

“Maybe once I find a good job, I will be better”: Seeking Mental Healthcare in Little Bangladesh, Toronto, Canada

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Abstract

Objective: In order to inform the development of culturally safe models of mental healthcare and promotion, this concurrent mixed methods study explored the following research questions: 1) What are the characteristics of community members with positive attitudes toward seeking mental health services and 2) What are the barriers and promoters of mental health service access for Bangladeshi immigrants living in the “Little Bangladesh” locale in Toronto, Canada which has one of the highest rates of people seeking mental health care in the city. **Method:** Participants were surveyed in the quantitative phase (n = 47) using a sociodemographic questionnaire and the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) and interviewed during the qualitative phase (n = 20). **Results:** The quantitative phase found that male gender, attending school in Canada, and being employed in one’s field of study/work were associated with more positive attitudes toward seeking mental healthcare. Lack of economic integration, mental health awareness and education, mental health literacy, and the presence of community mental health stigma were identified as the major barriers toward seeking care in the qualitative phase. **Conclusion and Implication:** After merging phases, the common factor that emerged from both legs of the study was the stressor of economic insecurity during the migration and resettlement process and how that acts as a barrier to seeking mental healthcare. Participants recommended a multi-pronged, targeted mental health outreach campaign to facilitate economic integration for new immigrants, address mental health stigma, promote available mental health resources, and develop new models of care.

Keywords: Mental health service access, immigrant, Bangladeshi diaspora, acculturative stress, financial insecurity, stress.

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It is estimated that one in five Canadians will experience a mental illness or addiction during their lifetime (Smetanin et al., 2011). Evidence suggests that immigrant mental health deteriorates after arrival in Canada (Ali, 2002; Bergeron, Auger & Hamel, 2009; Islam, 2013; Lou & Beaujot, 2005; Ng & Omariba, 2010). Moreover, mental health is a highly stigmatized issue within South Asian diasporic populations (those reporting origins in India, Pakistan, Bangladesh, Sri Lanka, and other countries) living in Canada (Cader, 2017; Islam, 2012). South Asian populations make up the largest visible minority group in Canada (Statistics Canada, 2008) and is projected to increase to over a quarter (28%) of the population by 2031 (Statistics Canada, 2016). Although sharing certain characteristics, South Asian populations come from vast and varying countries of origin, speak hundreds of different languages and dialects, are affiliated with different religions, and have diverse migration histories in Canada (Statistics Canada, 2007; Tran, Kaddatz & Allard, 2005). While studies on the Bangladeshi diaspora in London, UK have been used to inform culturally-safe mental healthcare practice (Dein, Alexander & Napier, 2008; Dein & Littlewood, 2016), very little research focused on specific countries of origin within South Asian populations has been carried out in Canada. It is estimated that 32,385 immigrants from Bangladesh reside in Toronto (6,870 people (21%) are recent immigrants who landed in the past 5 years) (Statistics Canada, 2017).

The Bangladeshi population in Canada is estimated at over 100,000 (Government of Canada, 2009). It is difficult

to determine the migration patterns of Bangladesh populations to Canada prior to the 1970's as the Census categorized Bangladeshis as "East Indian" prior to 1956 and as "Pakistani" until East Pakistan gained its independence in 1972 and formed present-day Bangladesh. However, it is likely that the number of immigrants at this time was quite small and did not exceed much over 100 people. Bangladeshi professionals and students began arriving in Canada in greater numbers following the opening up of immigration policy in 1967 with many also seeking asylum during the war for independence with Pakistan in 1971. This initial wave of immigration started a chain reaction with many immigrants sponsoring their relatives from Bangladesh. Since 1986, Bangladeshi immigrants to Canada have been steadily increasing with the majority settling in Ontario and Quebec (Encyclopedia of Canada's People, n.d.).

There are no published prevalence statistics available for Bangladeshi communities; however, South Asian populations underutilize mental healthcare services in Canada. Gadalla's (2010) analysis of eight ethnic groupings in Canada found that South Asian populations had the lowest odds of seeking mental health services. Moreover, South Asian individuals with major depressive episode reported the highest proportion (48%) of unmet mental healthcare need and highest proportion (33%) of perception of barriers to the availability of mental healthcare compared to eight other ethnic groupings in Canada (Gadalla, 2010). Only 5.7% of South Asian immigrants sought mental healthcare services (Tiwari & Wang, 2008) compared to the 10% national average (Lesage et al., 2006). Moreover, amongst those with a mental health disorder, only 37.5% of South Asians sought professional help (Tiwari & Wang, 2008). When determinants of help-seeking were quantitatively analyzed for older adult South

Asians in Calgary, Alberta, older age, circumstantial challenges, poor physical health, being Hindu, being longer term immigrants, experiencing fewer health access barriers due to cultural incompatibility, having a lower level of agreement with traditional South Asian health beliefs, and a stronger identification with South Asian ethnic identity were identified as promoters of seeking mental healthcare services (Surood & Lai, 2010; Lai & Surood, 2010). Qualitative research revealed poor English language ability, cultural determinations of mental illness, fear of repercussions on the family, lack of knowledge of mental healthcare services, and racial discrimination as barriers to seeking care for Indian populations in northern British Columbia (Li & Browne, 2000).

