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Abstract

Despite an extensive history with immigration, structural barriers and health inequities for immigrant and refugee populations continue to be widely documented within Canada. As a result, attention to particularly vulnerable subgroups such as newcomer children has become increasingly paramount. However, large gaps concerning newcomer children's wellbeing persist within previous literature. In response, this study examines newcomer children's issues, the roles of family and community support systems, and the impact of sociopolitical factors from the perspective of key stakeholders. A total of 15 newcomer parents and community professionals were interviewed in order to illuminate the current context of support for immigrant and refugee children living in the Waterloo Region.

Throughout stakeholder discourse, large, structural factors such as neoliberalism were documented as having a strong impact on the lived experience of newcomer parents, children, and community organizations. Newcomer children were established as an invisible population whose needs were largely overlooked on account of a preoccupation with adult concerns and the expectation of childhood resiliency. Lastly, a paradox regarding newcomer parenthood was documented, in which newcomer adults were simultaneously responsibilized for the care of their children and faced with structural barriers that restrict their parenting capabilities. Overall, this study demonstrates the importance of the critical, multi-level analysis of newcomer children's support systems, with particular attention to the diverse perspectives of key stakeholders.

Exploring Diverse Perspectives on the Mental Health & Community Support Systems for

Immigrant and Refugee Children

INTRODUCTION

In recent years within both Canada and the international community, mental health, immigration, and child development have each been the subject of exponential attention, research, and policy formation. These three major trends overlap within the area of immigrant and refugee children's mental health. Despite its significance, this zone is only in the beginning stages of comprehension. In response, this project will examine the community services and familial support available for young immigrant populations from the perspectives of key stakeholders.

Large-scale immigration is a central policy strategy within Canada; it has been heralded as the catalyst for continued population growth and economic stimulus within globalizing markets (Reitz, 2013). These contributions have shaped Canada as a 'nation of immigrants' in which migration has become a key element of nation-building and social transformation (Simmons, 2010). In addition to economic-driven immigration, humanitarianism has played an important role within Canadian political affairs; the nation has received international praise for its provision of asylum to a diverse array of refugees (Beiser, 2009). Throughout this research, the term 'newcomers' will be used to jointly represent immigrants and refugees, indicating any individual or family that has moved to Canada from another country within recent generations. Overall, as they constitute an increasingly large proportion of newcomers, children (age 0 to 18) play a particularly important role in what Simmons (2010) calls the 'imagined futures' of Canada. However, many researchers are wary that without reliable support systems to complement admission rates, Canada's immigration system is not practical and supplies newcomers with "little more than an idealized myth" (Hennebry & Preibisch, 2012).

In response to the apparent incongruity between the ideal and reality of experiences with arrival in a Canadian context, researchers have begun to examine the impact of immigration and settlement on mental wellbeing (see Hansson et al., 2010). Such attention is aligned with the growing rate of Canadian research and policy development on mental health in general, which has only recently begun to look at diverse populations like immigrants and refugees; even fewer projects have examined the mental wellbeing of subgroups such as children. Within this paper, the WHO (2007) definition of mental health will be applied. This interpretation views mental health as not only the absence of mental illness, but a state of wellbeing in which individuals can cope with stress, contribute to their community, and realize their full potential. Understanding and responding to these elements of mental health is an essential prerequisite to the realization of immigration ideals. Without addressing the health disparities that exist across demographics, at-risk populations like newcomer children will continue to face disadvantageous circumstances. All immigrants and refugees must receive unconditional support to ensure universal success, health, and opportunity.

Canadian policy has also increasingly recognized the importance of healthy child development. However, this investment must be extended to immigrant and refugee children, whom are particularly vulnerable on account of the compounding challenges of psychosocial development, settlement, and cultural integration. Shaping the future of globalization and transnationalism within Canada, first and second-generation children constitute an important ingredient to the success of our nation and deserve the provision of sufficient support. However, current political-economic agendas display an illogical and negative correlation, as immigration rates remain high while support services continue to decline; this creates extensive barriers to positive wellbeing for both immigrants and refugees within Canada. Ultimately, national prosperity and growth depends largely on the successful integration of newcomers and their children, but "rarely has so much return been

expected from so little investment" (Beiser, 2005, p. S5).

Profile of the Waterloo Region

Waterloo Region is currently one of the top 7 communities in Canada for resettlement, with immigrant and refugee citizens comprising 23 percent of the population (Immigration Partnership, 2014). Within the next 15 years, this figure is expected to continue to rise to an estimated 30 percent with a large proportion being children (Ibid). Preliminary evidence gathered in local focus groups has indicated the need for increased access to services and mental health support for newcomer children (Immigration Partnership, 2010). Despite such concerns, Waterloo Region has overlooked immigrant and refugee children as important priorities in the past. Previous research by Hoy and Ikavalko (2005) revealed that few programs in the Waterloo Region were geared towards newcomer children. Similarly in 2001, Janzen and his colleagues reported on the struggles newcomer parents experience while searching for support in the Waterloo Region. This study looked to update and expand upon the preceding research to understand different perspectives on the current needs, challenges, and avenues for support that exist in relation to newcomer children's wellbeing.

Central Research Questions

In the new Canadian Mental Health Strategy, Bartram et al. (2012) pose an important question for future research: "What are the best ways to organize services and resources so that they support people of all ages and backgrounds on their journey toward recovery and well-being?" (p. 116). With this question in mind, this research aimed to explore, from the perspectives of diverse stakeholders, the current state of mental health needs and the level of support available to young immigrant and refugee individuals. In the current study, the term 'stakeholders' will be used to represent the parents and community professionals interviewed, who are both highly invested in the wellbeing of newcomer children.

Overall, this project examined the experiences and perspectives of two very different informants: parents and community professionals. Specifically it developed a comparative case study of these stakeholders within a popular region for resettlement, Waterloo, Ontario, Canada. The following questions guided analysis: What do community professionals and parents view as the primary mental health needs of immigrant and refugee children? What tasks are both parents and community organizations considered responsible for in the procurement of children's wellbeing? Do both stakeholder groups desire the same level and types of support services for children? What successes and challenges do different stakeholders highlight within community service provision? How are the experiences and support of this population affected by the current sociopolitical context? Similarities and differences both *within* and *between* the informant categories of parents and professionals were compared and contrasted in order to shed light on the current system of support for newcomer children. By drawing on two very different types of experiences within children's support systems, this research worked to expose the presence of different social, political, and cultural ideologies, highlight their impact on vulnerable populations, and act as a catalyst for future research ventures and policy development.

Several prominent researchers have documented a wide gap in the literature on immigrant and refugee children and their support services (Beiser et al., 2005; Anisef & Kilbride, 2000; Shakya et al., 2010). Corroborating this paucity in research, Hansson et al. (2010) classified the investigation of mental health supports for immigrant children as an urgent need across Canada. In response, recent research on this topic has been expanding. However, such studies have been superficial as they tend to overlook younger children (0-12), rarely include the perspectives of parents or family members, and entirely omit a critical analysis of the findings derived from various informants and the influence of sociopolitical systems. Such an approach allows the literature to

report on uniform needs and recommendations without investigating the nuances of different ideas, experiences, and levels of power occupied by diverse stakeholder groups. This has relegated an overwhelming number of studies to what Raphael (2009) calls the 'phantom zone of irrelevance' that currently divorces research from the enhancement of social policies and lived realities.

