ACCESS TO MENTAL HEALTH CARE BY NEWCOMER CHILDREN AND YOUTH

BARRIERS AND FACILITATORS TO ACCESSING MENTAL HEALTH CARE BY ARABIC-SPEAKING NEWCOMER CHILDREN AND YOUTH IN HAMILTON, ONTARIO

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A Thesis Submitted to the School of Graduate Studies in Partial Fulfilment of the Requirements for the Degree Master of Science (Global Health)

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McMaster University MASTER OF SCIENCE (2022) Hamilton, Ontario (Global Health)

TITLE: Barriers and Facilitators to Accessing Mental Health Care by Arabic-Speaking Newcomer Children and Youth in Hamilton, Ontario.

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NUMBER OF PAGES: xi, 88

ABSTRACT

Background: Evidence suggests that refugee and immigrant children and youth are less likely to access needed mental health care. In most cases, settlement service providers may assist by connecting individuals with local resources to help with the transition and providing non-clinical mental health and wellbeing assistance. Few studies have examined the access to mental health care by newcomer children and youth, creating a knowledge gap in addressing the barriers and facilitators for accessing mental health services. This study aimed to explore the service providers' perceptions of the barriers and facilitators to accessing mental health services for Arabic-speaking newcomer children and youth in Hamilton, Ontario.

Methods: Data was collected using semi-structured key informant interviews with service providers (n=7) representing a variety of sectors. Data were analyzed using thematic analysis.

Results: Six themes identified the data's most significant and pertinent aspects relative to my research question. The attitudes of Arabic-speaking newcomers toward mental health and mental well-being, the stigma around mental health, and trust-related issues were identified as three distinct individual factors that can function as barriers to seeking mental health care. Another theme emphasized the importance of the cultural competency and diversity of service providers. Lastly, two themes addressed health system-related variables that highlighted the gaps and challenges in the existing mental health care system for newcomers and the detrimental effects of the COVID-19 pandemic.

Conclusion: Enhancing and enabling access to mental health care for all newcomer children and youth is essential for their current and future mental health and wellbeing. This study suggests a few recommendations and future directions for service providers, researchers, and decision-makers to promote newcomers' access to mental health care.

ACKNOWLEDGEMENTS

First, I would like to convey my gratitude and appreciation to Dr. Kathy Georgiades, my supervisor. I am so thankful for the time you devoted to meeting with me and providing me with your feedback and support. Drs. Amanda Sim and Bruce Newbold, my supervisors and committee members, I would like to express my deep appreciation and profound thanks to both of you. Your accessibility, continuous help, and feedback were extremely valuable.

I would also like to express my gratitude and appreciation for the opportunity to be a part of the Thriving Together Research Project, to work with a wonderful team of researchers, and to be able to learn from you all, which has vastly expanded my understanding of mental health and the challenges faced by newcomers. In addition, I am grateful to the participants who volunteered their time to participate in this study.

I would also like to thank Dr. Sonya Delaat and Adam Zvric for their constant support and encouragement. In addition, I would like to express my appreciation to Dr. Andrea Baumann and the Global Health Office for their guidance throughout my master's degree program.

Finally, I want to thank my family and friends for their everlasting support and encouragement. My children, Hazem and Judy, deserve special thanks for their love, understanding, and care. I dedicate this work to both of you.

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LIST OF ABBREVIATIONS

Attention Deficit Hyperactivity Disorder – ADHD

Canadian Coalition for Global Health Research – CCGHR

Computer Service Unit - CSU

English Language Learner – ELL

Hamilton Integrated Research Ethics Board – HIREB

Hamilton Wentworth District School Board – HWDSB

Information and Consent Form – ICF

Post-Traumatic Stress Disorder – PTSD

Service Provider - SP

United Nations High Commissioner for Refugees – UNHCR

World Health Organization – WHO

Young Men's Christian Association – YMCA

DECLARATION OF ACADEMIC ACHIEVEMENT

The following is a declaration that the content of the research in this document has been completed by Yasmine Shalaby and recognizes the contributions of Dr. Kathy Georgiades, Dr. Amanda Sim and Dr. Bruce Newbold in both the research process and the completion of this thesis.

CHAPTER 1: INTRODUCTION

According to the World Health Organization (WHO), mental health is "a state of wellbeing in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2004). Mental health is a far broader concept than the absence of mental diseases and represents a state of stability (Galderisi et al., 2015). In recent years, there has been a global awakening to the significance of mental health, as evidenced by various indicators, including the World Health Organization's declaration, "There is no health without mental health" (Malla et al., 2018).

Studies show that refugee and immigrant children and youth are exposed to a variety of risk factors throughout the migration journey and resettlement period that may contribute to poor mental health. Most studies on the mental health of immigrants and refugees have focused on the effect of pre-migration trauma. While pre-migration trauma is associated with mental problems and post-traumatic stress disorder, stressful experiences during the post-migration period have also been shown to be related to poor mental health (Hynie, 2018). Post-migration circumstances may impair refugees' capacity to heal from pre-migration stress (Hynie, 2018). Numerous studies have demonstrated that social stressors are associated with mental health outcomes postmigration. These include financial hardship and socioeconomic conditions, insecure housing, prejudice and discrimination, social and economic seclusion and loneliness, residence status, duration of the asylum procedure, and cultural and language impediments to integration, to name a few (Cratsley et al., 2021).

Some research indicates that refugee and immigrant children and youth are at a greater risk for mental health difficulties, such as post-traumatic stress disorder, depression, conduct disorder, and drug abuse-related difficulties (Kirmayer et al., 2011). Despite this increased risk, refugee and immigrant children and youth are less likely to access mental health care (Georgiades et al., 2019). Given the critical importance of accessing early and timely mental health care, research is needed to deepen our understanding of the factors associated with mental health help-seeking behaviors among immigrant and refugee children and youth.

My research focused on the Arabic-speaking population because of the significant number that immigrated to Canada as a result of the Syrian war. Since November 4, 2015, 44,620 Syrian refugees have arrived in Canada (Government of Canada, 2020). And in 2015, 982 government-assisted Syrian refugees resettled in Hamilton, Ontario (City of Hamilton, 2018).

1.1 Current Study

1.1.1 Research Question

What are service providers' perspectives on barriers and facilitators to accessing mental health services for Arabic-speaking newcomer children and youth in Hamilton, Ontario?

1.1.2 Study Objective

This study aims to investigate service providers' views about access to mental health care for Arabic-speaking newcomer children and youth in Hamilton, Ontario. The current study seeks to deepen our understanding of the factors that facilitate and hinder access to mental health care for Arabic-speaking immigrants and refugees' children and youth from service providers' perceptions. Focusing on a broader group of service providers' perspectives is meaningful given that they routinely encounter and communicate with diverse subgroups of newcomers, including newcomers with varying levels of health literacy, beliefs, and ideas about mental health; therefore, service providers have a unique perspective that merits further study. In addition, a more in-depth evaluation of the beliefs and attitudes of care providers is required to appreciate the values that govern their decisions and approaches while addressing the mental health concerns of Arabic-speaking immigrant and refugee children and youth. Furthermore, knowing about the perspectives of service providers on access to mental health care would facilitate the development of better outreach strategies and interventions designed to increase access to mental health care for newcomer children and youth, given that they are the ones who support and provide mental health care for this population.

Findings may contribute to informing the enhancement of existing services, highlighting gaps that need to be addressed to improve access to mental health care for Arabic-speaking newcomer children and youth.

1.1.3 Thesis Structure

This thesis' first chapter begins with an overview of the research topic and aims. The second chapter presents an overview of existing evidence on the mental health of newcomer children and youth in Canada. It identifies the barriers and facilitators to accessing mental health services by this population. The third chapter outlines the thesis methodology, which comprises study procedures, data collection, and data analysis. In the fourth chapter, results and major themes that arose from the data are presented. Chapter five presents a discussion of the study's findings, closing with recommendations and future directions for research and implementation.

CHAPTER 2: BACKGROUND

This section will begin with an overview of the mental health of newcomer children and youth in Canada, including the prevalence of mental health problems and some of the risk factors contributing to the development of mental health disorders in immigrant and refugee children. Next, the underutilization of mental health services by newcomer children and youth will be explored. Finally, the conceptual framework for the barriers and facilitators to accessing mental health services by this population will be addressed.

2.1 Overview of The Mental Health of Newcomer Children and Youth in Canada

Statistics Canada defines "newcomer children and youth" as those who arrived in Canada during their childhood, youth, or early adulthood, whether refugees or immigrants (Statistics Canada, 2021). Immigrants and refugees who arrive in Canada up to five years before a certain census year are considered ***"newcomers"*** (Statistics Canada, 2021). Newcomers can include both refugees as well as immigrants who have come via other programs such as family sponsorship or economic. The 1951 Refugee Convention has defined a "***refugee"*** as "A person who has fled his country because of a well-founded fear of persecution on one of five grounds: race, religion, nationality, membership of a particular social group or political opinion, or was forcibly displaced because of war or natural disasters (UNHCR Canada, 2016). At the same time, an ***"immigrant"*** refers to "A person who has been granted the right to live in Canada permanently by immigration authorities" (Statistics Canada, 2021).

According to the 2016 Canadian Census, 1,212,075 immigrants and refugees arrived in the country from 2011 to 2016 (Canadian Census, 2016). Around one-fifth of Canada's

population is foreign-born, and migration will account for nearly all the population increase by 2036 (Finnigan et al., 2021). Children or young adults account for 10% of migrants in North America (Finnigan et al., 2021). In 2020, around one-third of the 341,180 newcomers to Canada were under the age of 25 (Finnigan et al., 2021).

2.1.1 Prevalence of Mental Health Problems Among Refugee and Immigrant Children and Youth

Some research indicates that immigrant and refugee children and youth are at a greater risk for psychological illnesses, such as post-traumatic stress disorder, depression, conduct disorder, and drug abuse-related difficulties (Kirmayer et al., 2011). Other studies indicate a decreased prevalence of mental illnesses among immigrant and refugee children and youth, indicating that the evidence is still ambiguous (Gadermann et al., 2022). For example, in a study conducted in British Columbia, Canada, refugee and immigrant children and youth exhibited a reduced prevalence of conduct disorder, Attention Deficit Hyperactivity Disorder (ADHD), and mood/anxiety disorders vs. non-immigrant children (Gadermann et al., 2022). Some studies found fewer emotional and behavioral issues among refugee youth, while others found greater rates of psychopathology among refugee youth in comparison to their Canadian-born peers (Guruge & Butt, 2015). Post Traumatic Stress Disorder (PTSD) is the most prevalent mental health issue among children and youth exposed to war and violence, followed by depression (Hadfield et al., 2017). Additionally, refugee children have a greater proclivity for externalizing problematic behaviors such as aggression, and many suffer from sleep disorders (Hadfield et al., 2017; Hassan et al., 2016).

In Ontario, behavior problems were the most prevalent among all children, including immigrant and refugee children and youth, anxiety disorders were the most prevalent among youth, and substantial levels of despair and depression were found among young refugees (Georgiades et al., 2019; Kirmayer et al., 2011). Patterns in the distribution of mental health difficulties among children and youth have been identified, and gender has consistently been documented as being associated with poor mental health, with females at increased risk for internalizing symptoms and anxiety disorders, whereas males have a higher prevalence of behavioral difficulties and ADHD (Beiser & Hou, 2016; Georgiades et al., 2019). Generally, more young female refugees are diagnosed with mental health issues than their male counterparts (Marshall et al., 2016). These gendered patterns hold for non-immigrant, immigrant, and refugee children and youth (Beiser & Hou, 2016; Georgiades et al., 2019).

2.1.2 Determinants of Newcomer Children and Youth's Mental Health

The migration journey is divided into three stages: premigration, migration, and resettlement, each of which has its own set of difficulties (Herati & Meyer, 2020). According to Bronfenbrenner's ecological systems theory, child development is a complex system influenced by various layers of the surrounding environment, ranging from the proximate settings of family and school to broader cultural values, laws, and practices (Paat, 2013). Children may be subjected to violent and dangerous situations during the pre-migration phase and may get engaged in fighting (Fazel et al., 2012). Numerous children and youth may suffer the trauma of a family member's disappearance, whether lost or slain, and refugee families may acquire legitimate fears of persecution or injury before departure (Browne et al., 2017).

The migration phase, in many cases, especially for refugees, is characterized by forced and often abrupt departure and may include dangers such as a shortage of basic supplies, increased violence, and facing severe climate (Fazel et al., 2012). Additionally, the migration phase may include extended stays in refugee camps or urban centers in countries of first asylum, where discrimination and insufficient access to food, water, health care, security, and education are prevalent (Fazel et al., 2012). Refugee children and youth may suffer enormously throughout these two periods, as they may sustain injuries during conflict or on their trip to flee violence to safer regions, and they may acquire a dread of authority and a proclivity for seclusion (Fazel et al., 2012). Numerous researchers have shown the validity of PTSD symptoms by demonstrating relationships between the degree of traumatic exposure and the severity of symptoms in children and youth (Filler et al., 2019; Herati & Meyer, 2020).