A large concentration of the newcomer Bangladeshi community resides in “Little Bangladesh” in East Toronto, Canada, which is encompassed within the neighborhoods of East Danforth and Taylor-Massey (formerly Crescent Town). Estimates place the Bangladeshi population at over four thousand residents within this neighborhood (Keung, 2008). The “mental health crisis” and high rates of poverty in “Little Bangladesh” has made headlines (Lewsen, 2017; Monsebraaten, 2017; Recknagel, 2017). “Little Bangladesh” has the highest percentage of age-standardized mental health visits in the Toronto Central Local Health Integration Network at 12% (LHIN) (Sava et al., 2016; Toronto Central LHIN, 2016) and is described as a high needs neighborhood with high numbers of mental health emergency department inpatient utilization (Access Alliance, 2008; Sava et al., 2016; Toronto Central LHIN, 2016).

Cultural safety (Ramsden, 1991; 1992) in mental healthcare provision acknowledges power imbalances and racism present in healthcare and recognizes the

dynamism of culture. Static representations of culture, lack of acknowledgment of power dynamics, and lack of thoughtful review of effective service delivery practices have been identified as the major mental health system access barriers (Williams, 2002; Williams, 2006; Williams, 2010). The research to date has not provided details on the particular mental health concerns and access barriers experienced by Bangladeshi populations specifically, since the literature has more broadly covered the South Asian diaspora as a whole in Canada. Considering the vast differences in language, culture, religion, etc. across the South Asian diaspora it is important to elucidate concerns from specific sub-populations. Mixed methods research (MMR) studies are especially suited for this task as it uncovers quantitative trends and provides qualitative details that are important for understanding culture (Karasz & Singles, 2009). The combined use of quantitative and qualitative approaches can provide a better understanding of the issue than either approach alone (Robins et al. 2008). The use of mixed methods research to explore cross-cultural issues in mental health is beginning to emerge in Canada (Islam & Oremus, 2014).

The study addressed the following research questions:

1. Quantitative research question: What are the characteristics of community members who have positive attitudes toward seeking mental healthcare for Bangladeshi immigrant populations (measured with the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS))?
2. Qualitative research question: During interview discussions, what are the barriers to mental health service access identified by Bangladeshi populations? What are the promoters

or enablers of mental healthcare access?

3. Mixed methods research question: Is there agreement across the quantitative and qualitative phases of the study? Do the mental health access enabling factors from the survey phase correspond with the promoters/enabling factors identified during the interviews?

METHODS

Mixed Methods Research Design

A mixed methods design was used in this study with community members participating in a quantitative survey phase and qualitative interview. The study followed a concurrent/convergent parallel mixed methods research design (Creswell & Plano Clark, 2011) with the quantitative and qualitative data collection taking place in parallel from June – September 2013. The qualitative phase was given greater priority, as time constraints and limited funding for participant honoraria did not permit the recruitment of a sample size large enough for high level quantitative analysis, such as multivariable regression modeling.

Theoretical Frameworks

A Social Determinants of Health (SDOH) and intersectionality lens was applied to this research project. Mikkonen & Raphael (2010) stress the importance of considering social factors impacting upon health such as socioeconomic status, health access, and ethnicity. The sociodemographic questionnaire included questions on social determinants of health (e.g. socioeconomic status). The concept of intersectionality (Crenshaw, 1989) focuses on understanding an individual's social location by understanding the intersecting systems of oppression in our lives (e.g. race, class, gender, religion, nationality, etc.). These intersecting systems of oppression were

considered in the construction of the interview protocol and explored in the interview discussions. Mental health and attitudes towards seeking care are complex phenomena, and this study cut across many intersections such as migration, mental health, and gender. Important contextual variables such as gender, social support, and socioeconomic status were included in the sociodemographic questionnaire and explored during the interviews to provide as complete a picture as possible of the participants' lived experience.

Sampling

Purposive homogenous sampling (purposeful/non-random sampling from a single segment of the population (Creswell & Plano Clark, 2011)) was carried out by posting promotional flyers in public areas of congregation (community centres, Bengali supermarkets, places of worship etc.) in the neighborhood of "Little Bangladesh" in Toronto, Canada (East Danforth and Taylor-Massey). Snowball recruitment took place by asking initial participants to refer their friends and relatives. Forty-seven Bangladeshis (11 men; 36 women) were recruited to participate in the quantitative survey phase of the study, and a subset of twenty (4 men; 16 women) from this initial sample was invited to take part in one-on-one interviews.

Translation of IASMHS and Face Validity Examination

The Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) (Mackenzie et al., 2004) was translated into Bengali. This scale adapts and builds upon Fischer & Turner's (1970) Attitudes Toward Seeking Professional Psychological Help Scale. A face validity examination of the translated Bengali survey instrument and of the back-translation was carried out. The two back-translations were compared with the original English with 100% concordance

between the back-translation and original survey in content and meaning.

Quantitative Phase

Forty-seven Bangladeshi participants were recruited for the survey phase (IASMHS (Mackenzie et al., 2004) (Appendix A) and sociodemographic questionnaire). One Indian-Bengali individual also completed the survey but was excluded from analysis for not being born in Bangladesh. Forty-eight eligible people were approached with one person refusing to participate (98% response rate). Data collection took place between June – September 2013. Three versions of the IASMHS were offered: 1) English only, 2) Bengali only, and 3) English and Bengali.

