. If that does not work, then should use the other medicine [western].

As is evident in the comments above, most participants mentioned that herbal alternatives such as ginger tea and certain herbs reduce stress and tension, and should be considered before consulting the medical doctors. None had received support from a mental health professional at the time of data collection.

Barriers to Accessing Mental Health Services

Participants had substantial knowledge gaps about existing mental health services in Regina, as was mentioned by one of the participants:

> I do not know where to go if I need help with mental health here in the city. We go to the hospital maybe? And it might be expensive. If I have problems I talk to my family and get help. I hope all have good mental health.

Although counselling was acceptable for some participants, language proficiency hindered access to such services. Participants emphasized that without knowledge of culturally acceptable behavior, counsellors might not comprehend clients' perspectives or be able to offer culturally acceptable solutions. Consulting counsellors within smaller ethnic groups was challenging for confidentiality reasons, as one participant commented: "My community is small everyone knows everyone, I cannot talk about personal things." Participants showed considerable knowledge gap about family physician's role in managing mental health conditions and those services were often under-utilized.

A few participants commented that family physicians/general practitioners are for physical health complaints only. As one summarized: "family doctor is for simple problem, for big problems you need specialist or go to the hospital." Participants would not consider consulting family physicians for mental health, as general practitioners were viewed to manage mild physical conditions only. One participant expressed that: "general doctor only check fever, stomach problems, you need specialist when the person is totally crazy and it is very bad and you cannot control the person."

Discussion

The study demonstrated that irrespective of country of origin and gender, participants subscribed to a holistic approach to health, as proposed by the World Health Organization

(2020). Study participants emphasized that a balance between mind and body was necessary for overall wellbeing. Most participants rated their current health status positively. As the mean length of stay in Canada ranged between 2.8 and 3.4 years between females and males respectively, this possibly reflects the healthy immigrant effect observed among new immigrants and is well documented in the literature (George et al., 2015; Kirmayer et al., 2011). Consistent with the literature, participants reported experiencing acculturative stress resulting from relocation and challenges faced during assimilation (George et al., 2015; McDonnel et al., 2012). It is likely that relocation stress is manifested in the sleep disturbances reported by 59% participants. Expression and manifestation of physical symptoms for mental health conditions are reported in other studies (Fang, 2010; Kirmayer et al., 2011). Due to stigma and fear of social ostracization, patients may describe mental health conditions as somatic symptoms such as body pain, sleep problems and fatigue (Fang, 2010; Kirmayer et al., 2011). Consistent with the literature, we argue that immigration is stressful and emotional distress experienced during the resettlement phase impacts sleep (Schneeberger et al., 2019). According to the transactional model of stress and coping proposed by Lazarus and Folkman (1984), the physical and psychological response of individuals facing similar stress varies. Stress experienced by an individual is mediated by the extent to which a stressor is viewed as a threat and an individual has adequate resources to respond to the stress (Lazarus & Folkman, 1984). In the present study, participants perceived stress as normal and related to the instability experienced temporarily during resettlement. Participants were satisfied with their decision to relocate and reported coping satisfactorily using various self-help measures. Other studies have also reported optimism and hope among newly arrived immigrants while dealing with relocation stress (Delera, 2016; Kirmayer et al. 2011).

Models of Coping Behaviour, Acculturation and Adaption:

The study results also add to the discussion on four conceptual models of coping behaviors, acculturation, and adaptation carried out by Kuo (2014). In this discussion Kuo includes the following four conceptual framework of stress coping and adaption for new immigrants. The First Model discussed by Kuo (2014) was the multivariate stress, mediation and outcomes model for Mexican Americans by Cervantes and Castro (1985). This models focus on the impacts of stress, coping and adaption to examine the mental health outcomes and inform clinical intervention. The second model discussed was suggested by Berry (1997) focus on the way in which individual level and group level factors prior to and or during acculturation can impact individuals' ability to adapt and assimilate with the host culture. The third model discussed is the Resilience based stress appraisal coping model by Castro and Murray (2010). It proposed that wellbeing of immigrants are influenced by whether they perceive events as opportunity or threat which in turn also determines their response. However, individual's response, resilience and coping behavior is influenced by immigrants' personal competence or skills that can enable them to attain their goals and outcomes. The final model discussed was the stress and coping grounded theory for recent immigrants proposed by Yakushko (2010) which describes a process model of coping and cultural adaptation in which acculturation related stress arises as the second step of cultural adaptation and is followed by the efforts by individual's efforts to respond and manage stress. Comparing the four models of coping behaviors, acculturation, and adaptation, Kuo (2014) observed three common themes. First all models identified coping as an important factor influencing immigrants' cultural adaptation in the host country (Kuo, 2014). Second, Kuo (2014) observed that individuals' coping mechanisms influenced the extent to which stress impacted them, as well as their ability to adapt psychologically and socially (Kuo, 2014). Third, Kuo (2014) mentioned that coping strategies and coping behavior was also shaped by immigrants' cultural and social contexts and backgrounds.