During the post-migration phase, children and youth often experience acculturative stress and financial difficulties, and they have to learn a new language, renegotiate their cultural identity, and struggle with social isolation, racism, prejudice, and discrimination (Kirmayer et al., 2011). Settlement-related stresses arise because of being a newcomer to the nation. Many immigrants and refugee children and youth suffer from continuing separation from family and friends, as well as the vague loss of those whose fate is unclear; they may also experience additional stress when reunited with any family member that has been lost, which all pose difficulties over an extended time since even the most resilient are likely to have their resources depleted (Filler et al., 2019; Tulli et al., 2020).

The difficulties connected with transitioning to the Canadian school system were noted as significant stresses throughout the resettlement process by newcomer children (Shakya et al., 2009). Moreover, while navigating new educational environments and a considerable number of

classmates, many children and youth suffer from missing close friends from their home country. The requirements of newcomer youth are distinctive and intricate, given adolescence evolving obstacles, as well as learning how to adapt to their new lives in host nations while coping with significant emotional hardship and mental health concerns related to the settlement process's past and current stressors (Finnigan et al., 2021; Herati & Meyer, 2020; Shakya et al., 2009). Mental health problems that begin during adolescence can also last throughout adulthood (Foster et al., 2015).

Moreover, having no or limited English language fluency exacerbates the difficulties that newcomer children and youth face, including problems making friends, comprehending the teacher and the curriculum being taught, and being harassed for having low English fluency or an accent, with the possible results including low self-esteem and aggravated stress and anxiety (Shakya et al., 2009). On the other hand, newcomer children and youth usually adapt and absorb the host society's language faster than their parents; they regularly take on adult responsibilities to aid their families, such as interpreting for their parents or even working to support their families, which increase their obligations and strains in life (Henley & Robinson, 2011). Not only do linguistic and cultural problems make it difficult for them to make new acquaintances, but they also encounter prejudice and rejection at school from teachers and other students and face social exclusion (Tulli et al., 2020). Furthermore, children and youth may avoid informing their parents about their difficulties at school due to their parents' long hours jobs and the stress caused by the relocation process (Filler et al., 2019; Forrest-Bank et al., 2019). Research has, for example, identified the associations between reported discrimination, mental health, and ethnocultural identification among newcomer children and youth (Shakya et al., 2009).

Discrimination and isolation are significant threats to the socio-economic and mental health of newcomer children, youth, and their families (Shakya et al., 2009).

There is a shortage of research on the relationship between parental health literacy and children's physical and mental health outcomes. However, the current body of knowledge on the impact of parental health literacy on children's physical and mental health outcomes is mixed and varies according to the population studied (Khuu et al., 2016). Immigrant and refugee parents, for example, are disproportionately at risk of inadequate health literacy, and their children are less likely to have seen a mental health professional prior to their immigration or relocation (Khuu et al., 2016).

Previous studies indicate a higher incidence of behavioral issues in preschool children from low-income families and a direct effect of poverty on youths' mental health, demonstrating a link between socio-economic inequality and widespread mental health disorders (Reiss, 2013). Children from socio-economically disadvantaged households were about two to three times more likely to suffer from mental health issues than those from socio-economically privileged families (Reiss, 2013). This finding is important for immigrant and refugee families since many of them struggle financially (Beiser & Hou, 2016). Regardless of the migration stage, children and youth are the most exposed populations to mental health concerns (Cratsley et al., 2021).

2.1.3 Underutilization of Mental Health Services by Immigrant and Refugee Children and Youth

There is consistent evidence that suggests refugee and immigrant children and youth are less likely to access needed mental health care (de Anstiss et al., 2009). People of ethnic minority and immigrant origins use mental health services at a lower rate than other groups (Georgiades et al., 2019). In a Canadian multi-province study by Edward Ng and Haozhen Zhang on the use of mental health services by immigrants and refugees, immigrants were substantially less likely to seek mental health consultations than Canadian-born individuals (Ng & Zhang, 2021). Refugees aren't any more likely to report mental health consultations than immigrants of other admission groups (Ng & Zhang, 2021). This study also revealed that refugee youth were more likely than non-immigrant youth to arrive in the emergency department with their first mental health crisis (Ng & Zhang, 2021). In most cases, settlement service providers may assist by offering information about the community, connecting individuals with local resources that can help with the transition, providing non-clinical mental health and wellbeing assistance, and directing individuals to community health services (Government of Canada, 2022). Schools were the most frequent sites for mental health-related encounters with diverse providers (Georgiades et al., 2019).

Another Canadian research in Ontario sought to determine how immigrant youth perceive barriers to discussing mental health; immigrant and refugee youth underutilize acute care and outpatient mental health treatment services compared to long-term citizens (Finnigan et al., 2021). Consequently, youth who could benefit from mental health services but do not utilize them are left to deal with distressing experiences as they face day-to-day obstacles (Finnigan et al., 2021). Unfortunately, Canada still lacks a national policy or framework for child

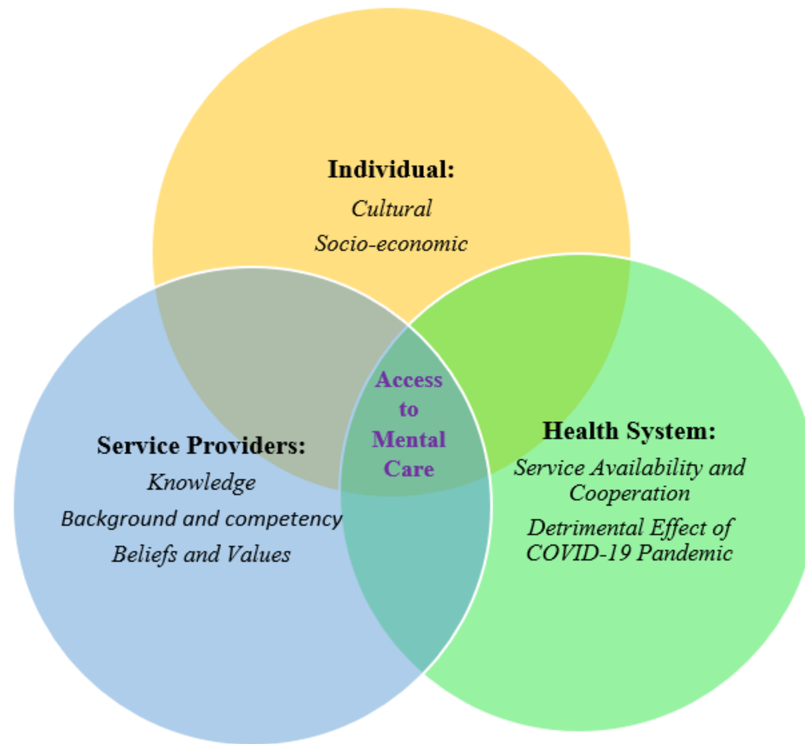
and youth mental health, and mental health services are fragmented for all children and youth, especially for marginalized groups such as newcomers (Alimi et al., 2021).

Widespread underutilization of mental health services by refugees and other ethnic minority children is a problem that is not unique to Canada. In an Australian study by Helena de Anstiss et al., findings showed that children from refugee families might be at a higher risk for mental health issues and have greater difficulty gaining access to mental health care (de Anstiss et al., 2009). Most of the literature on ethnic minorities indicates that young refugees are more likely to seek assistance through informal networks such as family, friends, religious counselors, and spiritual healers than from mental health professionals (de Anstiss et al., 2009). Another research conducted in Sweden in 2022 revealed that immigrant and refugee children and youth used fewer mental health care services than their Swedish counterparts (Gubi et al., 2022).

Overall, these previously mentioned studies demonstrated that western mental health systems continue to fall short of meeting the requirements of ethnically diverse populations in general and children and youth in particular.

Conceptual Framework of Barriers and Facilitators to Accessing Services

Figure 1



Note. The image was adapted to represent the Conceptual Framework for Barriers and facilitators to accessing mental health care, from

Ross, L. E., Vigod, S., Wishart, J., Waese, M., Spence, J. D., Oliver, J., Chambers, J., Anderson, S., & Shields, R. (2015). Barriers and facilitators to primary care for people with mental health and/or substance use issues: A qualitative study. *BMC Family Practice*, *16*(1). https://doi.org/10.1186/S12875-015-0353-3

I am utilizing this conceptual framework to examine the reasons why refugee and immigrant communities underutilize mental health services. This conceptual framework was adapted from an *Access to Primary Care* framework (Ross et al., 2015). It aids in comprehending the elements that either promote or impede access to mental health care services by breaking

them into three primary overlapping and interacting aspects: Individual-related factors, service provider-related factors, and health system-related factors.

According to the literature, individual barriers/ facilitators are based on the newcomers' cultural background and socio-economic circumstances. Other hurdles/ enablers associated with service providers include their knowledge, background, competency, and values that influence their conduct when dealing with newcomers. Finally, health system barriers/ facilitators include service availability and cooperation in addition to the detrimental effect of the COVID-19 pandemic. These interrelated variables create a complicated scenario that requires a profound understanding to facilitate more efficient and successful access to mental health care services.

For the purposes of this literature review, I included studies that involved all immigrant and refugee children and youth (i.e., including those who arrived more than five years ago) since there are few that focus specifically on newcomers (i.e., those who immigrated over the last five years).

2.2 Barriers and Facilitators to Accessing Mental Health Care

2.2.1 Individual Barriers/Facilitators

Cultural Factors

Differences in values, cultures, and social backgrounds may obstruct the development of a global agreement on the idea of mental health, which necessitates a more nuanced knowledge of culture to comprehend good health and wellbeing-promoting behaviors (Galderisi et al., 2015; Ogundare, 2019). Culture may be described as a collection of practices and behaviors determined

by norms, habits, language, and location that groups of people share, and it is neither good nor evil (Cauce et al., 2002). However, ignoring the impact of culture on health and wellbeing can allow detrimental effects to remain unchecked and disrupt the coercive and voluntary processes that lead to the decision to seek care (Cauce et al., 2002; Ogundare, 2019). The way in which health is conceptualized and perceived, as well as how it is evaluated, diagnosed and the illness is treated, varies among cultures (Ogundare, 2019). For example, on a fundamental level, some cultures believe that the best approach to cope with psychological difficulties is to quit worrying about them (Cauce et al., 2002; Edge et al., 2014).

Attitudes toward mental health services, such as openness to treatment, self-consciousness, and stigma tolerance, vary among cultures and have also been associated with seeking mental health support and using professional mental health services. For instance, seeking assistance is seen as a cause of humiliation in several East Asian societies (Cauce et al., 2002; Finnigan et al., 2021; Ogundare, 2019). In Syria and neighboring nations, outward displays of intense emotions may be socially unacceptable. Emotional distress is seen as a natural part of existence, but still, it is the explicit labeling of discomfort as a mental health condition that causes shame, humiliation, and anxiety of scandal and of being labeled 'crazy' or 'mad' with the possibility of spreading the embarrassment to the patient's family and accordingly, this will impact the patient's efficient utilization of mental health treatments (Hassan et al., 2016; Tulli et al., 2020).

Newcomer children's mental health needs are often unmet owing to a variety of access and cultural barriers (Cauce et al., 2002). Differences in parents' "distress thresholds" in response to their children's mental health issues have been noticed across cultures and affect the parents' perception of whether a condition is classified as mental health related (Cauce et al.,

2002; Tulli et al.,2020). Mental health illiteracy and the parents' level of awareness about mental health concerns are other barriers to recognizing the mental health needs of their children and youth, affecting the parents' abilities to seek proper care (Henley & Robinson, 2011; Tulli et al., 2020). Even when suffering is detected, immigrant and refugee children's parents may be reluctant to seek help for their children due to the stigma associated with mental health issues which makes them feel isolated as they can't even discuss their children's needs or seek knowledge from their community (Tulli et al., 2020). The conceptualization of adolescence and the developmental process changes according to culture and socio-economic status. When youth disclose mental health difficulties or discomfort to another individual, it is most typically a friend or relative, regardless of gender and ethnic group, since they often feel fearful that their experiences would be misunderstood or dismissed or due to the preconceived assumption that personal information should be kept private, or their lack of trust in others due to previous negative experiences (Edge et al., 2014). Nevertheless, cultural communities seem to vary in terms of whom they reveal to (Cauce et al., 2002).

Moreover, the existing diagnostic categories for the mental disorder are based on western viewpoints of what defines deviant conduct and presuppose an individualistic understanding of the mental disorder, overlooking other cultural considerations. For example, in the Syrian emergency context, the majority of distress idioms have not been verified for usage (Hassan et al., 2016; Ogundare, 2019). Thus, only a small proportion of people with mental health problems obtain treatment in a specialized mental health care system, and starting the therapy is usually delayed for years (Edge et al., 2014; Kohn et al., 2004). This delay in seeking mental health care can be attributed to various cultural-related reasons, including avoiding seeking help because of believing that the problem will resolve on its own and wishing to resolve the situation without

outside assistance (Edge et al., 2014; Kohn et al., 2004). The complexity and diversity of these dimensions serve only to underscore the critical need to take culture and context into account when researching Arabic- speaking newcomer children and youth (Cauce et al., 2002; Hassan et al., 2016).