The IASMHS addresses limitations of earlier scales (e.g. Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970)) and has a better ability to predict behavior and behavioral intention of help-seeking (Mackenzie et al., 2004). The inventory consists of 24 items using a 5-point Likert scale and has three internally consistent factor subscales (psychological openness, help-seeking propensity, and indifference to stigma) with 8 items per subscale. The IAMSHS has been used before in Asian diasporic samples (e.g. David, 2010; Pilkington, Msetfi & Watson, 2011). The overall and three subscale scores were used as the attitudes toward seeking care outcome measures. The questionnaire was used to assess potential sociodemographic, health behavioral, and health access-related covariates. The surveys took 25 minutes to complete on average. Participants who agreed to partake in the survey phase were given a \$20 gift card.

Qualitative Phase

A subset of twenty participants was chosen from the forty-seven quantitative phase participants (4 men; 16 women). Depending upon the participants' preferences, the interviews were offered in Bengali (n = 19) and English (n = 1). A semi-structured interview protocol was followed. Interview participants were given a \$20 gift card upon agreeing to partake in the study. The 30-minute interviews were audio-recorded. The mp3 files were transcribed and translated into English from Bengali by the lead researcher.

Rigor

Several strategies were employed to ensure rigor (or quality of the qualitative research process) (Guba & Lincoln, 1981; Guba & Lincoln, 1982; Lincoln & Guba, 1985). A sample size of 20 participants was collected for the qualitative phase to allow for rich data collection and data saturation. A self-reflexive journal and field notes were kept for reference and to contextualize the analysis of the data. A second translator was asked to translate to ensure intertranslator agreement. Researcher positionality was noted as the researcher could be viewed as both an insider (Bangladeshi, immigrant to Canada) and outsider (born and raised in “the West,” academic). Researcher triangulation was carried out with the preliminary coding of five interview transcripts and intercoder agreement (Miles & Huberman, 1994) was reached after individual coding of transcripts. Member checking was also carried out by the lead researcher, who shared key findings from the study in an interactive workshop forum in “Little Bangladesh” with community members. Workshop participants felt the findings were accurately representative of their life experiences. Further knowledge translation was also carried out by presenting key findings to a community health center in “Little Bangladesh.”

Data Analysis

Quantitative phase analysis

IASMHS scores were calculated following IASMHS scoring guides (Mackenzie et al., 2004). The overall IASMHS score reflects the participants' degree of positive or negative attitude towards seeking professional mental health services. The psychological openness subscale is a measure of how open the individual is to recognizing psychological problems and the possibility of seeking professional psychological help. The help-seeking propensity subscale measures how willing and able the individual was to seeking professional help. Lastly, the indifference to stigma subscale reflects the individual's beliefs and concerns over how others might perceive them if they were to be discovered seeking psychological help.

The mean scores on the four IASMHS outcomes (overall score, psychological openness subscale, help-seeking propensity subscale, and indifference to stigma subscale) were calculated. Scores for the IASMHS were not assumed to be normally distributed (because of the small sample sizes) and bivariate-level non-parametric tests (independent samples Mann-Whitney U test and independent samples Kruskal-Wallis test) were run to determine if IASMHS scores were distributed significantly differently between the categories of the factors (e.g. was the distribution of total IASMHS scores different for men versus women?). This analysis was done to determine which characteristics/factors were significantly related to IASMHS scores and subscale scores. All analyses were run using Microsoft Office Excel 2010 and IBM Statistical Package for the Social Sciences (SPSS) Statistics version 21.

Qualitative phase analysis

Following Braun and Clarke's (2006) guide on thematic analysis, the basic elements of interest in the transcribed interviews were preliminarily coded. This coding was largely conceptually/theory-driven, since it was stated at the outset that the main focus on this study was to identify barriers and promoters of seeking mental healthcare. Qualitative analysis was done manually, and codes were organized into sub-themes and overarching themes. A thematic map was finalized, and detailed analyses were written for each theme. A constant comparative technique and iterative refinement process was utilized throughout.

Ethics

Research ethics were submitted to York University's Research Ethics Board. The study was approved by Research Ethics Human Participants Review Sub-Committee Board.

RESULTS

Sample Profile

Analysis of the sociodemographic and mental health characteristics of the quantitative phase participants (n = 47) yielded the following sample profile. The majority of participants falls into the 20-40 year old age range (34.0%, n = 16), were married (40.4%, n = 19), Muslim (27.7%, n = 13), and considered themselves to be moderately proficient in English (25.5%, n = 12). Over half of the participants (51%) reported living in low income situations with an annual income less than \$29,999. Participants reported stress (66.0%, n = 31), worrying/missing family (42.6%, n = 20), anxiety (36.2%, n = 17), and depression (34.0%, n = 16), as the most prevalent mental health issues. Moreover, almost half of respondents reported lifetime mental health consultation in Canada (43.5% newcomers; 45.8% longer-term immigrants). Close to a

third of the participants reported lifetime mental health consultation (29.8%, $n = 14$). Most reported consulting with a family physician ($n = 17$), social worker ($n = 5$), and counselor ($n = 2$). Seeking help from family and friends was more prevalent (68.1%, $n = 32$).