Thus, by focusing on the different positions of parents and professionals, this research problematized the dominant conceptualizations of newcomer children's wellbeing and questioned the assumptions of homogeneity that permeate the literature. Insight into the way that various parties construct newcomer children's mental health and their lived experiences can critically inform the body of research on the strengths, risks, and functionality of the support systems for this particularly vulnerable population. In order to achieve a holistic analysis, the perspectives of key stakeholders have been analyzed within the framework of Bronfrenbrenner's (1979) ecological paradigm, which postulates that micro (individual), meso (family and community), and macro (societal) level factors will intersect to influence human development. Consequently, this research examined how pronounced factors within each ecological sphere were perceived by stakeholders as shaping the wellbeing of young populations, the position of their families, the state of community services, and the complicated interface between them all.

LITERATURE REVIEW

In order to provide a background for the analysis of immigrant and refugee children's wellbeing and support systems within the Waterloo Region, an extensive literature review was completed of local, national, and international studies. The following sections explore the past research that has been conducted on the various factors impacting newcomer children's health, the role of support from parents and the community, the current status of services and resources within Canada, and the sociopolitical context molding migration and service provision.

Micro-level Factors: The Health of Immigrant and Refugee Children

Countless sources reinforce the notion that healthy childhood development is an important prerequisite and determinant of lifelong health (Raphael & Bryant, 2006; Irwin et al., 2007). Despite such knowledge, children fare worse in Canada in comparison to many other developed nations (Raphael, 2014). By occupying two vulnerable subgroups – newcomers and children – the risk factors involved are twofold for young immigrants and refugees (Beiser & Stewart, 2005). Mental health issues can further exacerbate this state of vulnerability and create a form of 'triple disadvantage' or 'triple segregation' (Rong & Brown, 2002). Overall, in addition to the standard developmental transitions experienced by all children, newcomer children face settlement related stressors and challenges (Chuang, 2010; Shakya et al., 2010). Consequently, this demographic faces compounded obstacles to positive mental wellbeing.

The Healthy Immigrant Effect

Several studies have documented the *healthy immigrant effect* within newcomer populations throughout Canada, noting lower levels of both behavioural and emotional problems in comparison to native-born children upon arrival (Ma, 2002; Beiser et al., 2002). However, this 'health advantage' has not been unequivocally confirmed; both higher and lower qualities of mental health have been found across smaller scale studies (Lustig et al., 2004; Cole, 1998). Furthermore, ample evidence exists for the *transitional effect* or decline of children's health over time due to detrimental post-migration circumstances (Alati et al., 2003; Seat, 2000). The *migration-morbidity hypothesis* is also cited in the literature as a potential explanation for studies that have found poorer mental and physical health in newcomer populations (Alati et al., 2003). It is notable that the majority of the data cited for the *healthy immigrant effect* in young populations was derived from the National Longitudinal Survey of Children and Youth, which

has been criticized by Beiser et al. (2005) for its small, unrepresentative newcomer sample. Therefore, although select studies indicate superior health levels for newcomers, Beiser et al. (2005) warn that complacency is not justified and at-risk individuals must not be overlooked.

Specific Mental Health Concerns of Immigrant and Refugee Children

An extensive review of the literature has revealed that the majority of research on newcomer mental health, settlement, and integration challenges have focused on adult populations. As a result, the research that directly addresses young first and second-generation children (0-12 years) is extremely limited, and only slightly higher for adolescents (12-18 years). The research that does exist appears to focus on the implications of specific psychosocial determinants of health. All of these factors have been documented as leading contributors to the development of mental health concerns such as depression, anxiety, low self-esteem, stress, identity confusion, and poor settlement and integration (Ngo, 2005; Shakya et al., 2010).

Financial Insecurity and Poverty

Poverty is a well-established risk factor for newcomer children's poor mental health (Beiser, 2014; Anisef, 2005). Currently, approximately 33 percent of new immigrants live beneath the low-income cut off rate within Waterloo (Waterloo Region, 2011); this rate also reflects national trends in which a third of immigrant families live in poverty (Beiser, 2014). Such economic instability threatens the healthy development of children, putting them at higher risk for mental health problems, school dropouts, developmental challenges, and poor wellbeing that extends into adulthood (Waterloo Region, 2011). Overall, the likelihood of living in poverty is heightened for newcomer children, which can lead to poor settlement, adjustment, and overall declined wellbeing.

Language Barriers

Language proficiency is a central component to integrating within a new country. Although children are on average able to learn a new language faster than their adult counterparts (Suárez-Orozco & Suárez-Orozco, 2001), poor ability to communicate in the receiving-society nevertheless jeopardizes children's mental health (Beiser, 2010, 2011). Across studies participants reported feeling fear, confusion, withdrawal, guilt, isolation, and marginalization due to poor communication skills (Seat, 2000; Anisef, 2005). Consistently, language barriers have been ranked as one of the top challenges for newcomer children living in Canada (Chuang, 2009, 2010; Janzen & Ochocka, 2003; Shakya et al., 2010).

Discrimination

The ethnic and racial backgrounds of Canadian newcomers are becoming increasingly diverse (Stats Canada, 2011). National statistics suggest that these newcomers are frequent targets of racism, with 34% of racialized immigrants and a startling 42.2% of their children having experienced discrimination (Statistics Canada, 2003; Reitz & Banerjee, 2007). Such encounters negatively impact newcomer families' life satisfaction and sense of belonging within Canada (Ibid; Khanlou et al., 2009), while also contributing to elevated rates of stress, depression, low self-esteem, and behavioural problems (Shakya et al., 2010). All of these effects have been demonstrably greater in children, in particularly those that are second generation; the phenomenon of weakened integration across subsequent generations of immigrants is known as the 'immigrant paradox' (Berry et al., 2006) and is closely tied to heightened experiences of discrimination and racism (Hall & Carter, 2006).

Cultural Identity

Berry et al. (2006) demonstrate that healthy identity development typically involves the

retention of cultural identities alongside acculturation within the new society. However, such

negotiations often leave youth feeling "caught between two cultures" (Khanlou et al., 2009,

p.17). Feeling divided between their new and home cultures results in many immigrant children

living 'double lives', which negatively impedes positive identity formation and mental health

(Ochocka et al., 2006). Additionally, some first generation children may experience a

combination of culture shock and 'cultural bereavement' after relocating (Lustig et al., 2004),

which involves sentiments of discomfort, anxiety, and isolation (Ngo 2005).

Social Networks and Support

Social isolation is a common issue for young newcomers. In fact, Banerjee and Reitz

(2007) reported that second generation children have the very lowest levels of social integration,

and high levels of exclusion and alienation. The literature shows that both mental and physical

health problems are more probable within children who are less socially integrated. Hyman et al.

(1996) discussed the high levels of depression that result from newcomer children's weak

community involvement. This lack of social support is also correlated with difficulties forming

new friendships and limited access to positive mentors and role models (Ngo, 2009).

Age at Migration

Age during arrival influences the settlement and adaptation process, and then

subsequently shapes mental wellbeing (Seat, 2000; Hurlock et al., 2004). In recent research,

Beiser (2014) discovered an inverse relationship between age at arrival and mental health risk.