Socio-Economic Factors

The socioeconomic status of an individual or group is their social standing or social class, and it is frequently determined by social and economic factors (American Psychological Association, 2022). These interrelated and interdependent determinants include individual or family income, social standing, education, and background history (Macintyre et al., 2018). Poverty associated with housing instability and lack of transportation may contribute to parental anguish since half of the new immigrant families and two-thirds of refugees live in poverty (Beiser & Hou, 2016). This indirectly affects children and youth by reducing parents' ability to detect their children's distress as their burdens increase, making them less likely to identify psychological issues in their children (Cauce et al.,2002; Beiser & Hou, 2016). Studies on the effect of migration status on access to mental health care services revealed that individuals who entered Canada on a work/study visa or whose asylum claims were being processed feared deportation or the expiration of their authorization to remain (Salam et al., 2022; Salami et al., 2019). In cases of significant mental distress, these individuals were unable to seek out mental health care services or go to the hospital’s emergency department due to their unstable legal standing (Salam et al., 2022).

The level of education and background play an important factor in accessing mental health care services (Henley & Robinson, 2011; Tulli et al., 2020). The language barrier,

resulting from inadequate English proficiency, impedes receiving mental health care since it impairs individuals' capacity to articulate their emotions precisely (Salami et al., 2019).

2.2.2 Service Providers' Related Barriers/Facilitators

Knowledge

The awareness level of service providers about the mental health needs of refugee and immigrant children and youth may hinder their ability to deliver effective assistance, which could be one of the most significant obstacles. Although there are evidence-based therapies for trauma, health care practitioners' professional toolkits far too infrequently contain strategies for evaluating newcomer children and youth's need for assistance, much alone the means for acting (Beiser & Hou, 2016). There are two kinds of evidence-based trauma-focused therapies available: treatments such as trauma-based cognitive behavior therapy, which was not designed expressly for newcomers but has been effectively modified for use with these groups; and narrative exposure therapy, which was developed specifically for helping refugees but has been used chiefly in refugee camps (Beiser & Hou, 2016). In addition, while the bulk of the data tends to support the cross-cultural applicability of PTSD symptoms, the manner these symptoms cluster and the prominence of specific symptoms may differ between cultures (Henley & Robinson, 2011).

Background and Competency

Multiple studies suggested that the training, skill sets, and experiences of mental health service practitioners were crucial for delivering adequate, culturally aware or relevant, and trauma-informed treatment for immigrants and refugees, particularly cultural competence

training, which was mostly seen as a critical concern (Ross et al., 2015; Salam et al., 2022; Salami et al., 2019). Culture is essential to examine while attempting to understand patients better. Misdiagnosis and pervasive clinical biases based on race, ethnic origin, and gender emerge because of disregarding socio-cultural factors that contribute to inequalities in mental healthcare, where there are considerable disparities across countries in terms of the frequency of different diseases, service utilization by gender, and the proportion of children receiving treatment (Ogundare, 2019; Cratsley et al., 2021).

Cultural competency, which is described as the ability to provide superior services to diverse cultural groups because of a better understanding of their background, and lifestyles, aims to bridge the cultural divide between service providers and the populations they serve by focusing on providers' expertise, attitudes, and growing abilities, as well as on the establishment and nurturing of meaningful connections (Colucci et al., 2015; Finnigan et al., 2021). It has been established that when child mental health treatments are culturally appropriate and collaborative with teachers, they are agreeable to newcomer families (Henley & Robinson, 2011).

Even while some providers had relevant training, they had never particularly dealt with refugee clients and their complex, trauma-related needs (Kerman et al., 2017; Salam et al., 2022; Salami et al., 2019). Some other service providers lacked a comprehension of the contextual circumstances of recently arrived migrants, such as relocation challenges (Kerman et al., 2017; Salam et al., 2022; Salami et al., 2019).

Beliefs and Values

The beliefs and values of service providers may have an unfavorable effect on the experience of Arabic-speaking newcomer children and youth seeking mental health treatment.

According to studies, refugees and immigrants were subjected to bias and discrimination by their mental health care provider or their personnel, either while seeking mental health services or during their treatment sessions (Salam et al., 2022). Newcomers reported experiencing discrimination based on their intersecting gender, migrant class, and ethnic identities (Salam et al., 2022).

Coordination with colleagues or the utilization of a qualified, professional translator with in-depth knowledge of mental health may be necessary to ensure proper evaluation and service implementation; however, their participation creates ethical and practical concerns around confidentiality and communication quality (Finnigan et al., 2021; George et al., 2015; Tulli et al., 2020). Even if the newcomers are fluent in English and can hold a conversation with the service providers, the service providers will frequently ignore the newcomers and only communicate with their designated interpreter (Salam et al., 2022). It is also crucial to take into account the issues of authority and neutrality when providing mental health services to newcomers, as this raises the issue of power dynamics that must be carefully considered to avoid creating situations in which people feel inferior and utterly reliant on the practitioners' knowledge and skills, especially refugees who have been displaced, they have been stripped of authority and control over the majority of their life, and many of them may see the professional position of the assistance as disempowering and invalidating their ability and creating another barrier for them to seek help (Khuu et al., 2016).

2.2.3 Health System Level Barriers/Facilitators

Service Availability and Cooperation

There are several gaps in the policy process in Canada, ranging from data collection capability to the resources required to create and administer mental health services and interventions within society (Malla et al., 2018). As mentioned before, Canada continues to lack an adequate framework for children and youth's mental health, which affects the cohesiveness of the mental health care system (Alimi et al., 2021; Malla et al., 2018). There was no budget devoted entirely to child mental health policy, and the lack of funds has also hindered the capacity of skilled researchers to perform more studies on the mental health of newcomer children and youth (Malla et al., 2018). Moreover, public health insurance excludes several methods of mental health care delivery from coverage, such as community-based mainstream mental health services, which are pretty expensive (Salami et al., 2019).

In addition, while primary health care technically addresses youth's mental health, it primarily focuses on physical health, providing limited structure and resources to address mental health concerns (Malla et al., 2018). In general, children and youth seeking assistance, including newcomers, face several obstacles, involving limited access to programs and lengthy wait periods of close to a year which casts doubt on the mental health care system's efficacy in addressing their concerns (Malla et al., 2018; Shakya et al., 2009). Furthermore, the majority of screening instruments concentrate only on pathological symptoms, paying little consideration to resilience and coping with a restricted emphasis on the consequences of previous events without regard for present living conditions may result in combining symptoms of PTSD or clinical depression with discomfort caused by post-migration stresses (Hassan et al., 2016).

As well, mental health problems are often missed since there are no required screening systems in place (Khuu et al., 2016). Moreover, although an increasing number of studies have aimed at leveraging educational settings to implement interventions for various disorders, little emphasis has been paid to mental health literacy interventions (Khuu et al., 2016). Lastly, the absence of collaboration between organizations that support the mental health of newcomers can pose a significant barrier to help-seeking (Ee et al., 2020; Salami et al., 2019). Collaborative care requires concerted efforts to increase inter-organizational communication. It is a complicated strategy that tries to establish tight working connections between service providers in various organizations in order to offer efficient services (Ee et al., 2020). It may help eliminate health care inequities among patients from diverse socio-economic and ethnic backgrounds, increasing treatment access (Ee et al., 2020; Salami et al., 2019).

The Detrimental Effect of The COVID -19 Pandemic

The COVID-19 pandemic has exacerbated mental health issues and the ability to address them. The pandemic has aggravated already-vulnerable populations' mental health concerns, with the United Nations High Commissioner for Refugees (UNHCR) noting that the pandemic has resulted in "widespread despair" among refugees (UNHCR, 2020). UNHCR and partners have offered mental health and psychosocial assistance to more than a quarter of a million individuals, including children, since the outbreak of the pandemic as implications of a lengthy COVID-19 pandemic have worsened socio-economic circumstances, have extended relocation, and have created a significant shortage of displacement measures (UNHCR, 2020). COVID-19's isolating settings might negatively influence the health and development of newcomer children and youth. Depression, anxiety, and physical stress are all linked to a lack of school connection; although some students may benefit from online learning, inadequate technical literacy among

some of the newcomers' families creates a barrier to remote learning (Brickhill-Atkinson & Hauck, 2021).

During the COVID-19 pandemic, mental health services shifted quickly to virtual care. Despite the fact that this transition enabled access to treatment during the pandemic lockdown regulations, it has posed unique obstacles, particularly for newcomers (Suurmond et al., 2022). Virtual treatment was associated with significant technical difficulties, communication, and privacy concerns (Benjamen et al., 2021). The new mental health services may exacerbate health disparities by selecting enhancing services for affluent or comparably advantaged technology users, indicating that newcomer refugees, who face various hurdles to access, may not have benefited from the change to virtual care (Benjamen et al., 2021; Suurmond et al., 2022). In addition, online psychological therapies have encountered some opposition, notably from mental health professionals, due to misconceptions about telepsychology, inadequate training, worry over legal and professional rules, and payment concerns (Suurmond et al., 2022).

2.3 Knowledge Gaps

Several gaps in the literature have been identified. For instance, generally, in comparison to the adult population, there are far fewer studies on the mental health of youth, with the majority of studies conducted on older adolescents and very few on the mental health of younger adolescents in junior and senior high schools, where the large number of studies focused primarily on assessing mental health awareness and related features such as perceptions toward seeking help and social stigma (Lam, 2014; Tulli et al.,2020). In addition, most help-seeking research has focused on western and, to a lesser degree, ethnic minority adult populations that

are not refugees (de Anstiss et al., 2009). Research on mental health is significant for immigrant communities and subgroups, such as refugees. Few studies have evaluated newcomers' access to mental health care by specific immigrant-related characteristics throughout Canada (Ng & Zhang, 2021).

Another gap is the lack of research on barriers to accessing mental health care for recently arrived individuals with specific socio-demographic factors that may limit access to services, such as being Arabic-speaking and entering primarily as refugees. (Caldararu et al., 2021). In addition, there is a dearth of research on how the COVID-19 pandemic has impacted access to mental health care for newcomers (Serafini et al., 2021).

Furthermore, research on the views of service providers dealing with newcomers in Canada is limited (Sethi, 2012). These knowledge gaps impede service providers and policymakers from comprehending, designing, and offering effective and accessible mental health interventions for newcomers. In my thesis, I intend to go more deeply into service providers' perspectives about access to mental health care for Arabic-speaking newcomer children and youth, aiming to add more of their valued insights to the existing literature.

2.4 Summary

This chapter provided an overview of the mental health of newcomer children and youth in Canada, including the prevalence of mental health disorders in this population and the risk factors contributing to these issues. In addition, a review of the evidence on the underutilization of mental health services by newcomer children and youth and barriers and facilitators to receiving mental health care at the individual, service provider, and health system levels was also

conducted. Finally, several knowledge gaps were discussed. In the subsequent chapter, my thesis methodology is presented.

CHAPTER 3: METHODOLOGY

In this chapter, the methodology employed in this thesis is described. The chapter begins by describing the study design, including philosophical orientation and reflexivity. This will be followed by a description of the study procedures, including study setting, sampling strategy, recruitment, and ethical considerations. Lastly, the data collection and analysis will be explained.

3.1 Study Design

This thesis represents a sub-study of a larger project: **Thriving Together**: Assessing the Mental Health Needs of Newcomer Children and their Families by Drs. Amanda Sim and Katholiki Georgiades**.** The Thriving Together project seeks to deepen our understanding of the mental health needs of newcomer children and families, including the nature of mental health concerns and sources of strength and resilience, obstacles and facilitators to accessing mental health services and supports, and preferences for receiving mental health services. Evidence arising from this project is designed to directly inform the creation of programs and initiatives for promoting and preventing mental health among Hamilton's newcomer children and families.

My study is a qualitative descriptive study composed of semi-structured key informant interviews to investigate service providers' perspectives on barriers and facilitators to accessing mental health services by Arabic-speaking newcomer children and youth. Incorporating educators, school-based resettlement support workers, mental health experts, and community partners benefited my thesis. It enhanced my data with the varied perspectives of individuals who aid newcomer children and youth. The strength of a multi-sectoral perspective for children and youth mental health research is that its ultimate objective is a profound alteration of social

reality and betterment of the lives of all parties concerned and having the community as the study's beneficiary (Baum et al., 2006). Additionally, participatory research may increase people's awareness of their resources. It is a method of scientific inquiry in which community participation in the study process enables a more precise and proper analysis of social reality (Baum et al., 2006).

The qualitative descriptive study produces a thorough overview of a particular phenomenon in plain, factual language that facilitates comprehension across disciplines. (Colorafi & Evans, 2016). It provides a wide variety of options for theoretical or philosophical orientations, using a purposive sampling approach, observations, semi-structured interviews or focus group questions, and content analysis as data analysis tools (Colorafi & Evans, 2016). The strength of the interview method is that it enables the participants to express themselves and their experiences more on their terms and provides a chance to learn more about their perceptions (Sheppard, 2020). This method is also flexible and gives the chance to change the questions according to necessity. The language and its use, physical patterns, pauses, and nonverbal clues offer an additional dimension of significance (Sheppard, 2020).

I joined phase 1 of the Thriving Together Project for my thesis project, which is the **project inception phase.** Throughout this phase, the principal investigator of the research formed a project advisory committee comprised of newcomer parents, English Language Learner (ELL) teachers, school resettlement support workers, mental health practitioners, and other community stakeholders working with newcomer children and families. The advisory committee provided feedback on the study's subject matter and methodology. During this phase and as a part of my thesis project, I conducted key informant interviews with educators, resettlement support workers, and youth and community service professionals who work with newcomer

children and youth to identify the obstacles and facilitators to gaining access to mental health care.