Consistent with the discussion carried out by Kuo (2014), the present study participants reported implementing many coping strategies to help them deal with relocation stress. Study participants reported several self-help strategies, developing new social connections through the English language classes and also in their ethnic communities. Study participants also claimed that they felt adequately supported and capable of managing relocation stress. Study participants—especially those from war torn and developing countries—highlighted the opportunities for themselves and their families in the host country. It is also possible that study participants viewed stress to be temporary and associated with resettlement and therefore were optimistic about their future in the host country.

Attitudes Towards and Utilization of Mental Health Services

Study participants had limited knowledge about existing mental health services in Regina, Saskatchewan. Gopalkrishnan (2018) proposed that culture and religion has real implication on how individual experience mental illness, their motivation to seek treatment, support received from family and communities, whether help is sought from healthcare providers or traditional healers or spiritual leaders and finally their treatment outcome. Religion and spirituality might also influence individuals' belief about causes of mental disease and remedies that will be considered as solutions

(Chaze et al., 2015; Gopalkrishnana, 2018). For example, individuals who associated hardships with good and suffering or mental distress with karma or bad deeds done in past lives might visit healing temple and observed penance to relieve the situation (Gopalkrishnan, 2018). Koenig and Larson (2001) proposed that most religious traditions advocate a hopeful and optimistic world view in which individuals are encouraged to practice forgiveness, patience, kindness and compassions, and promotes commitment towards family and community which tend to have a positive influence on mental health. The results show that participants' views were strong influenced by their culture and experience with healthcare system in the country of origin. Study participants discussed a three-step approach to managing daily stress and mental health issues. As a first step, study participants proposed that daily stress should be managed with herbal medicines and self-help strategies. As observed in other studies, women participants suggested a variety of self-help, social, cultural, and religious supports for the purpose of gaining better insight of the roots to the problem, to find culturally acceptable alternatives, and to find hope during a difficult time (Chaze et al., 2015; Derr, 2016; MacDonnell et al., 2012). To maintain confidentiality and avoid stigma, seeking support from close friends and relatives, especially for relationship problems and life challenges, was considered as the second step in stress management. Finally, accessing specialist care and pharmacological treatment was considered appropriate only for severe mental health conditions with extreme symptoms and when all other strategies were ineffective. Most study participants mentioned that these strategies were preferred in their country of origin as well. As observed by Kirmayer et al. (2011), study participants would not consider consulting family physicians for mental health concerns, as they were perceived to manage mild physical problems only. Counselling was acceptable to some participants. However, as observed in previous research (Delera, 2016; Derr, 2016) participants in the present study mentioned language barriers, stigma, confidentiality issues, and cultural competency as major barriers to accessing counselling or other mental health services.

This three-step approach to accessing mental health services can create additional barriers for new immigrants. First, social networks and the cultural and religious supports available for mental health issues in their country of origin might be unavailable post immigration. As observed in other studies, this problem can be further aggravated for those unable to form new social connections due to low ethnic density (Bhugra & Becker, 2005; George et al., 2015; MacDonnell et al., 2012; Zhao et al., 2010). Second, family physicians are the first point of contact in Canada for healthcare delivery; they manage follow-up and linkage to specialist care. Therefore, reluctance to consult family physicians for mental health concerns can further delay diagnosis and timely linkage to appropriate care. Third, without knowledge about the host healthcare delivery system, immigrants are likely to search for services that they were familiar with in their country of origin. This creates barriers to accessing care when the two healthcare systems vary. Although, consultation with a family physician and specialist is covered after three months stay in Saskatchewan, Canada costs for other mental services such as counselling have to be managed through independent insurance or as out of pocket expenses.