Accordingly, immigrating as a young child is typically associated with more successful

integration and the development of stronger Canadian identities; being below age 10 was found

to be the critical cut-off point for easier integration (Beiser et al., 2005). Researchers have also

documented high levels of mental health issues within adolescent newcomers; the Canadian

Mental Health Association (2003) reports that newcomer youth are twice as likely to experience depression in comparison to individuals over age thirty-five. Conversely, very young children have their own propensities towards social difficulties, as they tend to adopt majority cultural values quicker which can lead to higher levels of intergenerational conflict with parents and elders (Beiser et al., 2005).

<u>Refugee Status</u>

Although economic and family class immigrants share many similar experiences with refugees during the resettlement process, it is worth highlighting the differences that have been observed in mental health. In general, refugees are more commonly exposed to detrimental circumstances within the three stages of migration (Lustig et al., 2004). The pre-flight stage can often include social upheaval, natural disasters, war, torture, or loss of loved ones. The flight stage represents a period of displacement and often involves family separation. Finally, the resettlement stage involves the balancing of two cultures and often a lack of social support. All of these factors impede the development of positive mental health and increase the risk of post-traumatic stress disorder, depression, anxiety, anger, and psychosomatic symptoms, particularly for children (Hyman et al., 1996; Pfarrwaller & Suris, 2012). Therefore, refugee children tend to be at an even greater risk for mental health issues than both immigrants (Hyman, 2001) and the general population (Pfarrwaller & Suris, 2012; Seat, 2000).

Meso-Level Factors: The Role of Family and Community Services

The paramount role of supportive environments in facilitating settlement, integration, and wellbeing of children is frequently emphasized (Raphael, 2006). In fact, both formal and informal support systems are labeled as crucial determinants of population health (Ibid; Fantino & Colak, 2001), as individuals with supportive families and communities have been found to be

particularly resistant to mental illness and maladaptation (Beiser, 2009). Ma (2002) demonstrates

that the social climate and available resources are *exceptionally* important for the wellbeing of

newcomers, whereas individual characteristics were more predictive of non-immigrant health.

Consequently, the following section looks at the 'meso' level, which concerns the role of family

and community support systems.

Support from Parents and Extended Family

Across all cultures parent and family wellbeing have been acknowledged as important

determinants of children's mental health (Beiser et al., 2014; Ma, 2002; Hoy & Ikavalko, 2005).

Essentially, parents are key agents for the socialization of young newcomers, which places them

in the prime position to raise successful and 'resilient' children (Kilbride &Anisef, 2001).

Supportive parenting, family stability, and economic security are all strong sources of protection

for children as they deal with settlement and acculturation stressors (Sabatier & Berry, 2008).

However, the task of managing personal mental health and social issues can compromise

parents' caregiving abilities (Janzen & Ochocka, 2003). Beiser et al. (2002) has linked the high

rates of economic disadvantage within newcomer families with several determinants of

children's mental health, including ineffective parenting and intrafamilial hostility. Furthermore,

rather than prioritizing children's mental health, families burdened by financial insecurity are

preoccupied with meeting basic needs first (Ellis et al., 2011). Familial stressors can also be

exacerbated by 'asymmetric acculturation', in which children adapt much faster than their elders

(Stevens & Vollebergh, 2008). This can cause 'role reversal' in which children act as the cultural

brokers responsible for their family's navigation of society (Janzen & Ochocka, 2003). These

processes can place tremendous stress and confusion on children and undermine their parents'

authority (Khanlou et al., 2009). Many families also undergo periods of separation during

immigration. As a result, 'astronaut parents' and 'satellite kids' are now commonplace occurrences (Ali et al., 2012). Such instability has been associated with deleterious effects on children's wellbeing (Beiser et al., 2014; Suarez-Orozoco et al., 2010).

Types of Community Organizations and Resources

In addition to family systems, community services provide essential tools to guide the adaptation and integration of newcomer families (Ansief & Kilbride, 2000). Within various studies, both immigrants themselves (Beiser 2009; Hansson et al., 2010) and community professionals (Anisef & Kilbride, 2000; Anisef, 2005) have identified mental health services as a primary need. In the Waterloo Region, both Ochocka et al. (2006) and the Immigrant Partnership (2010) have identified the improvement of services for newcomers as local priorities.

A diverse array of service providers have been identified in past studies, including youth centers (Khanlou et al., 2009), school-based supports (Shakya et al., 2010), formal settlement and mental health services (Ibid), recreational and cultural activities (Beiser, 1988), ethno-cultural communities (Xu & McDonald, 2010), and religious institutions (Khanlou et al., 2009). Informants throughout all studies identified the positive role that these organizations can have in resettlement. Unfortunately, resources that can help to build resiliencies and improve newcomer communities have been largely undervalued and underutilized (Hansson et al., 2010).

Perspectives of Community Professionals and Parents

As important contributors to the wellbeing of newcomer children, families, and communities alike, community professionals have been recognized as key stakeholders in research on immigrants and refugees. Across many studies, professionals have been utilized as participants within interviews, focus groups, and steering committees (see Chuang, 2009; Ngo, 2004; Hansson et al., 2010; Simich et al., 2005; Steele et al., 2002; Ansief & Kilbride, 2000).

Researchers have recognized the invaluable insight that is obtained from the unique vantage point of professional staff (Chuang, 2009). For instance, Burstein (2010) highlights how the inclusion of professionals is especially needed for the subsequent creation, implementation, and dissemination of best practices and recommendations that will improve support services.

However, the vital contributions of affected individuals with lived experience cannot be overlooked. Children themselves typically lack power in society and are dependent upon adult populations to recognize their needs and ensure their care, protection, and healthy development (Sadoway, 2002). Therefore, in the investigation of matters related to children, parents are often cited as valuable informants (see Child and Youth Advisory Committee, 2010; Janzen et al., 2001; Anisef & Kilbride, 2000). Throughout the literature, many researchers recognize that the contributions of both family and community stakeholders are essential for holistically understanding and supporting the wellbeing of immigrant and refugee children.

Social Support and Social Capital

A central component of both community services and parenting is the establishment of social support and social capital for children. Both are seen as vital to maintaining health and wellbeing (Simich et al., 2005). Anisef (2005) defines social capital as the "networks of social relations that provide access to needed resources and support" (p.4), which is comprised of two distinct forms. The first is 'bonding' which refers to developing relations within families and members of similar ethnic groups (Ibid). As the primary caregivers for their families, parents are the most attuned to their children's needs and play a key role in the development of 'bonding' within families and communities. Alternatively community organizations tend to promote 'bridging', which involves deepening connections between different ethnic groups, including relations between newcomers and the host population (Anisef, 2005; Burstein & Esses, 2012).

By maintaining connections with both family and the wider community, children are able to build networks that foster informational, instrumental, and emotional support (Simich et al., 2005). The facilitative role of support systems is especially important within vulnerable and often isolated populations, such as newcomer children and their families (Khanlou, 2009).

Societal Benefit

Investing in these types of community resources and family relationships is also seen as financially beneficial for society as a whole. Countless researchers underline the importance of prevention and intervention within vulnerable populations. A report by the Child and Youth Advisory Committee (2010) estimates that for every dollar spent on childhood interventions, eight dollars are saved. Essentially, by using services to promote wellbeing early in life, the need for more costly, remedial support later on is reduced (Bartram et al., 2012; Ministry of Children and Youth Services, 2006). The human capital of newcomer children and their families can be activated by quality, accessible services (Beiser, 2010); however, without proper support, society may face the "life-long underutilization of [the] human potential" of newcomers (Ngo, 2009).