3.2 Philosophical Orientation

The philosophical orientation of this study is a constructivist approach. Due to the nature of the study, multiple truths are constructed. Discrepancies built upon opinions, knowledge, attitudes, and beliefs will be present (Onwuegbuzie et al., 2014). I am keen to learn more about the viewpoints and experiences of service providers toward newcomer children and youth. I know that their responses may be influenced by their earlier experiences or social and cultural influences. Also, my analysis and interpretation of participant responses are influenced by my experiences and understandings. Knowledge regarding issues, in this case, will be produced by recognizing and understanding previous interactions and will be subjective (Onwuegbuzie et al., 2014).

3.2.1 Reflexivity

Reflexivity is widely acknowledged as a vital approach in the qualitative research knowledge-generation process (Berger, 2015). It is a significant component of "*Humility*," one of the guiding principles of Global Health Research (CCGHR, 2015). As defined by Berger, reflexivity is "the process of a continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgment and explicit recognition that this position may affect the research process and outcome" (Berger, 2015). To completely comprehend the participants, study questions, data, and analysis, one must be mindful of one's

biases. The credibility and reliability of a study increase when its researchers are honest about their own biases, expertise, and viewpoints (Cutcliffe, 2003).

Throughout the entire study process, I was aware of my biases during the development of the study, data collection, and analysis. I was keen not to include my perceptions in the study or influence others' opinions. I am an Arabic speaker, and I was not born in Canada. I have my own opinions on Arabic culture, Arabic-speaking newcomers' attitudes toward mental health, and some of the possible individual hurdles to this population's access to mental health care. I acknowledged that my view might differ from that of the participants due to the many elements that impact the formation of perceptions that differ across cultures and from the western perspective of mental health. I was keen not to include my perceptions in the study or influence others' opinions. Throughout the study, bias was reduced by preserving and referring to my notes, in which I maintained a constant emphasis on the participant's opinion and perspective and made sure they did not reflect my own.

3.3 Study Procedures

3.3.1 Study Setting

The study was conducted in Hamilton, Ontario. Hamilton is a Canadian port city on the western tip of Lake Ontario. More than 500,000 people dwell in the multicultural Canadian city of Hamilton (Statistics Canada, 2022). According to Statistics Canada, more than 24% of Hamilton's population is foreign-born. Hamilton is the third most popular destination for new immigrants to Ontario (Statistics Canada, 2022). The Philippines, China, India, and Iraq are recent immigrants' top four countries of origin (Statistics Canada, 2022). The City of Hamilton's

2021 population has increased by 6% since 2016, surpassing the Provincial Average of 5.8%, and its population is projected to increase by nearly 20% between 2011 and 2036 (Statistics Canada, 2022).

Hamilton was selected by the Thriving Together research team purposively since it has a relatively high number of families from the conflict-affected Middle East and North African countries. Arabic is currently the most commonly spoken non-official language in Hamilton. (Canadian Census, 2021).

3.3.2 Study Sample and Sampling Strategy

The population of interest is service providers who support newcomer children and their families in Hamilton, representing a variety of sectors, including resettlement organizations, educational organizations, religious organizations, youth services organizations, community organizations, and mental health counseling organizations.

Inclusion criteria: Service provider who: (1) works with newcomer children and youth and adults (those who came to Canada within the last five years), (2) is fluent in English, and (3) works in Hamilton. Purposive sampling was used to identify the participants. Using purposive sampling gave an excellent opportunity to have a broader and better understanding of the phenomenon of interest by including participants with in-depth knowledge across diverse settings, sectors, and experiences, maximizing differences across informants' perspectives (Patton, 2002). It also enabled the identification of common patterns that cut across participants despite the diversity of experiences. The Project Advisory Committee suggested potential participants from agencies across Hamilton's health, settlement, and education sectors.

3.3.3 Participant Recruitment

The principal investigator and the co-principal investigator of the Thriving Together Project have established partnerships with Hamilton-Wentworth District School Board (HWDSB), Hamilton Immigration Partnership Council, Young Men's Christian Association (YMCA), Wesley and Refuge Hamilton Centre for Newcomer Health, and the City of Hamilton's Children's Services and Neighborhood Development Division, which assisted in identifying important prospective stakeholders and inviting them to participate in the research. When a possible participant is identified using a purposive sampling approach, and with the cooperation of the Thriving Together Project's partners, and after verifying their eligibility using our inclusion criteria, I made initial contact by email to introduce the study (Appendix B: Key Informant Recruitment Email) as well as provide the Study Information and Consent Form (ICF) (Appendix C: Key Informant ICF). By signing the Key Informant ICF and sending it back to me, interested individuals were asked to declare their willingness to participate. Prior to beginning the interview, I also requested the participant to reaffirm their agreement to participate and be recorded. Snowball sampling was used with participants asked to identify additional contacts who meet the study requirements and may also be willing to participate, thus establishing a growing network of participants (Snowball Sampling - Research Repository, 2019).

3.3.4 Ethical Considerations

Ethics approval for the Thriving Together Project was obtained from The Hamilton Integrated Research Ethics Board in Health Sciences (HIREB) (Appendix A). The ICF highlights that participation is voluntary and that participants may withdraw from the interviews at any time. Even though programs like Zoom include many security features meant to protect the

anonymity of meeting attendees, this cannot be guaranteed. A disclaimer in the consent form to inform the participant of this potential risk has been included.

Each recorded interview was transcribed. All identifying information, including names, organizations, and any other information that may identify the participant, was erased. All participant responses were held in strict confidence. Participants' confidentiality was honored. Each participant was assigned a unique identification number, and only this number was used to identify interview responses. Only authorized members of the research team had access to the personal information of participants. All data is securely saved and protected on a McMaster-approved, password-protected network drive given by the Computer Services Unit (CSU) for research purposes only and will be erased when the Thriving Together Project concludes.

3.4 Data Collection

Data collection occurred in February 2022 through Key informant interviews. Key informant interviews were conducted on the Zoom platform with service providers. The total number of key informant interviews conducted for the Thriving Together Project was 25 interviews. I conducted 7 of these interviews myself, and my thesis focuses only on those seven (n=7). They reflected the intended diversity and were selected based on logistical considerations, scheduling resources, and analytical considerations to ensure data collection satisfaction. Upon receiving the Key Informant ICF confirming their willingness to participate, emails were sent with recommended interview dates and times for them to pick their convenient ones. I then provided them with a Zoom link for the agreed-upon interview day. Before commencing the interview, I gave the participants an overview of the research and sought their verbal agreement

to participate and have the interview recorded voluntarily. Each interview lasted around sixty minutes. I utilized two semi-structured interview guides for the key informants' interviews, one for administrators, organizational leadership, and policymakers (Appendix D) and the other guide for educators, counselors, and social and settlement workers (Appendix E), which were the same scripts used by the other interviewers with the larger participant pool of the Thriving Together Project. Questions included what they think are the main barriers to Arabic-speaking newcomer children and families accessing existing mental health support, what they believe are the main barriers to the effectiveness of the existing mental health support for this population, and how they would define and measure the impact of the services they provide. The interview questions were prepared by the principal investigator of the Thriving Together Project.

I used the Otter software to transcribe my interviews, after which I verified all transcripts for the correctness and eliminated any direct and indirect identification, replacing them with pseudonyms where appropriate. As soon as all interviews had been transcribed and evaluated, I deleted all recordings. Only the study team had access to de-identified transcripts that were kept on a McMaster Faculty of Health Sciences secure network drive.

3.5 Data Analysis

This data was analyzed according to the guidelines of Braun and Clarke (2006) for Thematic analysis (Braun & Clarke, 2006). According to their standards, there are six processes involved in thematic analysis: 1) Familiarizing yourself with the data, 2) Generating starting codes, 3) Searching for themes, 4) Examining prospective themes, 5) Defining and labeling themes, and 6) Generating the report (Braun & Clarke, 2006). I have opted for a hybrid approach

to data analysis, combining deductive and inductive methods, where at the beginning, I focused on specific aspects of the data that relate to my guiding conceptual framework (deductive approach), then created more codes based on the data to discover meaningful and possibly significant portions of the text (inductive approach).

First, I listened to the audio recording of the interview in order to reintroduce myself and acquaint myself with the subject matter. I then reviewed and reread the interview transcript, making notes of my observations and remarks on the content, language, and background. Doing so prompted me to think more analytically about the data and consider how the participant's experience and knowledge affected their view. Next, I went on to another transcript to repeat the procedure, as I have done with all my interview transcripts. This corresponds to the first phase of Braun and Clarke's (2006) methodology for thematic data analysis (Braun & Clarke, 2006).

Second, I constructed an initial set of codes to identify and name a data aspect relevant to my research topic regarding the barriers and facilitators to accessing mental health care by Arabic-speaking newcomer children and youth from the service providers' perspectives and the conceptual framework, using a deductive method of analysis or top-down coding (Braun & Clarke, 2006). I then went over the data and assigned excerpts to codes. During this process, I produced a second set of codes drawn from the data that were intriguing or revealed a recurrent pattern in an open coding inductive technique that proved useful for elaborating on ideas, thoughts, and perceptions (Braun & Clarke, 2006). For my coding, I used the Delve software program, which helped me initiate codes, describe them, organize them, and facilitate coding the relevant portions of the data. I created a mixture of descriptive codes that summarize the text's content into a description. Other codes were based on in vivo coding (using the participant's own words), and a few interpretative codes were based on my interpretation as a researcher. I then

finalized my coding framework and went back and re-coded all the transcripts using my final coding framework.

The third phase was grouping my codes into themes. The purpose of themes is to represent a pattern within the data and gather relevant information within the data pertaining to my research topic (Braun & Clarke, 2006). I examined the coded data to find broader categories and establish links between codes by attempting to notice circumstances and context, delving deeply into a specific issue, and locating areas of overlap and similarity. During this process, I pondered how these themes might aid me in constructing a narrative of my data since this was crucial for reporting my results and answering my research question. In accordance with Braun and Clarke (2006), I have developed a miscellaneous theme for the codes I could not fit into other themes until I could either create themes for them or abandon them (Braun & Clarke, 2006).

In the fourth stage, I edited and analyzed my themes to verify that they had adequate evidence from the data to support them, deleted themes without enough data to back them up, ensured themes were unique from one another and merged similar themes. I next re-evaluated my themes for the complete data set by reviewing all the data and confirming that my themes reflected the significant parts of my data (Braun & Clarke, 2006).

According to Braun and Clarke (2006), the fifth step of thematic analysis includes labeling and characterizing my themes (Braun & Clarke, 2006). I assessed each theme and all the retrieved data pertinent to each theme and then wrote a description of each theme based on this analysis. This helped me construct a narrative of the data, its significance, and how it answers my research question. I attempted to integrate descriptive and conceptual approaches to theme

analysis by interpreting the data and aiming to link it to my research question and conceptual framework (Braun & Clarke, 2006). I sought to accomplish this with each theme and established linkages between each theme, my research question, and other themes. At this stage, I concentrated on giving each theme an informative and succinct name. Throughout my data analysis process, I have constantly evaluated and discussed my developing themes with Dr. Amanda Sim to ensure their validity in relation to the obtained data.

For the final phase of my thematic data analysis, which is reporting my findings, I attempted to construct my narrative by linking themes together and organizing and reporting my findings based on the conceptual framework I have described in my Background chapter.

3.6 Summary

In the third chapter of my thesis, I discussed my research methodology, data gathering, and analysis. In the next chapter, the results of my study will be presented.

CHAPTER 4: RESULTS

This section will present a brief description of the demographic information of the study participants, followed by the six themes that emerged from the semi-structured key informant interviews with service providers (SP).

4.1 Demographic Information

Service providers (SP) (n=7) represented a variety of sectors, including resettlement organizations, educational organizations, religious/ community organizations, youth services organizations, community organizations, and mental health organizations. Service providers' experience ranged from a few months to fifteen years. Two males and five females were interviewed. More than half are Arab/Arabic-speaking like the population of interest.

Table 1

Demographic Information for Service Provider Participants

Identification Number	Type of organization	Gender	Ethnicity	Years of Experience with Newcomers
SP1	Resettlement	Male	Persian	10 years
SP2	Education	Male	Black or African	14 years
SP3	Religious/ Community	Female	Arab	6 years
SP4	Youth Services	Female	Arab	5 years
SP5	Resettlement	Female	Arab	15 years
SP6	Mental health/ Community	Female	Arab	4 years
SP7	Community	Female	South Asian	4 months

Six themes identified the most significant and pertinent aspects of the data relative to my research question about the service providers' perspectives on barriers and facilitators to accessing mental health services for Arabic-speaking newcomer children and youth in Hamilton, Ontario: 1-Attitudes of Arabic-speaking newcomers toward mental health and mental wellbeing; 2-The stigma around mental health; 3-Trust-related issues; 4-Cultural competency and diversity among service providers; 5-Gaps and challenges in the existing mental health care system for newcomers; and 6-The detrimental effects of the COVID-19 pandemic.

These themes have been grouped under three categories: individual factors, service providers' related factors, and health system-level factors, according to the guiding of the **Access to Mental Care** conceptual framework I used earlier in the **Background** chapter of my thesis.