This study results reiterate findings from others studies indicating that new immigrants who are satisfied with their decision to relocate, are able to re-establish social networks, and can maintain cultural identity and spirituality are likely to better manage relocation stress with a variety of self-help strategies (MacDonnel et al. 2012; Delera, 2016; Robert & Gilkinson, 2012; Khanlau, 2010; Lai & Hynie, 2010; Zhao et al., 2010). This study also highlights the important role of community organizations in serving new immigrants. Although the language classes were aimed at improving English language proficiency only, these classes had a positive impact on other aspects of participants' lives, as was also observed by Chadwick and Collin (2015). Consistent with other studies, the classes were a means to form new social connections, help address social isolation, and provide credible information required during the resettlement phase (Chadwick & Collin, 2015; Kirmayer, et al., 2011; Lai & Hynie, 2010; Zhao et al., 2010). Many study participants found kinship and solace in knowing that others were experiencing similar problems, and improved language skills can help address many of the problems.

Figure 1 illustrates that different coping mechanism might not be adequate to managed mental distressand individuals might require additional support. However, several barriers further hinder access to existing mental health supports. The diagram highlights the need for mental health education and information on ways to navigate existing mental health services.

Recommendations

The present study findings reiterate results from previous studies indicating that mental health services for immigrants should be based on an education framework that emphasizes a holistic model of health, mental health promotion, prevention, development of resilience, healing, and overall wellbeing (Chaze et al., 2015; Delera, 2016; MacDonnell et al., 2012). Chaze et al (2015) proposed that religious teachings and spirituality are important aspects of health and healing in many cultures and that these should be incorporated by healthcare providers caring for immigrants where applicable and feasible. Clinicians should be supported to implement the cultural

competency and cultural safety directives provided by the College of Family Physicians of Canada in their daily practice (Shaw et al., 2017). Researchers have proposed the need for healthcare providers to include pertinent family members in the development and delivery of culturally acceptable mental health care (Fang, 2010; Kirmayer et al., 2011). Using simple words such as worry, sad, feeling low, etc. can help reduce stigma and also help initiate discussion with immigrants who have low English language proficiency. Further, clinicians should be encouraged to use client-centered language such as "a person living with mental illness" rather than "a mentally ill person" (Mental Health Commission Canada).

As suggested in the literature, individuals from ethnic groups who can serve as medical interpreters and cultural brokers should be identified and trained to assist healthcare providers in the delivery of culturally responsive care (Chaze et al., 2015; Kirmayer et al., 2011; Salami et al., 2019). Recognizing the vantage point that RIWC and other community organizations have, the provincial health authority should foster partnerships with these organizations. The partnerships can be leveraged to reach new immigrants who are already accessing the organizations. Other studies emphasize that interpreted assisted culturally responsive education sessions should be delivered through community organizations and settlement agencies serving new immigrants (George et al., 2015; Kirmayer et al., 2011; Salami et al., 2019). The present study results indicate that information sessions delivered through community organizations, in collaboration with family physicians, can help new immigrants engage in discussions about mental health, thereby enhancing mental health literacy and reduce stigma. Mental health promotions and prevention programs can be integrated within existing programming offered by RIWC and can be delivered in collaboration with family physicians. Further, information on mental health conditions, available mental health services, the role of a primary care provider, and ways to access such care should be disseminated in multiple languages through the websites of applicable government agencies (e.g., provincial Ministries of Health, Health Authorities) employing simple language and interactive diagrams. As proposed in the literature, multi-lingual videos and patient testimonies promoting mental health should be delivered through health websites and linked to the websites of community organizations serving immigrants (George et al., 2015; Kirmayer et al., 2011). More community outreach programs including home visiting programs should be provided to better support new immigrants and those with mental health issues. Such outreach programs can be delivered in collaboration with community organization such as RIWC.

Limitations

Participants were recruited from the English language classes offered primarily to women at RIWC. Therefore, their views may not reflect those of new immigrant women who have advance English language abilities. Due to selection bias, participants might not be representative of the majority of new and/or male immigrants in Regina. Further, gender roles and socially acceptable behavior for males may vary between different ethnic groups. Therefore, research targeting male immigrants is required to understand their mental health needs.

Conclusion

Most participants acknowledged the importance of mental health. Participants exhibited considerable resilience managing stress during relocation. Family physicians' services for mental health management are often underutilized due to knowledge gaps on the part of the immigrants (e.g., not knowing that family physicians are the gatekeepers for other services). Targeted culturally responsive approaches that enhance mental health literacy that increase awareness about existing mental health services (including the knowledge gap about the family physicians' services for mental health management) can address mental health needs of new immigrants. The results of the study are timely and relevant for countries receiving ethnically and linguistically diverse immigrants from around the world.

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Declarations

Conflict of interest Authors disclose no conflict of interest.

Ethical approval Ethics approval for this study was obtained from the Research Ethics Board of the former Regina Qu'Appelle Health Region, within the Saskatchewan Health Authority (REB 14–122). The manuscript has not be been submitted to any other journal at present.

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