Quantitative Phase

Overall IASMHS scale

Overall IASMHS scores were calculated for 45 participants (two participants did not fill out the survey entirely and could not be scored) (Table 1). IASMHS scores range from 0-96 (higher scores indicating more positive attitudes towards seeking mental health services). The Cronbach alpha (a measure of internal consistency) for the overall IASMHS scale in this study was .60, while the original validation study (Mackenzie et al., 2004) had an alpha of .87. The mean IASMHS score for the Bangladeshi study sample was 61.29 (SD 10.34).

Psychological openness subscale

Psychological openness subscale scores were calculated for 46 participants (one participant did not fill out the necessary survey items). The three subscale scores range from 0-32. The Cronbach alpha for the psychological openness subscale in this study was .65 (the original validation study (Mackenzie et al., 2004) had an alpha of .82). The mean score on the psychological openness subscale for the study sample was 16.02 (SD 6.05).

Help-seeking propensity subscale

Help-seeking propensity subscale scores were calculated for 45 participants (two participants did not fill out the necessary survey items). The Cronbach alpha for the help-seeking propensity subscale in this

study was .59 (the original validation study (Mackenzie et al., 2004) had an alpha of .76). The mean score on the help-seeking propensity subscale was 23.22 (SD 4.11).

Indifference to stigma subscale

Indifference to stigma subscale scores were calculated for 46 participants (one participant did not fill out the necessary survey items). The Cronbach alpha for the indifference to stigma subscale in this study was .53 (the original validation study (Mackenzie et al., 2004) had an alpha of .79). The mean score on the help-seeking propensity subscale was 22.15 (SD 6.23).

Quantitative Results of IASMHS Score and Subscale Scores

Bivariate analysis revealed that men ($p = .049$) and those who attended school in Canada ($p = .038$) had significantly higher scores on the Psychological Openness scale compared to women and those who did not attend school in Canada, respectively. In addition those who were employed in Canada in their field of study or work scored significantly higher on the overall IASMHS scale ($p = .037$).

Qualitative Phase

The sample profile and demographics for the qualitative phase participants are summarized in Table 2. A thematic map (Figure 1) of the barriers and promoters of mental health service access identified by participants was developed by organizing factors by mental health system level, and community and individual levels. The factors identified by newcomers and longer-term immigrants were similar, so all factors were collapsed across the community sample.

Government-Level Barriers and Promoters

Social Determinants of Mental Health: Migration, Resettlement, and Economic Precarity

The mental health system and government-level barriers and promoters of mental health service access for the Bangladeshi community are summarized in Figure 1. The stressors of migration and resettlement in relation to economic precarity continually emerged throughout the interview discussions as a major barrier to seeking mental healthcare. Participants strongly felt that the government needs to take more action in securing economic viability for newcomers. Participants could recognize the incredible stress and pressure they were under in trying to settle their family in Canada. However, they felt they had to continue to seek economic security for their family before they could focus on their emotional problems. As one participant stated, “Maybe once I find a good job, I will be better.” (“Nusrat,” woman). The extreme struggle to make ends meet and put food on the table made it almost impossible for participants to prioritize their mental health and seek the help they needed. While more than half of participants reported lifetime mental health consultation, the majority spoke only to their family doctor and did not seek further and more specialized mental healthcare. Adding to this stress, the loss of economic stability and status came as a shock for many participants and sharply contrasted to the life they enjoyed in Bangladesh.

Personally when I was in Bangladesh, I worked. I had a good job there. I led a busy life...Now...mentally I am very upset because I am not working...When I am alone there are many times when I think about this and feel bad. Many times, I have tears running down my eyes. – “Rimi,” woman, 3 months in Canada

Those who come from Bangladesh are in a job crisis, financial crisis...new culture, new lifestyle, because we are not used to this. Every

family, husband-wife, children, we all suffer. New society, culture, to get used to this takes at minimum 2-3 years and during this time most people go through mental stress. So during this time, support is extremely crucial. – “Ashoke,” man, 1 year in Canada

The Challenges of Parenting in Canada

For women specifically, the stress of raising children in a new country without social and family support and watching their children become increasingly alien took a toll on their mental health. One participant shared the story of a neighbor who had died by suicide because of these struggles.

“...it is not easy to get a job...Can’t find the opportunity...On top of that, for women and children...This country is totally different...children don’t listen to them...Taking all of this together, depression starts. I know someone that committed suicide from stress. Wasn’t able to tolerate all of this, and mentally they became sick.” – “Farzana,” woman, 6 months in Canada

Women also expressed the profound isolation that stay-at-home-mothers often experience, which could perhaps be alleviated with accessible childcare.

“Some women don’t go outside, they stay at home. Some people think that a woman’s life is all about raising children. No one is noticing the fact that these women are mentally depressed or mentally upset.” “Nusrat,” woman, 2 years in Canada

Mental Health System-Level Barriers and Promoters

Developing Accessible Mental Health Services

As outlined in Figure 1, at the mental health system level, participants pointed out the importance of resources in Bengali and of stressing the confidentiality of services in order to appeal to the Bangladeshi community. They recommended this information be included with health information upon arrival in Canada, ads be put up in well-traversed areas like the subway, community centre, cultural events (*melas*), near public schools and parks, and in areas where people may be more receptive to the information (family doctor's clinic). Participants identified their family doctor or general practitioner (GP) as a gateway to mental health service information and referral to specialists.