4.2 Individual Factors

4.2.1 Attitudes of Arabic-Speaking Newcomers Toward Mental Health and Mental Wellbeing

Service providers identified a few variables that influence the attitudes of Arabic-speaking newcomers toward mental health, such as lack of awareness about mental health problems, mental health not being a priority, and gender-related issues.

Six out of the seven study participants recognized that one of the major barriers to seeking mental health care by Arabic-speaking newcomers is the lack of awareness about mental health problems and, consequently, available mental health services, which hinders their ability to access those services. This was reflected in several aspects of the data. One of the service providers said:

> … I noticed with a lot of my youth, like, they don't acknowledge that this is anxiety, or this is depression, this is trauma, it's because they're not aware of it because we don't talk about it…Imagine your life being taught one thing, and then you say no, don't believe in that. Now you have to believe this. And I think that's how it is for some families because they didn't get the opportunity to; actually, it's all a matter of education and being educated and being aware because that kind of leads to the ignorance of not being aware of mental health. (SP4)

Study participants also recognized that even when newcomers are able to identify that there is a mental health concern that needs attention and care, it may not be prioritized. As reflected in one of the service provider's opinions when stating:

> …I think one of the biggest challenges might be if it's not on the priority list of the family and that it's a big hiccup. (SP1)

Almost all service providers agreed that Arabic-speaking newcomers would address their mental health concerns only after resolving other family-related problems and fulfilling the different material needs, with one of the participants noting:

> …You know, as a priority, they're not giving this topic as a priority, and they still have to really, you know, they're at the stage of really trying to find to establish and settle and establish a good life, you know, a basic life, I mean, you have the habit of worrying about housing, they worried about, you know, registering good schools, you know, getting like a pattern or getting assist, like, you know, a routine in their life. (SP5)

Nearly half of the service providers highlighted that different gender-based stereotypes could function as obstacles to seeking mental health care. They found that certain gender-based assumptions may inhibit the willingness of newcomer children and youth to seek help, as stated by one participant addressing issues related to boys:

> …keep in mind also the gender differences, like, you know, male or boys tend to really, not really expressing themselves, and not really translating their behaviors into something difficult or, you know, abnormal…the older son, you're expected to be, you know, taking

> care of everybody, you know, being not supposed to make mistakes, not supposed to be, you are supposed to take care of your all their siblings (SP5)

Another service provider identified some issues specifically related to being a female:

> When we talk about females, they also sometimes deal with a lot of family pressure. And that's absolutely valid. So they could not have the opportunity to talk openly, and they really could be at risk of that. And they could end up, you know, harming themselves or think of suicide. (SP6)

4.2.2 The Stigma Around Mental Health

All the service providers emphasized that the stigma associated with mental health is a critical aspect that poses a substantial barrier to seeking help. They identified that mental health conditions are so taboo in the Arabic culture that nobody would discuss them. One of the participants claimed:

> …It is, like mental illness still in our community as Muslim in general and as Arab people likes and specifically Arab people, is still like something we don't talk about. They feel like, I don't know that ashamed maybe, or I don't know. (SP3)

Almost all the service providers emphasized that denial of mental health conditions by Arabic-speaking newcomers and refusing to acknowledge their existence is a serious concern that impedes effective intervention and may lead to mental health deterioration before recognizing that assistance is required. SP5 expressed:

> …So for them, the best approach is just, you know, being in denial, not really accepting that you have this …You know, I've dealt with many like, and, sometimes those clients really, it takes a long time and a lot of losses in order for them to finally admit they have mental health Illness. (SP5)

Participants also highlighted that in the eyes of parents, mental health difficulties are equivalent to losing one's mind, discouraging children and youth from opening up and seeking assistance from their parents. One of the service providers said:

> …Because I know one of like, I'll give you an example, one of the girls, she always comes up to me, and she's like, I can talk to you about this, but I can't talk to my mama. But that's because my mom would say, I've gone crazy. (SP4)

4.2.3 Trust-Related Issues

The study participants unanimously agreed that establishing a connection between the service provider and the newcomer is crucial, especially for youth. This relationship would foster the trust necessary for them to share their thoughts and worries. When I questioned one of the service providers about facilitators for obtaining mental health treatment, she replied:

> …the more the Arabic speakers feel that they have that connection with that person, the more that they can actually open up. But if you don't have that connection, you can't open up. And that's the major things that you need… It's all that building relationship that can be very difficult and takes time… Because when you get that one-to-one service, where you get to connect with them at that level, that's when you like, okay, I can actually acknowledge. (SP4)

But participants also stated that establishing the necessary level of trust takes time, which may exceed the time allotted by the system for mental health sessions for newcomers, particularly refugees. As one of the service providers claimed:

> …But no, sometimes six sessions could take just to build the trust in our community, and I always tell them that trust comes first when it comes to mental health support in our community because we don't open up. We don't tell our secrets. And we've been stabbed, backstabbed from our government, from the authorities. So, we don't trust authority. And we don't trust the community. We have deep trust issues when it comes to that type of thing or secrets or family issues. (SP6)

Service providers have emphasized the importance of activities that are designed to build rapport. They have also advised that the facilitators of these events should be young adults, which would develop a more profound link between them and the children and youth, leading to a better outcome. One participant said:

> …We try to do some activities for them. Specifically for them, to bring them closer to the masjid to make them like feel like more comfortable and open to talk to somebody… having somebody like speaker, youth speaker or somebody talk to them feel that they are close to them if they have any problems in general not only mental health problem, in general, if they have any if they are struggling with something, so they can talk about it, at least somebody they can trust. (SP3)

4.3 Service Providers' Related Factors

4.3.1 Cultural Competency and Diversity Among Service Providers

Under this theme, service providers highlighted a few aspects that affect access to mental health care by Arabic-speaking newcomers, including cultural competency, the lack of availability and diversity of appropriately trained mental health care professionals, and language difficulties.

All the service providers emphasized the significance of cultural competency as a vital aspect that might significantly improve access to mental health treatment for Arabic-speaking newcomers. They recognized that the western approach to mental health impacts the cultural appropriateness for Arabic-speaking newcomers since it disregards their mental health needs. SP1 addressed this point in his interview:

> …So, the term mental health is a very westernized term. I wish there were lots of work done on it, mental health, and culture, and then combine these two together… Our mental

> health is very westernized, even our counseling is very westernized, and you miss a lot of information, a lot of cultural pieces that can be important for the family, in order to meet the needs of the families, compared to their culture… And then from, the health agencies didn't have the capacity in terms of the cultural piece because they have their own interpretation of mental health that might not be defined in Arabic culture. (SP1)

In addition, participants also identified the western approach and ideology of depriving Arabic-speaking individuals of their own unique experiences, implying that immigrants and refugees are not fully aware of their emotions and needs. According to the service providers, this makes the individuals sense a loss of autonomy and total separation from service providers, hindering the connection required to feel secure enough to open up and seek support. It was reflected by SP2 stating:

> …And another piece is also one of the issues that a lot of them face is that the assets that they bring are often dismissed. It's not often acknowledged, so people start to engage Arabic-speaking newcomers or refugees as if they've never existed on planet Earth before. And that they're just learning life from scratch. And truth be told, some of the experiences far exceed anything you and I may have ever seen… So, I think it is cultural relevancy, everything from connecting to engaging, that is missing. A lot of people are not accessing programs because it doesn't meet their needs in ways that are culturally reflective and relevant to them. (SP2)

Another significant point stressed by all the interviewed service providers was the lack of availability of appropriately trained mental healthcare professionals, which impedes timely access to mental healthcare by newcomers. As mentioned by the service providers, this is an issue that must be addressed and resolved to facilitate access to adequate mental health care. One participant claimed:

> …And I think for me, for mental health issues, the biggest challenge still, because we've kept it in a clinical setting, we've excluded a lot of people who could potentially be mental health workers, so only a certain type of people are in mental health, mostly white, you see, all the time, it's not because there are a lot of people who have all kinds of skill set that could be important within the mental health ecosystem… But the moment

> you start to deconstruct other aspects of it, like the resiliency frameworks or whatever, now you can also have different types of mental health workers out of social service or somewhere else that are not clinicians, but they are providing extremely important services that facilitate good mental health. (SP2)

Based on the viewpoints of the study participants, the lack of diversity among mental healthcare practitioners and service providers also exacerbates the challenges of rapport creation and cultural competence. One of the service providers stated:

> …And then when it goes to the other part of the spectrum, we do need to see a specialized, diverse group to understand the culture and the language and can build out a rapport with the family…A lot of mental health workers, usually are women and they're white. You go to the hospital, and a lot of social workers in the hospitals are white women… Although they are claiming that they are diverse, but you don't see the diversity within the system, or the system is based on a very Ben White way of thinking of mental health and health and stuff like that. (SP1)

Moreover, all service providers acknowledged that the language barrier continues to limit adequate access to mental health treatment, which might be ascribed to the scarcity of Arabic-speaking service providers. As SP3 said:

> …Maybe the language is one of these things because till now, it's very hard to find somebody like a therapist or something who speaks that language and the culture of course. (SP3)

Participants have all agreed that when Arabic-speaking service providers are available, individuals feel more at ease seeking assistance, and access to mental health treatment is greatly facilitated. One participant stated:

> …We do have one person that came that spoke Arabic. Actually, we did have that one. And yeah, sometimes it feels good when someone speaks your own language. And I noticed this there was like, I think it's #Diana#. It's an organization that she created. Her

> name is #Diana#. That's for mental health. We also had her join us. And she spoke about mental health, which was good because it's more in Arabic. So, it was really good. (SP4)

4.4 Health System-Level Factors

4.4.1 Gaps and Challenges in The Existing Mental Health Care System for Newcomers

Service providers have acknowledged several systemic challenges that impact proper access to mental health care by newcomers, such as deficiency in mental health programs targeting newcomer children and youth, difficulties navigating the system, and lack of comprehensive coordination between different organizations. Limited tools and resources for Arabic-speaking newcomers, the high cost of mental health treatment, inadequate funding for mental healthcare services, and lengthy wait times have all been addressed.

Almost all the service providers addressed a deficiency in mental health programs targeting newcomer children and youth that are engaging and designed to raise their understanding of mental health and motivate them to seek appropriate care. One of the service providers emphasized this point:

> …Do we need more services? Of course, we do need more services… And I think it's really good to have specialized programs for newcomers when it comes to mental health… And also definitely go from a trauma-informed lens. And if we can have specialized trauma healing programs for the children, most of the families we receive, they have gone through a very hardship. (SP1)

Another aspect of the healthcare system that all the service providers have noted is the system navigation difficulties, where newcomers confront challenges in understanding how the Canadian healthcare system operates and how to seek mental health assistance. Participants

concluded that because of the system's complexity, individuals might become dissatisfied and abandon their pursuit of mental health care. One participant stated:

> …I don't know if I'm jumping to the how the strategies, but I would say the system is also a little bit way too complicated, complicated for these individuals. Even once they admit they want to seek help, it is like the system gets them, you know, discouraged. (SP5)

In addition, four of the seven interviewed service providers highlighted the need for a more inclusive and comprehensive system with effective coordination amongst organizations that provide mental health services for newcomer children and youth. SP5 claimed:

> …the thing is each agency will think from one angle, they don't think from all angles… maybe if they go seek a center or they seek help, that center will be dealing also with the schools or to be dealing, for example, with the children in society. They are involved, so they are more connected; it's not that each one will be working separately, you know… Like, look into all this in one place. The problem with the services, services are there, but it's scattered. And it's not good; it's not connected. (SP5)

Two-thirds of the study participants identified the inadequate tools and resources focused on Arabic-speaking newcomers as another barrier service providers must overcome to promote access to mental health treatment. They have remarked that it is a significant obstacle that impacts the quality of their provided services. SP2 said:

> …I will say, for us, it's been extremely challenging because nobody wants to provide resources for this. So, we have almost no capacity. So, it is our own staff already that is overstretched that have to try and do this. And sometimes it falls between the cracks, just because there are no resources for it, we don't have the capacity… There aren't resources for that… The most effective way to reach that I've seen is providing dedicated resources focused on those activities because organizations are only using what excess resources are left over to try and do whatever little that they can; like we see where everything is needed in an organization once, there are dedicated resources, that tends to have the focus and attention that it actually deserves. (SP2)

Other key obstacles highlighted by almost all of the service providers are the expensive nature of mental health therapy and the inadequate funding for mental healthcare services. They emphasized that mental health counseling is costly, and many organizations lack the funds to meet the demands of newcomers. As a result, the treatment process and outcomes are negatively impacted when financing runs out. SP1 raised this issue in his interview:

> …Is there any funding? I think there's no, not a lot of funding, focus on the newcomer mental health, which I hope should be a priority for the funders because down the road, that's going to have a huge impact on the family; on the kid…So I think we do need better funding. (SP1)

Finally, according to the study participants, the delay in delivering necessary mental health treatment influences the likelihood of seeking help. They identified that the prolonged wait time impacts the system's capacity to promptly provide newcomers with the treatments they need. One participant claimed:

> …I refer you to the doctor, we have to wait, for that, you know, I refer you to that center and the center, they have a long waiting list… You know, like, in order to see the specialist, it's gonna take them a year and a half. (SP5)

4.4.2 The Detrimental Effect of The COVID-19 Pandemic

In their interviews, six of the seven service providers voiced worry over the accessibility of mental health care during and after the COVID-19 pandemic. They highlighted that not all newcomer families had adequate access to technology, and as a result, youths have struggled to communicate effectively with their service providers. This has significantly impacted the connection between newcomer children and youth and mental health service providers established prior to the COVID-19 pandemic.