Current State of Services

Within the new Canadian Mental Health Strategy, Bartram et al. (2012) argue that our system of care is far from where it needs to be as particular demographics, such as newcomers and children, are currently neglected. The lack of attention, research, and services for newcomer mental health has been recognized within both pan-Canada (Hansson et al., 2010; Khanlou et al., 2009) and Waterloo specific studies (Janzen & Ochocka, 2003; Immigration Partnership, 2014). Overall, newcomer children have been sidelined and marginalized within social service settings (Ngo, 2009). Academics view these children as a 'forgotten population' (Tremblay, 2012) who consistently fall through the cracks that exist within the mental health and settlement systems.

Quantity and Quality of Services

Research uniformly documents the lack of services available for newcomer children across Canada (Shakya et al., 2010; Anisef & Kilbride, 2000; Chuang, 2009). While parental and community-based demands for services and support increase, resources remain scarce (Ochocka et al., 2006). Consequently the settlement and mental health infrastructures are overloaded, and effective service provision is compromised (Omidvar & Richmond, 2003). A lack of continuity of support is also an issue; without available resources, short-term programs that focus on the early stages of settlement are favored over long-term, multi-dimensional ones (Ngo, 2005). Ultimately, Simich et al. (2005) demonstrates how the current status of social services for immigrants reflects Hart's (1971) 'Inverse Care Law', as a counterintuitive and inverse relationship exists between the availability of care and its need within such demographics.

Information and Access Barriers

Previous research has acknowledged the existence of three major barriers to service utilization. They are lack of preparation, deficient knowledge on systems, and the inability to access appropriate services (Khanlou et al., 2009; Ngo, 2009; Lai & Hynie, 2010). Such obstacles arise through the conjunction of deficiencies in support both pre and post-migration. Before immigrating a general lack of knowledge on the issues faced by individuals in the new country exists; as a result expectations are not realistic, and newcomers are not be prepared for social, mental, and economic difficulties (Janzen et al., 2001). Secondly, many newcomers in past research have reportedly received insufficient information on the services available in their new community, which may lead to difficulties navigating unknown health systems (Ngo, 2005; Simich et al., 2005). Lastly, the programs that are newly *available* may still be inaccessible because they are not *appropriate* or *acceptable* for diverse clientele (Chen, 2010). Community

organizations have often lacked cultural sensitivity practices, such as having diverse languages, staff, and education on various cultural beliefs (Nadeau, 2005; Omidvar & Richmond, 2003). Research emphasizes that barriers to access can be even further pronounced for certain sub-populations such as those living in poverty or coming as a refugee (Hansson et al., 2010).

Coordination and Funding Barriers

Effective coordination and efficient funding of programs are particularly important within service provision for vulnerable demographics, and yet both elements have been projected as extremely deficient within services for newcomer children (Kilbride & Anisef, 2001). In such scenarios, resources are often wasted and holistic support systems are rare (Ngo, 2005). Researchers have reported that a lack of collaboration and coordination within the support systems for newcomer children may exist at 3 distinct levels. First, many regional reports have observed disconnections both *within* and *between* settlement services and mainstream health organizations (Ngo, 2009). Secondly, on a policy level, knowledge of services appears to be highly compartmentalized within government municipalities and ministries, which can result in a certain 'governance limbo' that lacks clarity on roles and responsibilities (Mwarigha, 2003; Burstein, 2010). Finally, Ngo (2009) criticizes the development of many past programs and services for overlooking the direct input of children and families (Ngo, 2009). Combined with competition for low, haphazard funding, services often develop into an ad hoc, incoherent, and highly uncoordinated system (Kirby & Keon, 2006).

Underutilization of Services

As evidenced above, extensive access barriers have been documented in previous research. These challenges are constructed by researchers as rarely occurring in isolation, but rather jointly manufacturing the low rate of service utilization (see Shakya et al., 2010; Nadeau

& Measham, 2005). One report estimated that 92 percent of immigrant and refugees in need of mental health and integration support never obtain any (Ellis et al., 2011). Beiser (1988) perceived the low rate of support available as placing vulnerable children in a state of 'double jeopardy'. Such underutilization is seen as not only affecting individual health but also becoming costly to the health care system (Kirby & Keon, 2006). Updated studies are required to investigate the validity of these claims within local contexts (Hansson et al., 2010).

Macro-Level Factors: Context of Service Provision

Research shows the strong influence that social, political, cultural, and economic environments have on the healthy development of diverse populations. National ideologies and systems also shape the procedures of non-profit organizations and public policies (Raphael 2009). Therefore, 'macrospheres' (Bronfenbrenner, 1979), such as neoliberalism and biomedicalization, may play a prominent role in the fields of mental health and immigration.

Neoliberalism

In the past few decades, the ideologies and policies of neoliberalism have played an increasingly important role within Canada. Ayo (2012) notes the complex nature of neoliberalism, which is defined as both a political and economic approach that favors free markets over government intervention, as well as a social and moral philosophy that diverts power and support away from vulnerable populations and sustains social inequality. In essence, neoliberalism is theorized as an "economic, political and moral doctrine that posits the individual [as opposed to the government] as the fundamental basis of society'' (Gill, 2000, p. 3).

As a result of neoliberal restructuring away from government responsibility, citizens are left with 3 alternatives for support: the family, the market, and the community (Ilcan & Basok, 2004); for newcomers this can put pressure on familial ties and community resources that are

already severely strained. However rather than develop sustainable support systems for newcomers, neoliberalism results in extensive funding cuts to social services (Sadiq, 2004), policies that ignore the social determinants of health (Raphael & Bryant, 2006), and the downloading of responsibility away from federal and provincial governments onto communities without an equal transfer of resources (Steele et al., 2002). Although government officials pay significant attention to the selection and admission of immigrants and refugees, investment in services addressing the subsequent integration and wellbeing of new citizens is lacking (Beiser et al., 2011). However, due to their dependent and vulnerable nature, the protection of social support systems and community interventions is especially important for child populations.

Biomedicalization

The term biomedicalization represents the increasingly complex, expansive, and technoscientific nature of medicalization, which is defined as the growing concern with personal health in our everyday lives (Clarke et al., 2003). Within the field of children's mental health, biomedicalization indicates the growing tendency to define children's lives and behaviours in medical terms (Clarke, 2013).

This ideology encompasses three major trends within the provision of health and social services. Firstly, biomedicalization supports the "centralization, rationalization and devolution of services" (Ibid, p. 167), which implies the merger of alternative services into more 'efficient' and 'central' systems of care. Consequently, biomedicalization justifies both the closure of many smaller, community-based organizations and the funding cuts that are inherent within neoliberal governance. Such processes in turn contribute to what Abate (2000) labels the 'medical divide'. In essence, the Western dominance of biomedicine tends to ignore the role of contextual factors such as culture, and therefore is unable to accommodate conflicting values, explanatory models

or treatment preferences into health care (Lustig et al., 2004). Consequently, biomedicalization has been accused of elevating barriers to culturally appropriate resources and sustaining inequality (Clarke et al., 2003). Finally, the logic of individualism and healthism, which view personal health as the result of individual responsibility and lifestyle choices (Lupton, 1995), are central within discussions of biomedicalization. Within such approaches, individual behaviours are targeted as opposed to the macro-social systems and environments that largely shape health outcomes for vulnerable demographics (Ayo, 2011). This complements neoliberalism and the shifting of blame and responsibility away from sociopolitical contexts.