For immigrants we have lot of mental difficulties – stress. I have seen this in my circle. We need the information. Where can we go? What can we do? – “Shamima,” woman, 10 years in Canada

Over half of the participants (51%) reported an annual income less than \$29,999. Free or low cost services were stressed especially since those who are in low income situations, unemployed or without health insurance would likely be most in need of mental health services.

Racist? Sometimes...Especially maybe not now, but earlier. When many people did not wear hijab as much. When I would go out, people would stare at me, look at me differently. Back then I did not understand much, English was a barrier. Now I can fight. But even now, I feel there is lack of respect and barrier. With hijab we are marked as Muslims. – “Shamima,” woman, 10 years in Canada

Most participants did not perceive any racism in the health system; however, some participants expressed they had experienced racism from the greater society (although this was not a direct question in the interview), particularly when trying to seek employment.

Community & Individual-Level Barriers and Promoters

Mental Health Stigma

Mental health stigma was most often cited as a major barrier. Bangladeshi immigrants expressed the social pressure to hide problems and the façade of perfection. They also identified the fear of labels, for example, having the community perceive them as *pagol* (crazy).

“Because Bengalis, we are a little conservative, we don't all trust each other. We don't willingly tell each other everything. We hide things. Then how are you supposed to know if someone is mentally affected? How can we solve it?” – “Farzana,” woman, 6 months in Canada

In the absence of information about the mental health system in Canada, they shared what they knew of services in Bangladesh, where mental health services are seen as a place of last resort for mentally ill patients that require institutionalization. The idea that mental health services could be accessed preventatively for less serious and common mental health issues, such as stress, was not prevalent in Bangladesh.

I can talk about Bangladesh. In Pabna [a city in Bangladesh] there is a mental hospital. You can talk to a doctor and they can refer you to a Pabna Mental Hospital. They can keep you for 2-3 months and stay there. Many can get better, I have

heard. It is important. But I don't know of services here [in Toronto]. I have no idea. – “Rubel,” man, 3 years in Canada

No, within our community there is a problem, people think that psychological counselling or the psychiatrist, that if you go there, you are pagol [crazy]. Those who are totally mad would access these services. – “Nusrat,” woman, 2 years in Canada

Social and Cultural Isolation

Moreover, Bangladeshi immigrants highlighted the relative lack of interaction with other communities and cited this social and cultural isolation as a possible reason for reluctance to seek mental healthcare since all of their information and views were often only shaped by the Bangladeshi community.

Participants expressed their lack of mental health literacy and not knowing how to navigate mental health system. They also felt that if certain perceptions of mental illness could change (e.g. the perception that it is not an illness that requires professional help), this would encourage people to be open to the idea of seeking help.

We need to talk to people. People need to be free. In the Bangladeshi community, especially women, are not free. Don't talk to people. We need to talk to them and show them that this is a good service, not something to be ashamed of. – “Joyeeta,” woman, 1 year in Canada

Both men and women in the study felt that women had a greater tendency to hide personal problems, which may be due to their greater cultural isolation and limited interaction outside the family and community. One participant felt that women

were especially slow to adopt change and adapt to the new culture in Canada. Recreation programs geared towards women were recommended to bring them out of their isolation.

Mixed Methods: Merging Results from the Quantitative and Qualitative Phases

From the quantitative phase, the following three factors were found to be significantly related to more positive attitudes towards seeking mental health services: 1) male gender, 2) being employed in one's field of study/work, and 3) attending school in Canada. From the qualitative phase, the stressors of migration and resettlement, particular those related to the lack of economic integration, coupled with mental health stigma and lack of mental health awareness and knowledge of resources, emerged as the most difficult stumbling blocks impeding the Bangladeshi community from seeking mental health services. When results were merged across the quantitative and qualitative phases, the stressors associated with seeking meaningful employment and economic security were common across both phases. The rich discussion from the qualitative interviews revealed the additional major barrier of mental health stigma and lack of mental health literacy, knowledge, and awareness.

DISCUSSION

This mixed methods research study surveyed and interviewed members of the Bangladeshi newcomer and immigrant community living in the “Little Bangladesh” neighborhood in the city of Toronto, Canada. The major barrier impeding access to mental health services that emerged from both phases of the study was that of the stressors of migration and resettlement, particularly those related to economic precariousness. The qualitative phase identified mental health stigma, the lack of mental health knowledge

and awareness, and the lack of culturally safe models of mental health as additional major barriers.

Economic stability emerged as one of the most important social determinants of mental health for Bangladeshi Canadians. A number of studies of migrant populations in Canada have also reported that financial insecurity during the migration and resettlement process is one of the major barriers to positive mental health (Access Alliance, 2013; George et al., 2015; Simich, Hamilton & Baya, 2006; Zunzunegui et al., 2006). For example, Sudanese newcomers facing economic hardship were three to four times more likely to experience a whole range of mental health issues compared to those who were not experiencing hardship (Simich, Hamilton & Baya, 2006) and immigrants living in neighborhoods of high unemployment experienced greater psychological distress (Zunzunegui et al., 2006). The majority of Bangladeshi participants in this study were living in low income situations (annual income less than \$29,999) and were unable to secure employment in their field of study. Participants recognized how the loss of their social networks after migration and the job precarity after migration led to their downward spiral of mental health, but at the same time, felt they were in survival mode and needed to continue pursuing economic stability for their family rather than focus on their mental health. Those rare individuals who were able to break through some of this initial postmigration struggle and have the opportunity to attend school in Canada or find employment in their field of study scored higher on the scale and had more positive attitudes towards seeking mental health services. Moreover, interviews with Bangladeshi community members in Oakridge revealed that lack of affordable childcare is a serious barrier to economic integration and mental health especially for

women living in “Little Bangladesh” (Monsebraaten, 2017). Accessible childcare could allow Bangladeshi women the opportunity to find meaningful employment, attend school, and help break through the isolation and loneliness they spoke about in this study.