> …And also, because of COVID we have been going back and forth. Yes, home visits, no home visits. Yes or no home visit. So, we had to use different tools, telephone. Newcomers are good at using WhatsApp, and Zoom links, but then again, technology, and not everyone is good with technology. Usually, the man of the family is good, but the woman are not, or the kids are not. So yep, it has definitely different levels of impact on the families. (SP1)

4.5 Summary

This chapter examined the study's findings and identified interrelated themes linked to the factors influencing Arabic-speaking newcomers' access to mental healthcare. Some of these issues affect all newcomers' access to mental health care. In addition, these elements are interconnected, such that some of the service provider-related factors may also be system-related ones; for instance, the lack of availability of service providers may be related to the gaps and difficulties in the health care system. The stigma-related factors could also be ascribed to a lack of mental health and mental well-being awareness.

These findings underscored the interconnectedness of various issues that, when appropriately addressed and resolved, might work as facilitators to mental health care, not only for Arabic-speaking newcomer children and youth but for all newcomers. The following chapter presents an analysis of the study's findings as well as a few suggestions for service providers, researchers, and policymakers based on these findings.

CHAPTER 5: DISCUSSION

This chapter includes an overview of the study's findings, as well as an analysis of the opinions of service providers regarding barriers and facilitators to Arabic-speaking newcomers seeking mental health care. This will be followed by recommendations for service providers and decision-makers on improving newcomers' access to mental health care. The study's limitations and strengths will next be explored. Finally, a conclusion of the study's findings will be provided.

5.1 Individual Factors

Service providers have highlighted a number of obstacles that potentially impede access to mental health care for Arabic-speaking newcomer children and youth. Some of these elements are associated with the attitudes of Arabic-speaking newcomers regarding mental health. According to service providers, the capacity to identify and acknowledge mental health needs and seek appropriate mental health assistance varies, and it is greatly affected by newcomers' level of awareness. This conclusion is supported by prior research demonstrating that limited mental health literacy hinders the ability of newcomer parents to seek care for their children and youth (Henley & Robinson, 2011; Tulli et al., 2020). In a study conducted by Khuu et al., In the United States of America, a parent's health literacy was defined as their ability to understand and use health information, as well as their knowledge and confidence in interacting with the healthcare system (Khuu et al., 2016). These results point to the dynamic and complicated nature of health literacy, as well as its relationship to other concepts like help-seeking and service use (Khuu et al., 2016). Having a high level of awareness and understanding of mental health

enabled newcomer parents to advocate for their children's mental health and provide necessary conduct and also trained them to handle their children and youth's mental health difficulties more effectively on their own and allowed them to seek external assistance when necessary (Khuu et al., 2016; Tulli et al., 2020).

Another important finding consistent with the literature is that Arabic-speaking newcomers are not able to prioritize mental health concerns in their children since newcomers face competing responsibilities and frequently prioritize supporting their families' fundamental needs above addressing their mental health requirements. Thus, even if a mental issue has been detected, assistance will not be sought until their basic and material needs are met. According to earlier research, one of the reasons why mental health is not a priority for newcomers is because material/basic needs are more pressing, and it is believed that material stressors contribute to mental health difficulties, and if these were eliminated, mental health issues would also disappear (Cauce et al., 2002; Edge et al., 2014; Hassan et al., 2016; Miller & Rasmussen, 2010). This would be compatible with Hynie's social determinants of mental health framework, which emphasizes the influence of material variables such as safe environments, sufficient food, shelter, and jobs on the mental health of newcomers (Hynie, 2018). In addition, economic burdens and resettlement stressors impact the parents' abilities to recognize their children's need for mental care (Cauce et al.,2002; Beiser & Hou, 2016).

When questioned about other issues that can limit access to care, service providers brought up gender stereotypes. They determined that in Arabic society, boys are not expected to display weakness or emotions, whereas girls are expected to bear household responsibilities and accept being overwhelmed and not feeling well mentally. This finding aligns with previous research findings regarding gender expectations' influence on help-seeking. In Arabic culture, as

in other cultures, men are supposed to be tough and self-sufficient to support their families, discouraging them from seeking help and leaving them battling mental difficulties that could be resolved with expert aid (Amri & Bemak, 2012; Hassan et al., 2016; Vogel et al., 2007).

For Arabic-speaking newcomers, stigma is a significant barrier to receiving mental health care. Service providers highlighted the impact of stigma on help-seeking, where newcomers feel ashamed to disclose having a mental condition since, in their perspective, it is associated with going insane, and no one should know about it. This perception of mental disorders affects the willingness of their children to seek appropriate mental care. In prior research, stigma linked with mental health has been identified as a significant barrier to assistance seeking. In the Arabic culture and many other cultures worldwide, mental health disorders are so taboo that no one would discuss them unless they are severe or dangerous (Hassan et al., 2016; Tulli et al., 2020). People feel embarrassed by others' impression of mental illness as madness and their humiliation at admitting that they are sometimes vulnerable (Tulli et al., 2020). They will be rejected and neglected instead of being seen as a health-related illness on par with other health conditions (Tulli et al., 2020). This also results in the denial of mental health disorders, which is a substantial obstacle to receiving mental health care and is strongly linked to the stigma around mental health. According to studies, Arabic-speaking newcomers appear to attribute their negative emotions to causes other than mental health issues requiring treatment (Cauce et al., 2002; Edge et al., 2014).

The interviewed service providers emphasized the significance of building trust and establishing ties between service providers and newcomer children and youth. Trust is essential for newcomer children and youth to express their concerns and seek support. This could be due to their fear of being misunderstood or criticized, or it could result from terrible past events that

have made them hesitant to trust others (Cauce et al., 2002; Edge et al., 2014). According to the findings of a Canadian study, therapists can assist refugee youth in establishing relationships in which they feel a sense of belonging, which has been shown to protect against anxiety and depression (Marshall et al., 2016). Due to perceived power disparities, some newcomer youth may be hesitant to accept aid from professionals (Marshall et al., 2016). Owing to this possibility of mistrust, it is suggested that service providers invest more time and energy in establishing rapport and a sense of safety with their children and youth clients (Marshall et al., 2016).

Establishing a connection and trust takes time and requires activities explicitly designed for newcomer children and youth to create a safe space for children to talk and overcome their fear of being judged, as mentioned by service providers and as suggested by previous studies recognizing the significance of social activities in facilitating engagement, which is useful in gaining trust and encouraging youth to seek assistance (Edge et al., 2014).

5.2 Service Providers' Related Factors

The western approach to mental health is one of the factors impeding access to care by Arabic-speaking newcomer children and youth. Service providers have reiterated the need for a more culturally sensitive approach that recognizes newcomers' backgrounds, traditions, and prior experiences. This will facilitate a better connection between newcomers and service providers and a better recognition of newcomers' needs, thereby facilitating help-seeking and access to mental health care. In literature, disparate cross-cultural perceptions of mental illness were among the main barriers that hamper meeting the mental health needs of newcomers that should be tackled with cultural sensitivity and using culturally appropriate tools (Bowers et al., 2013;

Forrest-Bank et al., 2019; Khuu et al., 2016; Salami et al., 2019). For some service providers, their grasp of fundamental health concepts varied significantly from that of their patients owing to their different cultural perspectives on health, and these distinctions may affect the relationships between service providers and newcomer parents, as well as the parents' assistance-seeking behaviors on behalf of their children (Khuu et al., 2016).

Inadequate availability of sufficiently trained mental health service providers was another critical finding identified as a significant contributor to the lengthy waiting times, whilst the lack of diversity among mental healthcare practitioners and service providers is a deficiency that exacerbates the challenges of cultural competency and help-seeking by newcomers. Diversity among service providers would create more connection to newcomers' experiences since it enables mentoring and inspires children and youth to develop their sense of empowerment and establish much-needed trust (Salami et al., 2019). Ethnic matching between newcomers and providers has been demonstrated to increase trust and communication between newcomer children and youth and service providers and can even result in improved mental health care outcomes (Henley & Robinson, 2011).

Moreover, the shortage of Arabic-speaking service providers has substantially influenced access to mental health services among Arabic-speaking newcomers due to language difficulties which have been identified as a trend in all the gathered data. Even if some Arabic-speaking newcomers knew some English, conducting a meaningful discussion in which they communicate their emotions and opinions would be difficult. In previous research, service providers expressed that the language barrier complicates every connection with newcomer children and youth and every aspect of service provision, including the dependence on interpreters with varying levels of

ethics, cultural competency, and proficiency (Forrest-Bank et al., 2019; Khuu et al., 2016; Salami et al., 2019).

5.3 Health System-Level Factors

Several system-related issues were identified, and it was determined by service providers that there is a deficiency in mental health programs to improve the awareness of Arabic-speaking newcomer children and youth and to urge them to seek assistance when necessary, utilizing culturally relevant tools and resources. Moreover, several variables impact newcomers' access to mental health care, including challenges in navigating the system, a lack of coordination, inadequate funding, and lengthy wait times. Previous research has addressed these concerns. Several studies have advocated for comprehensive intervention programs that can meet the needs of children and youth by providing appropriate information to both specialist and non-specialist support personnel, thereby enhancing their understanding of the mental health issues of newcomers and enabling them to better assist in the development of youths' self-esteem, decision-making, and sense of belonging to their new community, which would eventually encourage them to seek help when they need it (Edge et al., 2014; Hassan et al., 2016).

The high cost of mental health care is a substantial barrier to accessing mental health services for newcomer children and youth, as identified in earlier studies, and continues to impede access to care (Pfefferle, 2007). The availability of free services considerably boosted participants' access to them and gave them the time and resources necessary to address the issue of their lack of mental health awareness more effectively (Tulli et al., 2020). Among the most noteworthy are providers' thoughts on the system's inability to provide more free services. They

considered the cost of care a difficulty exacerbated inside Canada's mental health services since funding percentages have been dwindling for years (Kerman et al., 2017). Unfortunately, community mental health programs, which are essential for supporting individuals with mental disorders, have received less funding, with the majority of resources being allocated to hospital-based services, which hinders the development of these programs (Kerman et al., 2017).

Literature also addresses the system navigation problem, whereby newcomers face difficulties in understanding how the Canadian healthcare system operates and how to seek mental health assistance, necessitating collaboration between service providers and health care professionals to facilitate access to services by assisting clients with system navigation and coordinating consultations with caseworkers and interpreters (Henley & Robinson, 2011; Khuu et al., 2016; Tulli et al., 2020). Moreover, prolonged wait periods significantly deter seeking treatment (Forrest-Bank et al., 2019; Pfefferle, 2007). The longer wait time not only impacts the confidence of newcomers in the mental health system and the system's capacity to provide them with the treatments they need promptly, but it may also alter the prognosis of a mental health condition that may become more severe or even dangerous (Forrest-Bank et al., 2019; Pfefferle, 2007).

The impact of the COVID-19 pandemic on access to mental health was acknowledged. Restrictions on public health have resulted in unexpected consequences, including diminished access to care (Benjamen et al., 2021). The great bulk of mental health care services for immigrants and refugees are provided through primary health care, and the COVID-19 outbreaks shut down a significant number of clinics and drastically decreased in-person services (Benjamen et al., 2021). Although virtual care tools are intended to promote the accessibility of mental

health care services, data on their use during the COVID-19 pandemic, particularly among vulnerable populations such as refugees and immigrants, are scarce (Benjamen et al., 2021).

Access to mental health care services was affected due to disruption of proper communication attributed to technological difficulties. Many refugees could not afford computers, tablets, or internet access and lacked the language and computer proficiency required to obtain virtual care (Benjamen et al., 2021). Technical difficulties and privacy concerns are among the obstacles that have been identified to appropriate access to services (Suurmond et al., 2022). In addition to the need for training of service providers and mental health professionals on online psychological therapies (Benjamen et al., 2021; Suurmond et al., 2022). Further adjustment of legal and professional regulations is needed to facilitate virtual access to mental health care services for newcomers and organize the whole process (Suurmond et al., 2022).

5.4 Recommendations

This study's findings support four critical recommendations to help service providers, researchers, and policymakers improve access to mental health care for not only Arabic-speaking newcomer children and youth but for all newcomers. These suggestions include 1- expanding Arabic-speaking newcomers-specific programs, tools, and resources, 2- increasing the diversity of service providers, 3- more coordination and collaboration amongst groups supporting the mental health of newcomer children and youth is required and 4- improving online access to mental health services.

1- Expanding Arabic-speaking newcomers-specific programs, tools, and resources

My study identified a lack of programs designed to educate Arabic-speaking newcomers on mental health and mental well-being in an effort to reduce the stigma associated with mental illness, which would encourage more newcomers to seek mental health care for their children and youth. Community-based mental health programs that integrate with other social services for newcomer children and youth, as well as the employment of Arabic-speaking case managers and community navigators, would significantly improve establishing connections with newcomers, which is necessary and associated with positive outcomes (Bennouna et al., 2019; Salami et al., 2019). It is essential that these programs be culturally sensitive and take into account the traditions and backgrounds of the Arabic-speaking population. In addition, cultural competence could be improved by procedures that permit and reward professional development in cultural orientation and the provision of services that suit the different needs of newcomer clients, such as access to interpreters (Edge et al., 2014; Finnigan et al., 2021; Henley & Robinson, 2011).