The Impact of the Sociopolitical Context

Overall, the literature demonstrates how the sociopolitical ideologies of neoliberalism and biomedicalization are seen as different means to the same end, together working to justify the competition and closure of many community-based organizations, while simultaneously amplifying the obstacles to health equity for diverse populations. The current political and biomedical systems have been marked as inadequately supporting newcomer children, a population whom Hansson et al. (2010) believes are dependent on support systems and disproportionately affected by social determinants of health. Such evaluations view formal support systems as inherently problematic, ultimately widening rather than reducing the gap between newcomer expectations and realities (Galabuzi, 2004). Further investigation of the current status and impact of sociopolitical ideologies is required within newcomer research, which has largely failed to consider their influence.

METHODOLOGY

In order to explore diverse perspectives on the needs, state, and future directions of support for newcomer children, this study conducted a comparative case study of stakeholder

perceptions within the Waterloo Region. The study is composed of qualitative interviews with two categories of informants: local community professionals and the parents of immigrant and refugee children. This research adopts a qualitative, rather than quantitative approach. Hansson et al. (2010) observed that the majority of published research on newcomers has utilized more quantitative, statistical methodology over qualitative, descriptive techniques. However, numerical data cannot adequately capture the depth and complexity of immigrant and refugee experience; nor does it provide holistic insight into how people from diverse social locations socially construct their perspectives on personal experiences and sociopolitical conditions. Ultimately, as they are the best option for preliminary, exploratory phases of research (Strauss & Corbin, 1998), qualitative methods were selected as the most appropriate course of action.

Theoretical Framework

While exploring the unique perspectives of two categories of stakeholders, this research adopted the theoretical framework of social constructionism. According to Cresswell (2013) a social constructionist approach recognizes that meanings and descriptions of experiences emerge in varied ways that are negotiated in an ongoing, interactive format. Consequently, discourse is highly dependent on the historical and sociocultural context of the speaker.

From the social constructionist perspective, variations in proposed definitions or understandings are considered as merely *different* ways of interpreting a phenomenon. Consequently, this approach was applicable for the current study, which explored the existence of varying experiential accounts and social realities amongst stakeholders that had been previously overlooked in research. Thus, the ontological assumption of this project is the existence of multiple realities, which can only be explored through the lens of in-depth, qualitative data. The epistemological assumption involved is that knowledge is extremely

subjective, experientially based, and therefore also highly dependent on context. Exploring the ways that both newcomer parents and community professionals support newcomer children and understand their lived experience will provide new perspectives that have not been explored in past research. Ultimately, the current study required a social constructionist framework to be sensitive to all different interpretations and experiences and avoid making any assumptions.

Comparative Case Study

The use of a case study within research allows for an in-depth, contextualized investigation of the ongoing processes occurring within a specific time and place (Denscombe, 2007). Utilizing this approach involved collecting detailed, varied, and extensive data on a small number of cases, with strong attention to context (Neuman & Robson, 2012). Burstein (2010) has documented the growing consensus for newcomer research to be spatially focused on specific cities and regions. Hence, this methodology was the most appropriate option for the current study, which recognized the importance of contextual factors within one specific area – the Waterloo Region. Prior research has demonstrated how newcomer experiences are shaped by the unique characteristics of each city (Mwarigha, 2002), which results in large regional variations concerning both challenges and needs (Anisef, 2005; Chuang, 2009). Therefore, narrowing the study down to one municipality was crucial to gain appropriate and usable data. Waterloo Region specifically makes an excellent case study, as a quarter of the population is made up of newcomers and it is consistently ranked as one of the most attractive cities for resettlement (Immigration Partnership, 2014). Including a comparative element between two types of informants further contributed to the development of a comprehensive case study.

Sampling Procedure

In total, 7 newcomer parents and 8 community professionals were selected to participate

in qualitative interviews for this study (see Table 1 and 2 below). In regards to the category of professionals, the sample aimed to represent the full range of service sectors providing mental health and community support. As such, participants from the community professional category were selected from within the 3 basic levels of service providers identified by Anisef and Kilbride (2000), which include mainstream community agencies, settlement services, and independent professionals, such as educators and doctors.

A major limitation of past research has been the predominant focus on professional opinions and evaluations, which has left the body of literature lacking a sense of understanding on the needs and challenges from those with lived experience. To close this gap, the parents of immigrant and refugee children were also sampled for the current study. In order to ensure coverage of diverse perspectives, the study aimed to recruit participants with a wide range of backgrounds, varying according to immigration status, ethnicity, profession, and gender. As opposed to newcomer children themselves, parents were selected as the subjects of this study on account of their lower levels of vulnerability, more extensive awareness of settlement and mental health challenges, and their unique perspective and supportive role. Furthermore, focusing solely on adult stakeholders allowed for a more useful comparison of ideas and opinions across groups.

Participants were selected based on non-random, purposive, and convenience sampling techniques. Qualitative studies often use purposive sampling in order to "select unique cases that are especially informative" (Neuman & Robson, 2012, p. 136). In this study, informants were required to have very specific characteristics, including either working with programs involving mental health, newcomers or children, or parenting a newcomer child within the Waterloo Region. Considering the busy nature of both non-profit work and parenting, the pool of available participants was fairly restricted. Additionally, as immigrants and refugees comprise a

considerable portion of the local citizenry, a sampling frame of all eligible candidates for the parenting category would be impossible to obtain. Therefore, participants were also selected for the study based on the convenience of their availability to participate.

Participants from professional organizations received an email detailing the nature of the study, the researcher's background, and a request for voluntary participation (see appendix 3). Participants for the parent category were recruited by working with schools and community organizations; signs were posted and emails were sent out to respective networks detailing the nature of the study (see appendix 4). Recognizing the time and fiscal constraints of many newcomer parents, financial remuneration was offered as compensation for participating in the study; this covered any extenuating circumstances, such as transportation and babysitting costs that could have hindered participation. Furthermore, all participants were offered informational compensation to incentivize participation; this will include the distribution of anonymous, post-research documents and findings that could help in the development of improved services and theoretical understanding of newcomer challenges. Finally, to avoid misinterpretation due to language barriers, participants had the option of utilizing professional interpreters and therefore did not have to be fluent in English.