These findings assert that a multi-sectoral effort that goes beyond the mental health system is required to combat the mental health crisis. The migration process in Canada needs to be reimaged to allow newcomers an opportunity to thrive. “Little Bangladesh” has one of the highest numbers of mental health visits in the city (Access Alliance, 2008; Sava et al., 2016; Toronto Central LHIN, 2016). One of the best ways to alleviate this health system burden is to allow for a smooth transition to economic integration for Bangladeshi newcomers after arrival. The institutional racism and intersecting systems of oppression which exclude newcomers from the workforce (e.g. covertly insisting on “Canadian” experience) need to be replaced with an anti-oppressive framework of inclusion. Simply put, allowing newcomers the opportunity for job-matching, skills bridging, economic advancement, and meaningful employment upon landing will pave the road towards better mental health. This proactive approach helps to waylay health system costs down the road.

Limitations

This study had a number of limitations. Volunteer bias (participants volunteering and self-selecting to participate in the study) and self-response bias (participants responding in a socially desirable manner in the presence of the researcher) may exist. The Bangladeshi community in the neighborhood of “Little Bangladesh” may differ, for example in terms of income level/education or circumstances of migration compared to other Bangladeshi

communities across Canada and even the Greater Toronto Area (low transferability/generalizability). As a result of homogenous purposive sampling, the findings may be applicable to this particular Bangladeshi population (internal validity), however, it may be difficult to generalize to other populations (e.g. Bangladeshi populations across Canada or other diasporic communities) (external validity). For example, the high concentration of Bangladeshis may mean health services may offer more linguistically- and culturally-appropriate options. The IASMHS does not define “psychotherapy,” “psychiatrists,” or “professional psychological help” and it is not clear how Bangladeshi participants perceive the concept of “help-seeking.” Posting of flyers in public places and snowball sampling may have led to sampling error, where only certain parts of the population were captured. Because the researcher was a woman and often visited the neighborhood during weekday work hours this study was more likely to capture women, who were at home at this time. A more equal distribution of gender would have made comparisons more possible. The small number of participants recruited for the quantitative phase ($n = 45$) did not allow for high-level statistical analysis (e.g. multivariable regression analysis). In the absence of a fully validated Bengali-translated version of the IASMHS, a short face validation of the translated instrument was carried out. The Cronbach alphas for this study were also lower than those in the original validation study. This may be related to difficulties in translating concepts of mental illness and seeking mental healthcare cross-culturally (Bhui et al., 2001; Dein, Alexander & Napier, 2008; Fenton & Sadiq-Sangster, 1996), which may have caused the Bengali-translated scale items to not adequately measure the constructs of attitudes toward seeking mental health

services comparable to the original English scale. The sample in the original validation study lacked ethnic diversity (Mackenzie et al., 2004), which may also be a reason for the different Cronbach alphas observed. Furthermore, there are cultural differences in the way individuals provide responses on Likert scales (Lee et al., 2002). Further validation of the Bengali-translated IASMHS is needed.

IMPLICATIONS

This study addresses some of the knowledge and research gaps identified by Canada’s Mental Health Strategy (Mental Health Commission, 2012). A three-pronged comprehensive strategy calls for greater government action through offering financial support, job and skills matching programs, and affordable childcare to ease economic integration so newcomers can find meaningful employment. Prioritizing immigrant mental health by offering information and tailored mental health programs for newcomers upon arrival is also needed. Secondly, at the mental health service planning and delivery level, models of mental healthcare grounded in cultural safety need to be developed. Translators can be offered but may impinge upon confidentiality. Matching programs need to be made available to match professionals and clients on language, gender, and other important factors. In addition, the mental healthcare role of the family doctor can potentially be expanded to meet service gaps as Bangladeshi populations were more likely to seek mental health consultation with their family doctor. Funding and efforts can be focused to expand upon initiatives and community education offered by the GP and within primary care centres. Recognizing the shortage of family doctors and stress already placed on the primary care system, McKenzie et al. (2014) outlines a comprehensive mental healthcare strategy used in the UK, where a

single clinic offers the ability to access or coordinate with mental health, health, legal, social, and community services all in one place. This type of “one-stop-shop” centre can help to offer cohesive, culturally safe mental healthcare that mitigates the stressors of migration and resettlement. This kind of service would also need to develop targeted Bengali-language and culturally safe outreach to be accessible to the Bangladeshi community. For example, making services accessible to a large population of women who are stay-at-home-mothers who are not very mobile can be challenging. Offering culturally safe parenting programs geared towards the Bangladeshi community can also help mitigate the cultural clash within the family and stress of parenting in a new country. In addition, new culturally safe mental health programming needs to be developed to address some of the specific stressors of migration and settlement experienced by the Bangladeshi community. Lastly, at the community and individual levels, community awareness campaigns that focus on the culturally safe dissemination of Bengali-translated information on mental health resources and educational programs that promote open discussion of mental health and seeking mental healthcare is needed. As the relative cultural and social isolation of the Bangladeshi community was the major overarching factor related to the barriers of service access, community programs that can increase multicultural socialization need to be created. Mental health stigma can be mitigated through educational and awareness programs where community members who have utilized mental health services can share their experiences. These findings can be used to help to inform the development and delivery of government policy and mental health programming for other diverse immigrant populations in Canada in order to create inclusive models of mental healthcare and a

mental health system that is able to address the needs of an increasingly diverse population in Canada.