Arabic-language resources and tools would greatly assist Arabic-speaking newcomers in overcoming some of their language barriers. Practitioners who avoid psychological jargon and psychiatric labeling may also generate less stigma and be more easily understood, leading to improved collaboration and treatment adherence (Cauce et al., 2002; Hassan et al., 2016). Nevertheless, it is hard to tailor programs to each particular culture within the mental health system, given the increasingly varied demography and the fact that having in-depth awareness of certain groups does not imply competence since each individual's cultural identity is unique, and it is impossible to master any culture entirely, but seeking an in-depth understanding of different cultures is extremely important for providing adequate mental health services (Hassan et al., 2016; Ogundare, 2019). Therefore, an integrated approach that combines broad strategies (based on commonality across all cultures) and specific skills pertinent to cultural groups within a given mental health service is required (Ogundare, 2019).

2- Increasing the diversity of service providers

According to the study's findings, organizations that promote the mental health of newcomer children and youth require diverse service providers. By acting as a bridge between schools and ethnically diverse populations, Arabic-speaking mental health care professionals may dramatically impact access to mental health care (Khuu et al., 2016). Diverse service providers can overcome obstacles and raise community understanding about mental health. They can provide valuable insight to other healthcare professionals dealing with immigrant communities and serve as mental health advocates within these groups (Salami et al., 2019).

Diverse service providers can be great allies in shaping care practices and enhancing health outcomes for vulnerable immigrant and refugee populations. Arabic-speaking service providers

demonstrate a superior understanding of the Arab newcomers' cultural, language, and structural obstacles. There is also a need to acknowledge and incorporate their skills in collaborative, interprofessional health service delivery approaches (Salami et al., 2019).

3- More coordination and collaboration amongst groups supporting the mental health of newcomer children and youth is required

There is a recognized need for more coordination and collaboration among organizations that support the mental health of newcomers. To effectively assist the mental and psychosocial wellbeing of Arabic-speaking immigrants and refugees, mental health support services must be functionally connected within a cohesive system with established referral and evaluation systems (Hassan et al., 2016). Creating venues for collaboration between mainstream healthcare practitioners and other mental health service providers could solve these distinct groups' knowledge gaps and training requirements. Positive mental health results are observed when mental health specialists and other healthcare practitioners collaborate (Salami et al., 2019). Encouraging collaboration between the settlement and health sectors is vital to allow access to needed mental health services (Shakya et al., 2009). Service providers believed that with effective coordination, families, schools, communities, and other organizations could continue efficiently assisting newcomer children and youth (Bennouna et al., 2019; Salami et al., 2019).

4- Improving online access to mental health services

Reducing technical obstacles and privacy issues is essential to improving access to virtual mental health care. In the framework of COVID-19, virtual mental health services spread rapidly and have the ability to fill gaps between newcomers' mental health care demands and accessible treatments. Virtual care may offer advantages for immigrant and refugee mental health care by

minimizing transit costs, enhancing triage and access, and linking to other virtual resources (Benjamen et al., 2021). In addition, due to the persistence of the COVID-19 pandemic and the unpredictability of other possible future pandemics, online service delivery is necessary. However, most virtual health programs are unsuccessful due to a lack of research on user needs, goals, and perceptions and a failure to address accessibility barriers for underserved patients (Suurmond et al., 2022). Access to mental health treatment remains precarious and may benefit from virtual care approaches, yet, further study is required to determine the effectiveness, feasibility and accessibility of these methods (Benjamen et al., 2021). Offering alternatives and ensuring clients are supported in selecting choices, including in-person care, is crucial to lessen each person's unique barriers to mental health services, given the diversity of newcomers' experiences and needs (Suurmond et al., 2022).

5.5 Limitations

The small sample size was one of the study's limitations in revealing a variety of perspectives. However, a saturation threshold was achieved. Among the downsides of the interview method for data collection is the process of organizing, executing, transcribing, and evaluating gathered data was time-consuming. It required training and the development of skills to deal with unforeseen scenarios, especially given that the interviews were conducted virtually. Another restriction was that the perceptions of psychiatrists were missing. They are treating children and youth with mental health issues and can shine a light on the factors influencing access to mental health care from their point of view.In addition, I could not include educators and school-based mental health professionals in my study since we were awaiting ethics

approval from school boards. Finally, four of the seven interviewed service providers were Arabs, which raises the possibility of bias in their perceptions regarding Arabic-speaking newcomers' access to mental health care.

5.6 Study Strengths

This study begins to address some significant gaps in the literature. First, there are significantly fewer studies on the mental health of children and youth than on the mental health of adults, and even fewer studies on access to care than on mental health awareness. This study tackles this gap by concentrating on children and youth's access to mental health care and examining the factors that hinder or facilitate this population's access to care. Second, in Canada, relatively little research on access to mental health care has focused on newcomers and even fewer on refugees. This study focuses on the access to care for Arabic-speaking newcomers in Hamilton, Ontario, including both immigrants and refugees. The limited number of studies examining the perspective of service providers on newcomers' access to care was another gap in the literature that the current study addresses. The in-depth examination of service providers' perspectives on access to care provides local evidence on what has been established and what needs to be addressed in the development of future initiatives and programs. This study's findings strengthen and extend what has been published in the literature.

5.7 Future Directions

This study provides several suggestions for future initiatives. More attention should be paid to alleviating the daily stresses faced by newcomers and facilitating their resettlement in

Canada, which would enable them to focus on their mental health and recognize any mental difficulties, thereby encouraging them to seek mental health care when necessary. Future research should focus on establishing mental health care outreach/engagement models that could assist in overcoming some of the individual and service provider-related barriers identified in this study. Further investigation of gender stereotypes and gender expectancies is necessary as these factors influence children and youth's readiness to disclose their concerns and seek mental health care.

5.8 Conclusion

This study used a qualitative descriptive approach to identify and describe factors that hinder or facilitate access to mental health care by Arabic-speaking newcomer children and youth in Hamilton, Ontario. The purpose of the study was to examine the factors that influence Arabic-speaking newcomers' access to care from the perspective of service providers who work for organizations that promote the mental health of newcomers. Access to mental health care for newcomers can be improved by gaining a greater understanding of enablers and barriers to care. The findings of this study attempt to address a few gaps in the literature by examining service providers' perceptions of the factors influencing access to mental health care by newcomers and the impact of these factors on access to care by Arabic-speaking newcomer children and youth.

The study findings highlighted several factors that influence access to mental health care. Some of these characteristics are related to the individuals, such as attitudes about mental health, stigma, and trust concerns. Others are related to service providers, such as cultural competency, diversity among service providers, and language difficulties. Few other factors are related to the

gaps and challenges in the existing mental health system and the insufficient cooperation between organizations that assist the mental health of newcomers. Furthermore, during the COVID-19 pandemic, virtual access to care problems was ultimately identified.

This study's findings highlight a few recommendations for service providers and decision-makers to promote newcomers' access to mental health care. The recommendations involve increasing the number of programs, tools, and resources tailored for Arabic-speaking newcomers with language and cultural competency to raise their awareness of mental health and wellbeing. Cultural competence would help ensure that these programs reach their intended clients. More collaboration amongst organizations working with newcomers would improve access to mental health services and alleviate navigational obstacles. In addition, a greater diversity of service providers would foster the necessary connectivity and trust for newcomers' children and youth to discuss their concerns, needs and aid in directing them to the appropriate services. Moreover, improving virtual access to mental health care for newcomers is necessary to address technological and confidentiality concerns. Enhancing and enabling access to mental health care for Arabic-speaking newcomers and all newcomer children and youth is essential for their current and future mental health and wellbeing.

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Appendices

Appendix A: Letter of Research Ethics Approval

Dec-16-2021

Project Number: 14005

Project Title: Thriving Together: Assessing the Mental Health Needs of Newcomer Children and their Families

Principal Investigator: Dr Amanda Sim

The Hamilton Integrated Research Ethics Board (HiREB) has reviewed and approved the abovementioned study. The following documents have been approved on both ethical and scientific grounds:

Document Name	Document Date	Document Version
Appendix N. Parent Survey	Aug-27-2021	1
Appendix O. Youth Survey	Aug-27-2021	1
Appendix H. Consent to Be Contacted	Aug-27-2021	1
Appendix M. Key Informant Interview Guide	Aug-27-2021	1
Appendix P. Parent Follow up Interview Guide	Aug-27-2021	1
Appendix Q. Youth Follow up Interview Guide	Aug-27-2021	1
Appendix I. Thank you script	Aug-27-2021	1
Appendix K. Follow up interview confirmation script	Aug-27-2021	1
Sim_Thriving_Together_Study_Protocol_v2_8Oct2021_CLEAN	Oct-08-2021	2
Appendix A. Key Informant Recruitment Email_v2_8Oct2021_CLEAN	Oct-08-2021	2
Appendix C. Study Introduction Phone Script_v2_8Oct2021_CLEAN	Oct-08-2021	2
Appendix F. ICF - Parental Consent_v2_8Oct2021_CLEAN	Oct-08-2021	2
Appendix G. Youth (12-15) Assent_v2_8Oct2021_CLEAN	Oct-08-2021	2
Appendix B. Key Informant ICF_v2_8Oct2021_CLEAN	Oct-08-2021	2
Appendix E. ICF - Adult - Email_Mail_Online_v2_8Oct2021_CLEAN	Oct-08-2021	2
Appendix D. ICF - Adult - Phone_v2_8Oct2021_CLEAN	Oct-08-2021	2
Appendix T. ICF - Youth (16-17 years) - Email_Mail_Online_v1_8Oct2021	Oct-08-2021	1
Appendix U. ICF - Youth (16-17 yo) - Phone_v1_8Oct2021	Oct-08-2021	1
Appendix R. Study Key_v2_8Oct2021	Oct-08-2021	2
Appendix S. Safety Protocol_v1_8Oct2021	Oct-08-2021	1
Appendix L. ICF - Follow up Interview - Phone Script_v2_8Oct2021_CLEAN	Oct-08-2021	2

The following documents have been acknowledged:

Document Name	Document Date	Document Version
Sim_2021_tcps2_core_certificate	Aug-27-2021	1
Hamilton Community Foundation CHERF_Sim2021_Budget	Aug-27-2021	1

In light of the current COVID-19 pandemic, while HiREB has reviewed and approved this application, the research must be conducted in accordance with institutional and/or public health requirements.

Please Note: All consent forms and recruitment materials used in this study must be copies of the above referenced documents.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of the HiREB meeting on September 21, 2021. Continuation beyond that date will require further review and renewal of HiREB approval. Any changes or revisions to the original submission must be submitted on a HiREB amendment form for review and approval by the Hamilton Integrated Research Ethics Board.

PLEASE QUOTE THE ABOVE REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Sincerely,

Dr. Mark Inman, MD, PhD

Chair, Hamilton Integrated Research Ethics Board

The Hamilton Integrated Research Ethics Board (HiREB) represents the institutions of Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, Research St. Joseph's-Hamilton, the Faculty of Health Sciences at McMaster University, and Niagara Health and operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practice Guideline (ICH GCP); Part C Division 5 of the Food and Drug Regulations of Health Canada, Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations. For studies conducted at St. Joseph's Healthcare Hamilton, HiREB complies with the Health Ethics Guide of the Catholic Alliance of Canada.

Appendix B: Key Informant Recruitment Email

KEY INFORMANT EMAIL RECRUITMENT SCRIPT

Dear ____________,

I am writing on behalf of Drs. Amanda Sim and Kathy Georgiades at The Offord Centre for Child Studies at McMaster University to invite you to participate in a research study, "Thriving Together: Assessing the Mental Health Needs of Newcomer Children and their Families." This study is being conducted in collaboration with organizations serving newcomer children and families in Hamilton. The purpose of the study is to assess the mental health and well-being of newcomer children and their families in order to inform the development of strategies and interventions for mental health promotion and prevention. You are being invited to participate because of your experience and knowledge of the mental health and well-being of newcomer children and their families in Hamilton.

Participation in the study is completely voluntary and your responses will be kept confidential. If you decide to participate in this study, we will ask you to take part in a one-hour interview on Zoom. We will ask you to describe your organization and role in relation to newcomer children and families, as well as your perceptions of their mental health needs and preferences for support. Attached to this email is a Study Information Sheet and Consent Form that provides more detailed information about the study. This study has been reviewed by the Hamilton Integrated Research Ethics Board, REB # 14005.

If you would like to take part, please review and sign (by typing your name) the attached consent form and return it to this email along with 3 available dates and times for us to schedule an interview. Please also feel free to suggest a colleague to invite to the interview if you are unable to take part.

We hope that you will consider sharing your knowledge and expertise with us in order to help improve programs and services for newcomer children and families in Hamilton. If you have any questions about the study, please contact Dr. Amanda Sim at siml3@mcmaster.ca.

Thank you very much for your consideration.