Table 1: Sample Demographics: Parent Stakeholders

Participant	Immigration Status	Gender	Profession	Native Country	Number & Age of Children	Gender of Children
1	Skilled Immigrant	Female	Architect seeking employment	Egypt	1: 4 years old	Male
2	Family Class Immigrant	Female	Psychologist	China	1: 13 years old	Female
3	Family Class Immigrant	Male	Unemployed; College Student	Guiana	1: 4 years old	Female
4	Government Sponsored Refugee	Male	Unemployed	Afghanistan	7: 5, 12, 14, 15, 17, 22, 24	Female & Male
5	Skilled immigrant	Female	Unemployed	Pakistan	3: 9, 12 & 13 years old	Female & Male
6	Family Class Immigrant	Female	Unemployed; College student	China	1: 14 years old	Male
7	Family Class Immigrant	Female	Unemployed	Pakistan	4: 12, 18, 23, & 25 years old	Female & Male

Table 2: Sample Demographics: Community Professional Stakeholders

Participant	Organization Type	Profession	Gender	Native Country	Visible Minority?
8	Mental Health	Senior Manager	Male	Canada	No
9	Health & Funding	Senior Manager	Female	Canada	No
10	Settlement	Program Coordinator	Female	Canada	Yes
11	Refugee Settlement	Senior Manager & Direct Service Provider	Female	Ireland	No
12	Settlement	Direct Service Provider	Female	Poland	Yes
13	Education	Direct Service Provider	Female	Canada	No
14	Mental Health	Coordinator & Direct Service Provider	Female	Portugal	Yes
15	Mental Heath Intensive Unit	Medical & Program Directors	Male & Female	United States & Canada	No

Data Collection

In order to complement the intensive, detailed nature of the study, semi-structured interviews were employed as the primary tool for data collection. An interview guide with predetermined questions was created to provide an outline and ensure some consistency across interviews. However, the semi-structured nature allowed for flexibility, which is essential to "bring out how the interviewees themselves interpret and make sense of issues and events" (Bryman et al., 2009). A sample of the questions used is located in Appendices 1-2. The selected questions were used to draw out the unique experiences and perspectives held by each participant regarding the various facets of newcomer children's mental health and service provision.

Trust and rapport are important elements within an interview setting. In order to develop both, interviews were held at a time and location of the participant's choosing. Additionally, participants were notified of the option to skip any questions they did not feel comfortable answering and were not asked to provide any names of their children or clients. To minimize distractions or fatigue, all interviews lasted between 1 and 1.5 hours in length. Participants were encouraged to communicate any questions or concerns at any point in the research process via phone, email, or in person. Overall, the goal was to develop a personalized but professional relationship in which participants felt comfortable throughout the entire study.

Analysis Procedure

In order to ensure uniformity and accuracy of all data, each interview was audio recorded and subsequently transcribed by the primary investigator and one research assistant. Upon completion of all of the interviews, an extensive analysis of the data was conducted. Due to their exploratory nature, case studies are best suited to an inductive analysis (Bryman et al., 2009). As opposed to a more deductive exploration of preconceived theories, inductive reasoning aids in

the extraction of patterns and themes by systematically organizing and interpreting the findings in order to construct new ideas and conclusions (Balso & Lewis, 2008). Thus, in an exploratory study that could not be based in a strong body of past literature, an inductive approach was the most fitting.

To complement an inductive methodology, thematic analysis, or the development and interpretation of patterns and themes within the data, guided the coding process. As Charmaz (2000) suggests, coding was initially open in order to generate as many new ideas and connections between interviews as possible, and then became more selective and focused. Essentially, this study utilized an iterative or cyclical process within analysis, in which concepts, codes, and relationships emerge from within the data and are constantly compared to one another and previous literature (Bell, 2010). Ultimately, for analytical purposes, this study collected, coded, and then analyzed each interview transcription, cross-referenced the codes across all data, and then recorded any subsequent theoretical or practical insights.

From a social constructionist framework it is important for research to be mindful of potential latent themes and negative cases throughout the analysis process. According to Braun and Clarke (2006), latent themes go beyond the manifest, semantic content of data in order to examine any assumptions, concepts, and ideologies that are underlying or informing the explicit data. This approach encourages researchers to maintain a critical perspective during analysis, to explore the potential depth of descriptions, and uncover deeper meanings and implications. Similarly, it is important for the researcher to make a rigorous effort to closely examine unexpected or divergent findings that emerge throughout the analysis of data. These types of findings are called 'negative findings' or 'negative cases' and are important as they often provide new opportunities for learning and depth (Maleku & Aguirre, 2014, p. 569). The data analysis

process was also mindful of the subjective rather than objective nature of qualitative interviews. It is important to acknowledge that participants uphold a version of reality that is socially constructed by their distinct experiences and beliefs. Therefore, it was recognized in the current study that the opinions, feelings, and perceptions of each participant do not reflect any external truths, but rather provide a glimpse into the experiences of a specific person with a certain social location. The viewpoint of each parent and professional interviewed is merely one perspective within a complex system of stakeholders (Steele, 2002). Consequently, subjectivities rooted in different positions of power must be acknowledged for their potential biases and limitations.

Ethics

As it involved human participants this research project required ethical approval, which was obtained from the Research Ethics Board at Wilfrid Laurier University (REB # 4137). Overall, the study was designated low-risk, as the particularly vulnerable population of children were not directly involved in the study; furthermore, it was clear that the benefits of participation greatly outweighed any potential risks (Neuman & Robson, 2012). By taking an inductive approach that is not testing preconceived theories, deception of participants was not required. Therefore, participants received full disclosure during the study, allowing full informed consent to be obtained. Following their voluntary agreement to participate in the study, a letter of consent was signed and obtained from each participant (see appendices 5-6 for examples of the letters).

In order to reduce any potential harm to participants, privacy, anonymity, and confidentiality were maintained throughout the research process. Participants were notified that they can vet any questions they were uncomfortable answering, and could withdraw from the study at any point without any repercussions. Any names or personal identifiers of the participants and organizations that have participated were not disclosed; instead, all references

have been replaced with numerical identifiers and categorization (e.g.: *participant 1, parent*).

Confidentiality was further maintained by erasing audio data after transcription, storing all

relevant files in a locked drawer, and saving electronic files under encrypted pseudonyms.

Limitations

Certain limitations were apparent within the study design. First, this research has chosen

to examine the general fields of immigrants and refugees, rather than specific subpopulations

within these groups. Previous research has indicated that factors such as gender, ethnicity, and

immigration status may have distinct impacts on newcomer wellbeing (see Khanlou, 2009;

Beiser et al., 2011; Kamal, 2012). However, as many differences and similarities exist both

across *and* within these sub-groups, this study selected an all-encompassing approach in order to

develop an informative, introductory case study.

Utilizing a case study approach contained its own benefits and limitations. Due to time

and fiscal constraints, this study was cross-sectional in nature, whereas academics have

demonstrated that immigrant adaptation is a dynamic, long-term process (Beiser, 2014).

However, this study can be viewed as a starting point to guide future, comparative studies across

demographics and time. Furthermore, as all qualified parents, community professionals, and

organizations were not involved in the study and participation was voluntary, bias may have

resulted from the type of participants selected. Such bias was countered by including a diverse

range of organizations, professional roles, ethnicities, genders, and newcomer categories. Finally,

case studies are often criticized for having low external validity (Neuman & Robson, 2012). This

is an acceptable limitation as the purpose of the study was not to generalize findings, but to

develop an in-depth examination of the support system for newcomer children within the

Waterloo Region. However, some elements may still be applicable to other regions and studies.

As Bassey (1981) argues, 'relatability' may be more important than generalizability within certain fields; this implies that similarities between cases may allow the application of certain findings. Regardless of external validity, case studies remain important sources of data that can be employed in both theory development and analysis (Bryman et al., 2009). This is particularly true for the present topic, which has received insubstantial exploration in prior research.