Conflict of Interest

Author FI, Author HT and Author NK declare that they have no conflict of interest.

Authorship Contributions

Author FI developed the research plan, collected the data, performed the data analysis, interpreted the results, and drafted the manuscript. Authors HT and NK supervised the research project, guided the research process, and provided critical revision of the manuscript.

Informed Consent & Ethics

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000 (5). Informed consent was obtained from all patients for being included in the study.

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Table 1

Characteristic profiles for IASMHS score and subscale scores for “Little Bangladesh participants

	Overall IASMHS score Mean, SD p-value	Psychological openness subscale Mean, SD p-value	Help-seeking propensity subscale Mean, SD p-value	Indifference to stigma subscale Mean, SD p-value
Gender				
Men	66.09, 9.61	19.36, 5.73	24.36, 2.80	22.36, 5.55
Women	59.74, 10.26 .094	14.82, 5.85 .049*	22.85, 4.43 .34	22.06, 6.60 .94
Age range				
20-40	61.48, 9.17	15.39, 5.88	22.90, 4.31	23.18, 4.90
41-60	60.75, 13.61 .79	17.42, 6.67 .37	24.08, 3.53 .47	19.25, 8.75 .27
Marital status				
Single	56.50, 0.71	14.50, 0.71	25.00, 1.41	17.00, 1.41
Married	61.51, 10.56 .37	16.00, 6.22 0.63	23.14, 4.18 .55	22.37, 6.34 .16
Religion				
Islam	60.89, 11.10	15.92, 6.18	23.36, 4.38	21.61, 6.51
Hinduism	62.89, 6.99 .65	16.00, 6.04 .79	22.67, 2.96 .35	24.22, 5.17 .43
English proficiency				
Not at all-a little bit	61.80, 11.56	16.20, 8.20	25.00, 2.35	20.60, 8.08
Moderate	63.65, 8.17	17.35, 5.23	24.15, 3.98	22.15, 6.06
Quite a bit-extremely well	58.80, 11.91 .28	14.45, 6.31 .25	21.85, 4.30 .14	22.50, 6.38 .84
Education level in Bangladesh				
< university degree	62.75, 11.76	17.00, 9.13	23.00, 5.48	22.75, 5.74
University degree or higher	61.28, 10.48 1.00	15.88, 5.93 .83	23.23, 4.09 .86	22.18, 6.46 .89
Education level in Canada				
Attended school	65.09, 12.38	19.00, 6.34	24.00, 2.86	22.09, 5.91
Not attend in Can.	60.44, 9.68 .17	15.06, 5.91 .038*	22.91, 4.58 .77	22.47, 6.57 .83
# of household members				
2-3	61.22, 9.86	16.17, 6.17	23.56, 3.71	21.50, 7.02

4-5	61.33, 10.89 .94	15.78, 6.15 .69	23.00, 4.41 .91	22.56, 5.87 .51
# relatives in city				
None	61.18, 11.6	15.95, 6.34	22.23, 4.47	23.00, 5.36
1-4	61.92, 9.73	15.54, 6.90	24.92, 3.97	21.46, 7.43
5 or more	60.70, 10.40 .97	16.40, 4.84 .99	23.20, 2.89 .10	21.10, 7.05 .87
Annual household income				
< \$29,999	63.16, 9.37	16.36, 6.70	23.84, 4.07	22.96, 6.34
\$30, 000-49,999	61.67, 12.96	16.67, 6.54	22.58, 4.70	22.42, 6.93
\$50,000+	54.83, 8.40 .18	13.33, 2.16 .31	22.00, 3.52 .46	19.50, 5.50 .34
Medical insurance				
none	62.31, 11.21	16.32, 6.58	23.00, 5.44	23.00, 7.31
OHIP only	59.73, 10.19	15.59, 6.14	23.05, 3.66	21.09, 5.90
Employer paid private insurance	65.00, 9.94 .59	16.83, 5.74 .94	24.33, 1.37 .71	23.83, 5.67 .36
Working status				
Yes	61.84, 13.24	17.69, 7.26	24.31, 1.97	21.85, 5.61
No	60.25, 9.00 .30	15.22, 5.51 .20	22.78, 4.67 .46	22.25, 6.64 .71
Employed in field of study/work				
Yes	70.00, 15.59	20.67, 7.50	25.67, 1.53	23.67, 6.66
No	61.29, 9.45	16.37, 5.84	22.94, 4.31	22.97, 5.73
n/a	52.57, 8.38 .037*	11.71, 5.19 .074	23.57, 3.78 .51	17.29, 7.59 .13
Self-rated health				
Poor-fair	60.14, 14.74	16.71, 7.20	22.71, 1.38	20.71, 9.18
Good	62.28, 9.18	16.59, 5.91	23.55, 4.10	22.14, 5.90
Very good-excellent	59.00, 11.11 .21	13.22, 5.67 .27	22.56, 5.61 .32	23.22, 5.52 .42

Note. Asterisk (*) indicates significant difference ($p < 0.05$).