Best regards,
Drs Amanda Sim and Kathy Georgiades
Department of Psychiatry and Behavioural Neurosciences
The Offord Center for Child Studies
McMaster University

Appendix C: Thriving Together Research Study-Key Informant Consent Form

STUDY INFORMATION SHEET AND CONSENT FORM

Title of Study: Thriving Together: Assessing the Mental Health Needs of Newcomer Children and their Families

Locally Responsible Investigator and Principal Investigator: Drs. Amanda Sim & Katholiki Georgiades, The Offord Centre for Child Studies, McMaster University

Funding Source: Hamilton Community Foundation

WHAT IS THE PURPOSE OF THIS STUDY?
You are being invited to participate in a research study conducted by Drs. Amanda Sim and Kathy Georgiades, in collaboration with organizations serving newcomer children and families in Hamilton. The purpose of the study is to assess the mental health and well-being of newcomer children and their families in order to inform the development of strategies and interventions for mental health promotion and prevention. You are being invited to participate because you have experience and knowledge of the mental health and well-being of newcomer children and their families in Hamilton.

HOW MANY PEOPLE WILL BE IN THIS STUDY?
We will invite 10-15 people with experience and knowledge of the mental health and well-being of newcomer children and their families to participate in this study.

WHAT WILL MY RESPONSIBILITIES BE IF I TAKE PART IN THE STUDY?
If you decide to participate in this study, we will ask you to take part in a one-hour interview on Zoom. We will ask you to describe your organization and role in relation to newcomer children and families, as well as your perceptions of their mental health needs and preferences for support. The interview will be recorded for transcription purposes only.

WHAT ARE THE POSSIBLE RISKS AND BENEFITS?
Participation in the study does not pose any risks. Your participation will help to increase knowledge of the mental health and well-being of newcomer children and their families and contribute to improving programs and services for newcomer children and youth.

WHAT IF I DO NOT WANT TO TAKE PART IN THE STUDY?
Participation is completely voluntary. You can choose not to take part in the study. You may also refuse to answer any questions or withdraw from the study after you have agreed to take part. You have the option of removing your data from the study by contacting Dr. Amanda Sim at siml3@mcmaster.ca.

WHAT INFORMATION WILL BE KEPT PRIVATE?
Your identifiable data will not be shared with anyone except with your consent or as required by law.[1] The recording of your interview will be stored on a McMaster University secure network drive and only accessible to designated research staff. The recording will be destroyed immediately after transcription is completed. All personal information such as your name and organization will be removed from the transcript and replaced with a participant number and pseudonyms. A list linking the number with your name will be kept in a secure place, separate from your data. The data, with identifying information removed, will be stored indefinitely on a secure network drive at McMaster University for research purposes only.

The Hamilton Integrated Research Ethics Board has approved using Zoom for this study. However, we cannot guarantee complete security as Zoom is an externally hosted service. Zoom's security and privacy policies are available here. Please do not make a recording of the interview for your own records to avoid any breaches of confidentiality.

If the results of the study are published, your name will not be used and no information that discloses your identity will be included.

For the purposes of ensuring the proper monitoring of the research study, it is possible that a member of the Hamilton Integrated Research Ethics Board and this institution and affiliated sites may consult your research data for quality assurance purposes. However, no records that identify you by name or initials will be allowed to leave the research office. By signing this consent form, you authorize such access

IF I HAVE ANY QUESTIONS OR PROBLEMS, WHOM CAN I CALL?
If you have any questions about the research now or later, please contact Dr. Amanda Sim at siml3@mcmaster.ca.

CONSENT STATEMENT

Participant:

I have read the preceding information thoroughly. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction. I agree to participate in this study.

Print Name	**Signature**	**Date**

Person obtaining consent:

I have discussed this study in detail with the participant. I believe the participant understands what is involved in this study.

____

Name, Role in Study **Signature Date**

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, Hamilton Integrated Research Ethics Board at 905.521.2100 x 42013.

Appendix D: Key Informant Interview Guide

(Version 4: 3 February 2022)

I. **For administrators, organizational leadership, and policy makers** (e.g. principals, superintendents, directors)

Introduction
Thank you very much for taking the time to speak with me today. I am part of a research team at McMaster University that is conducting a study on the mental health and well-being of Arabic-speaking newcomer children, youth, and their families who have moved to Hamilton in the last 5 years. We are focusing on Arabic-speaking newcomers because of the large numbers of refugees and other newcomers who have resettled to Canada from the Middle East in the last few years. We are conducting this study in partnership with organizations from the health, education, and settlement sectors in Hamilton.
Our discussion today should take no more than an hour. As described in the consent form, I would like to record our discussion to ensure my notes are accurate. Everything you say is confidential and your name or the name of your organization will not be used, unless you give us permission. I will not share the recording with anyone outside the research team and the recording will be deleted once we have transcribed the notes. If you want to skip any questions or stop at any point, please feel free to let me know at any time.
Do you have any questions?
I will begin the recording now. [PRESS RECORD]

Note to interviewer: Throughout the interview, probe for (1) how much responses are specific to Arabic-speaking newcomers versus relevant to all newcomers; and (2) how much responses are specific to challenges in the child and youth mental health care system in general versus specific to newcomer children and families.
Page Break
A. Background

1. Could you please begin by telling me about your current role and responsibilities?
2. What programs or services does your organization provide to Arabic-speaking refugee and newcomer children and families?

a. Are any of these programs or services related to mental health and well-being? (**If so, get a detailed description)**
- What do these programs or services involve/include?
- How do they address issues related to mental health and well-being?
- Who is the target population (e.g. parents, children, adolescents, refugees)?
- How do clients/individuals/families access these services (e.g. referral through schools, etc.)
- Who delivers these programs/services?

- What has been working well?
- What have been some challenges or gaps?

B. Mental health service mapping and assessment

3. Now I'd like to ask you about other available mental health and well-being supports for Arabic-speaking newcomer children and families in Hamilton. By mental health and well-being supports, I'm referring to both formal and informal supports as well as mental health promotion, prevention and treatment.

a. In general, how well are existing supports and services meeting the mental health needs of Arabic-speaking refugee and newcomer children and families in Hamilton?
b. Where are there gaps?
c. Are there new or different types of programs or services that are needed to meet the unique mental health needs of this population?

4. How has the COVID-19 pandemic affected the ability of service providers to support the mental health and well-being of this population?

C. Barriers and facilitators to access and effectiveness

5. What do you think are the main barriers to Arabic-speaking refugee/newcomer children and families accessing existing mental health support?
   a. What do you think would help to improve access?

6. What do you think are the main barriers to effectiveness of existing mental health support for this population?
   a. What do you think would help to improve effectiveness?

7. How does your organization/office/team define and measure the impact of your work on newcomer mental health and well-being?

Example probes:

a. What monitoring and evaluation systems are in place? How well/not well are they working?
b. How are social or cultural factors considered in measuring impact?

D. Coordination and representation

8. How well (or not) do the different partnerships, networks, and coordination mechanisms in Hamilton prioritize and support the mental health and well-being of newcomer children and families?

Example probes:

a. How do the various organizations, programs and services coordinate or work together?
b. What challenges have come up in working with different partners, organizations and services?
c. What suggestions do you have for addressing these challenges?

9. How are the voices and perspectives of Arabic-speaking refugees and newcomers represented and considered in work to support their mental health and well-being?

D. Reflection and support

10. What do you think should be key principles or values guiding mental health and well-being support to newcomer children and families?

11. What kind of support (e.g. training, tools, funding) would be most helpful to you and other organizations for facilitating your work with Arabic-speaking newcomer children and families?

E. **Demographics and Closing**

Thank you very much for sharing your experience and insights with me today. Your feedback has been extremely valuable.

12. Before we end, I'd like to ask you for some basic demographic information if that's ok. Feel free to let me know if you prefer not to answer.

a. What gender do you identify with?
b. What racial or ethnic group do you identify with?
c. Were you born in Canada?
d. How many years of experience do you have working with newcomers to Canada (or on issues related to newcomers)?
e. What is your current title/position? (if not already stated before)

Is there anything else you'd like to share or do you have any questions for me?

We would like to learn from other organizations as well as from staff who work directly with refugee and newcomer children and families. Is it ok if I follow up with you in an email to ask for suggestions for other organizations or colleagues we could speak with?
Thank you very much! [END INTERVIEW]

Appendix E: Key Informant Interview Guide

(Version 4: 3 February 2022)

II. **For service providers with direct experience working with refugee and other newcomer children, youth and families** (e.g. educators, social workers, counselors, psychologists, nurses, settlement support workers)

Thank you very much for taking the time to speak with me today. I am part of a research team at McMaster University that is conducting a study on the mental health and well-being of Arabic-speaking newcomer children, youth, and their families who have moved to Hamilton in the last 5 years. We are focusing on Arabic-speaking newcomers because of the large numbers of refugees and other newcomers who have resettled to Canada from the Middle East in the last few years. We are conducting this study in partnership with organizations from the health, education, and settlement sectors in Hamilton.
Our discussion today should take no more than an hour. As described in the consent form, I would like to record our discussion to ensure my notes are accurate. Everything you say is confidential and your name or the name of your organization will not be used, unless you give us permission. I will not share the recording with anyone outside the research team and the recording will be deleted once we have transcribed the notes. If you want to skip any questions or stop at any point, please feel free to let me know at any time.
Do you have any questions?
I will begin the recording now. [PRESS RECORD]

Note to interviewer: Throughout the interview, probe for (1) how much responses are specific to Arabic-speaking newcomers versus relevant to all newcomers; and (2) how much responses are specific to challenges in the child and youth mental health care system in general versus specific to newcomer children and families.

A. **Background**

1. Can you please tell me about your current role and responsibilities, including any specific experience you have working with Arabic-speaking refugee and newcomer children and families?
    a. In your role, what work do you do specifically around the mental health and well-being of this population?

Probing questions:

- What programs or services do you provide around mental health and well-being?
- Who do you provide these programs/services to (e.g. parents, children, adolescents)?
- How do clients/individuals/families access these services (e.g. referral through schools, etc.)

- Who delivers these programs/services? (e.g. social workers, psychologists, other)
- What has been working well?
- What have been some challenges or gaps?

B. **Refugee/newcomer child and adolescent mental health**

3. What are common mental health issues or difficulties you have observed or encountered in your work with Arabic-speaking newcomer children and adolescents?

Example probes:

a. How are these mental health issues identified?
b. How do the newcomer children and adolescents you've worked with describe or explain their mental health difficulties?
c. What are common symptoms or behaviors you've observed?

4. In your experience working with this population, what causes these mental health difficulties?

Example probes:

a. What makes some refugee/newcomer children and adolescents more at risk than others?

5. How do the refugee/newcomer children and adolescents you have worked with typically deal with their mental health issues?

Example probes:

a. Who do they turn to for help?
b. What are resources or strategies that they use to cope?
c. What prevents/protects them from developing or experiencing mental health difficulties?

6. What have been the impacts of the COVID-19 pandemic on the mental health and well-being of refugee and newcomer children and families?

a. How has the pandemic affected your capacity to support the mental health and well-being of refugee/newcomer children and families?

C. **Family engagement**

7. What has been your experience engaging with Arabic-speaking parents around their children's mental health and well-being?

Example probes:

a. What does mental health and well-being mean to them?
b. Who do they typically turn to for help?
c. What resources or strategies do they use to support their children's mental health?
d. What are successful strategies you have used to engage refugee/newcomer parents around their children's mental health and well-being?
e. What challenges have you experienced in engaging parents?

8. What help do Arabic-speaking refugee/newcomer parents need/want to better support the mental health and well-being of their children?

D. **Mental health services**

17. In general, how well are existing supports and services meeting the mental health needs of Arabic-speaking refugee and newcomer children and families in Hamilton?

a. Where are there gaps?

b. Are there new or different types of programs or services that are needed to meet the unique needs of this population?

18. What do you think are the main barriers to refugee/newcomer children and families accessing existing mental health support?

a. (If not mentioned before) What are challenges with identifying refugee/newcomer children with mental health needs?
b. What do you think would help to improve access?

19. What do you think are the main barriers to effectiveness of existing mental health support for this population?

a. What do you think would help to improve effectiveness?

20. How do you define and measure the impact or effectiveness of the services you provide?

a. What monitoring and evaluation systems are in place? How well/not well are they working? (if there's time, probe about involvement of children/families in this process and consideration of social/cultural factors)

21. **Reflection and support**

22. What do you think should be key principles or values guiding mental health and well-being support to newcomer children and families?

23. What kind of support (e.g. training, tools, more staff) would be most helpful for facilitating your work with Arabic-speaking newcomer children and families?

24. **Demographics & Closing**

Thank you very much for sharing your experience and insights with me today. Your feedback has been extremely valuable.

25. Before we end, I'd like to ask you for some basic demographic information if that's ok. Feel free to let me know if you prefer not to answer.

   a. What gender do you identify with?
   b. What racial or ethnic group do you identify with?
   c. Were you born in Canada?
   d. How many years of experience do you have working with newcomers to Canada (or on issues related to newcomers)?
   e. What is your current title/position? (if not already stated before)

Is there anything else you'd like to share or do you have any questions for me?

We would like to learn from other organizations as well as from staff who work directly with refugee and newcomer children and families. Is it ok if I follow up with you in an email to ask for suggestions for other organizations or colleagues we could speak with?

Thank you very much! [END INTERVIEW]