RESEARCH FINDINGS

As an exploratory study, this section aims to produce a comprehensive overview of the experiences of both community professionals and newcomer families as they support immigrant and refugee children. The findings presented below encompass key stakeholders' perspectives (both parents and professionals) on a variety of themes, including major challenges experienced by newcomer populations, the roles adopted by parents and communities, evaluations of the service sector, and the influence of the sociopolitical context. In an attempt to fully investigate an area that lacks prior research, the following sections are compartmentalized according to the Bronfrenbrenner's (1979) ecological paradigm. Such an approach has been recognized as essential in providing a comprehensive and holistic picture of the issues at hand.

Micro-level Factors: The Experiences of Immigrant and Refugee Families

Engaging in an inductive approach, this study first looked to contribute to the research literature on the obstacles immigrant and refugee children face while pursuing positive mental health, settlement, and general wellbeing. Developing a solid understanding of the primary emotional, behavioural, and social difficulties experienced by children is viewed as an essential prerequisite to the investigation of larger, macro-scale contexts of influence.

Challenges and Concerns of Newcomer Parents

In contradiction to the original intent of the study, participants were reluctant to elaborate on children's issues. Instead, both professional and parental discourse focused primarily on the impact of immigration on adults/parents. Across stakeholder responses, the primary challenges identified for parents can be summarized into 3 themes: language, culture, and employment.

Language Barriers

Language was consistently cited as the dominant barrier faced by newcomer parents. Lacking English proficiency was seen as a major hindrance to childrearing, social integration, and service navigation. Here a community professional notes the extent of such challenges,

"What I would say is if you are a new Canadian and you end up in a new community, there is a horrible sense of isolation, we do things very differently than other countries, things are called different names, and you end up in your cultural communities and they end up trying to be self sufficient" [Participant 8, Community Professional].

Both parents and professionals alike discussed how the issue of isolation is particularly prevalent within female demographics. Stakeholders provided examples of mothers who struggled with establishing community connections on account of barriers such as traditional family values, inaccessible transportation, poor language skills, and low education and employment.

Cultural Adjustment

Contributing to the sense of disconnection, families often struggled with the degree to which they should or could assimilate. One community professional discussed how parents were often unsure about how best to 'parent in two cultures', often hearing concerns from parents like,

"I'm worried about my child losing their culture, their faith, their religion, their language, I'm worried they are going to become too Canadian" [Participant 14, Community Professional].

Several parents interviewed also discussed this concern. The majority of parents preferred

integration and assimilation over segregation or rejection of Canadian culture. When asked about

their experiences with acculturation, one parent warned about the dangers of segregation,

"Some people really don't like it. Some people are very strict that I have to save my culture and do all of the traditions of my country. What I think is my opinion about this issue is so why did you come here? So you have to make a mix" [Participant 1, Parent].

Across both categories, stakeholders realized how difficult cultural adjustment was for parents.

Parents revealed how they were often unsure of how to blend native and Canadian values into

their parenting styles. Community professionals affirmed the challenging nature of multicultural

parenting. They discussed the tension created when children adopt Westernized lifestyles, which

might be perceived as undesirable by some families. Community professionals warned how such

incongruence between the values of public and private settings often fosters stress and doubt,

leading parents to recalculate the costs and benefits of relocating their children to Canada.

Employment and Income

The interconnection of employment, poverty, and education concerns was a consistent

focus during interviews with parents; parents were adamant about bringing issues such as under

and unemployment, international accreditation standards, and financial instability to the table.

For example, a parent who came as a skilled immigrant shared their frustrations about the

transition, stating,

"[Newcomers] come from back home where they have good jobs and they leave that for peace. They come here and I know a lot of people who were engineers or doctors and they start doing pizza delivery, security guard, they drive a cab or something. Its hard for them, back home they are officers, they are not officers here, they are like kings there. Their kids and family have good life there but not when they come here" [Participant 7, Parent].

Other parents similarly lamented about pressures to get a 'survival job' when they had entered

Canada with degrees in higher education. This was a consistent source of frustration for all

parents interviewed. Furthermore, parents discussed how employment challenges contributed to the already demanding lifestyles required of newcomer parents; for example, one parent explained how they struggled to juggle 3 part-time jobs, language classes, and family responsibilities. Community professionals were found to be much less likely to highlight the employment or income concerns of parent demographics.

Challenges and Concerns of Newcomer Children

Parents and community professionals were asked directly to detail the major challenges they witnessed newcomer children experiencing in the Waterloo Region. The predominant themes uncovered aligned with findings from previous literature. The majority of concerns were founded in language and cultural barriers, whereas subsidiary issues included bullying, isolation, role-reversal, and identity formation in multicultural contexts.

The Importance of Language

Repeating the dominant issue for parents, language was the most frequently cited concern for immigrant and refugee children. Across the stakeholder groups, language incapacity was viewed as adding a layer of immense difficulty for children undergoing resettlement, affecting all other aspects of their lives. Specifically, parents interviewed frequently connected language barriers with instances of bullying, isolation, and discrimination. One parent discussed with sadness the difficulty their child endured as a direct result of poor language ability,

"At first there was a problem with other students, especially because they didn't know English. There was a case of bullying, and also a couple of times it happened that they bit my children and then would themselves complain and they would put them in trouble. So they couldn't argue or say what happened. They took advantage of knowing English and explained the opposite" [Participant 4, Parent].

Particularly for adolescents, predominant challenges revolved around entering the education system with a non-mainstream language or cultural background. Parents and community

professionals both frequently expressed heartache and frustration regarding the alienation and

isolation experienced by children when they are unable to effectively communicate with peers.

Parent and Child Role-Reversal

In addition to the challenges associated with poor language skills, interviews also

revealed a connection between *good* communication and difficulties for children. A highly

discussed topic within community professional interviews was 'role reversal'. Children were

witnessed acquiring language and cultural nuances much more quickly than their parents. Such

differences were viewed as problematic when pressure is placed on children to assume

leadership roles in the family's assimilation process. In these cases children often experience

'role reversal', a phenomenon that is described by the following community professional,

*"[Children] end up speaking for their parents, because their parents don't have their confidence
in the English language, where their children will ask the questions and be the spokesperson for
the family. And that's a lot of responsibility put on the child" [Participant 13, Community
Professional].*

Additional situations when children were observed experiencing role reversal include navigating

the education system, obtaining employment to boost family income, and caring for siblings.

Overall, community professionals highlighted role-reversal as a major concern, whereas parents

declined to recognize such intrafamilial problems.

Cultural Identity Formation

The third most prominent source of conflict for children was the negotiation of

multicultural identities. Both stakeholder groups discussed the common manifestation of anxiety,

isolation, and unhappiness for newcomer children during identity formation. Here, a

professional discusses cultural negotiation as a common source of additional life stressors,

*"They have the tension between what becomes their peer group in school and what their family
culture is and they can get that increased sense of isolation because they don't fit in anywhere
anymore…that increased isolation leads to anxiety and depression, and bullying can occur in*

those situations, and you can end up in a spot where you don't feel connected or supported and that's when those challenges come in to play" [Participant 8, Community Professional].

In the following excerpt, a parent describes the phenomenon of children living a 'double life',

"It's really hard, being a second-generation immigrant. They are born here but they are born in a different situation, different environment. When they come out of their house it's a different world. Inside it's a different world and outside it's a different world. It affects the kids" [Participant 7, Parent].