Note. P-values reported are from bivariate-level non-parametric tests (independent samples Mann-Whitney U test and independent samples Kruskal-Wallis test)

Table 2

Sample demographics of qualitative phase participants (n = 20) by length of stay in Canada

	Participants n(%)
Age range	
20-40	16(80.0%)
41-60	4(20.0%)
Gender	
Male	4(20.0%)
Female	16(80.0%)
Marital status	
Single	1(5.0%)
Married	19(95.0%)
Religion	
Islam	13(65.0%)
Hinduism	7(35.0%)
English proficiency	
Not at all-a little bit	0
Moderate	12(60.0%)
Quite a bit- extremely well	8(40.0%)
Annual household income	
< \$29,999	12(60.0%)
\$30, 000-49,999	5(25.0%)
\$50,000+	3(15.0%)
Employed in field of study/work	
Yes	0
No	16(80.0%)
n/a	4(20.0%)

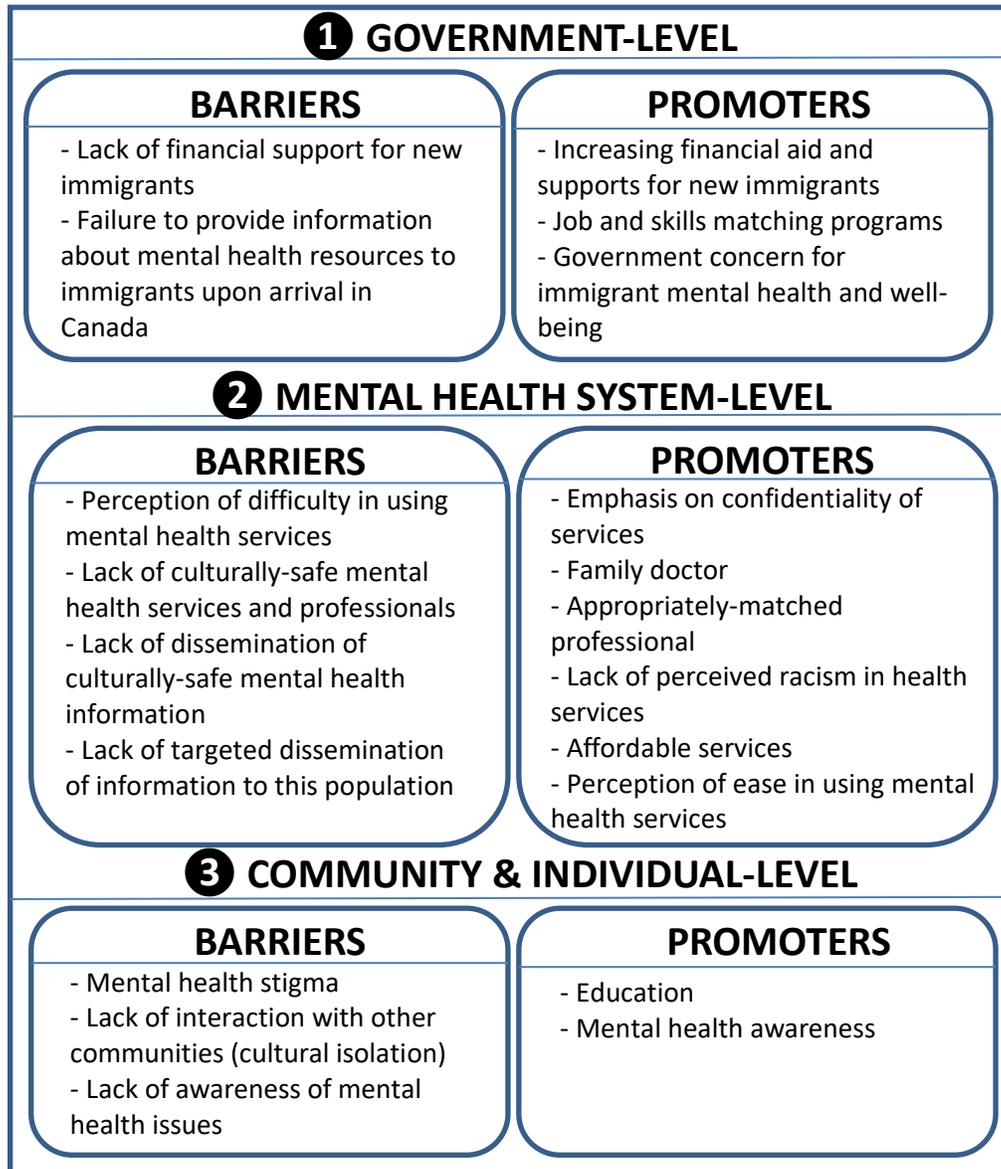


Figure 1. Thematic map of perceived barriers and promoters of mental health service access identified by Bangladeshi populations living in the “Little Bangladesh” locale in Toronto, Canada.

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