Next to language, cultural isolation and alienation were observed as the topmost challenges. Ultimately, both categories of stakeholders highlighted how children often struggle to find a sense of belonging in family and peer contexts.

Successes and Resiliency

Despite encountering the challenges and barriers to positive mental health and wellbeing that have been outlined above, a key theme that emerged within all interviews was resiliency. Rather than concentrating on difficulties, parents often redirected the conversation towards the successes of their children, detailing the number of awards, friends, or high grades they have garnered post-migration. This positive demeanor can be seen in the following reflection,

I think there's lots of positive things, even though I faced lots of challenges here but I still think it's a very wonderful experience" [Participant 6, Parent].

As evidenced in the following statement, the majority of community professionals were similarly positive, often admiring the strength and hope maintained throughout the immigration process,

"It's amazing the resilience they have and I find it very humbling working with these people every day. Because they are just so positive and upbeat and optimistic about things. They have come from tragedy a lot of them, and they are resilient to it" [Participant 13, Community Professional].

Overall, in spite of many taxing difficulties, both parents and community professionals remained relatively optimistic when looking towards the future.

Meso-Level Factors: The Roles of Parents and Community Services

Within a multi-level analysis, the intermediate support systems that exist between children and their wider environments must be examined. The components of this 'meso-level' constitute a buffer zone, mitigating the impact that the macro context has on individual wellbeing. The following sections examine the role of such support networks, deconstructing stakeholder perceptions on parents, community organizations, and the service landscape overall.

The Role of Parents in Supporting Immigrant and Refugee Children

Overall, parents described their own role as primarily establishing a better life for their children. However, beyond the initial effort of immigration, parents focused predominantly on the provision of their children's basic physical and social needs. Parents rarely mentioned direct parental intervention regarding children's mental health or emotional issues. Advice offered to other parents focused on community involvement and was often variations of the following,

"The only advice is that they have to get involved with other kids in order to not feel like lonely or something. You have to do a lot of activities. In order to not feel different, because they can face mental situations if not" [Participant 1, Parent].

"Learning how to step out from your comfort zone, not just mingling with your own circle. So having programs like the button factory that are open to the whole community, why not join? Join a group" [Participant 2, Parent].

Alternatively, community professionals highlighted a much stronger role for parents. Professionals believed parents were the primary agent for the provision of emotional, informational, social, and acculturation support. As one professional outlined below, parents were largely perceived as key figures in both the surveillance and maintenance of their children's emotional wellbeing,

"I think really parents need to be open to new information and accessing resources and connecting with their children to find out how are you dealing with this – acting as a counselor. They are parents, they have to play that role" [Participant 10, Community Professional].

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Community professionals emphasized the additional responsibility that is unique to newcomers to help their children successfully navigate a new cultural milieu. Here one professional discusses the irreplaceable role of a parent's bond during the cultural adjustment period,

"It's very possible to feel a connection to both cultures. But there is a process to that and the way to help your children through it is not saying "do this or else", that's not going to help navigate the realities of their lives. Because they are having pressures at school, and pressures at home, and they really need to have the parents to go to. Because the parent is always going to be the first person you go to. If you get pushed away you cannot go far on your own. So we are trying to continue the idea of attachment principles and how they benefit your child" *[Participant 14, Community Professional].*

Ultimately, within the current study community professionals advocated a much stronger role for parents in childrearing than newcomer parents viewed for themselves.

The Role of the Community in Supporting Immigrant and Refugee Families

Parents and professionals interviewed in the current study affirmed the important role of community support. Parents viewed community professionals as upholding expertise that they personally lacked. The resources of formal community organizations were perceived as useful tools for providing emotional, informational, and social support to families, particularly during times of additional stress such as post-migration. Below, a parent highlights the supplementary role the community often fulfills for newcomer children,

"If the children are not supported well from their parents, schools or environment, the teachers can play an important role. Or if the community provides programs they can become a part of the community through like soccer, or swimming or whatever is offered in the community they can become part of the site very easily. Then they will feel included…they will feel more confident" *[Participant 5, Parent].*

Community professionals further emphasized the importance of their own role. All professionals acknowledged the fact that as immigrants or refugees themselves, parents are undergoing challenges that can cause family instability. Community professional stakeholders outlined the gaps in support that are created as a result of the demands placed on parents,

"They may have their own mental health challenges, they may think mental health is not an issue, or live in poverty so they are more concerned with getting food on the table rather than dealing with the mental health problems at hand, its all that they have ever known" [Participant 8, Community Professional].

In response to the demands placed on newcomer parents, community professionals felt a sense of responsibility for assisting families in realizing both the basic and complex social, emotional, and educational needs of children. Professionals advocated that by utilizing community resources, the pressure to be the sole provider for children's needs could be removed from parents who are feeling overwhelmed by resettlement.

<u>Parental Support as a Priority</u>

A major theme that emerged in this study was advocacy for the provision of increased support to parents. Rather than solely promoting the implementation of more services and programs for children, both groups of stakeholders deemed the provision of training and support for parents as a topmost priority. The logic of many stakeholders interviewed was as follows,

"It is important to first educate the parents. If the parents first know how to do it, then they will help the kids. So programs are important not just for the kids, but also programs for the parents" [Participant 2, Parent].

Across interviews, parents agreed with this advice and suggested that community resources be focused on the development of 'good' parents. Surprisingly, professionals similarly concentrated on the power of constructive parenting techniques and downplayed their own role and capacity for direct impact on children. Community professionals all agreed that they can assist parents, but ultimately they cannot replace them as the key provider of long-term support for children. This rationale is demonstrated below,

"You could see a child for an hour every week, but if they are coming home to a difficult situation…it has to start with the root, with the parents. And it makes sense, they are the parents, they are the most important people in the child's lives. We are just the counselor, we can support you, we can give you tips, help talk things out, but really you want the child to be able to talk to the parent about these things and be able to respond when you hear them. Because

that is for life, it's a life long relationship and you are always going to be their parents"
[Participant 14, Community Professional].

Thus, on account of their constant presence and connection with their children, stakeholders across both categories suggested that parents are the wisest investment for community resources. Stakeholders encouraged parents to engage with community services in order to take care of their own mental health, to learn how to navigate Canadian systems, and to understand the intricacies of common childhood challenges. Ultimately, the fundamental idea conveyed was to first support parents so that they can support their own children, downgrading the need for direct services.

Meso-Level Factors: Evaluation of the Service Landscape

Elaborating further on the role of the community, stakeholders discussed in detail their opinions on the current state of services for immigrant and refugee communities. Participants addressed the successes, challenges, and general strategic direction of service organization within the settlement and mental health sectors. Overall, a multifaceted landscape, with often inharmonious positive and negative qualities, emerged from within the data.

Successes within Service Provision

The majority of past studies reviewed have disproportionately focused on the negative, challenging factors inherent within service provision. In order to provide a more balanced representation, stakeholders were asked about the positive and successful elements they perceived while either utilizing or working within community and mental health services.

Effective Collaboration and Coordination

For community professionals, collaboration and coordination were the fundamental factors required for effective and efficient service delivery. Strategies focused on the collaboration of 3 different stakeholder groups: organizations, parents, and children. Community professionals attributed great importance to the development of strong connections between

organizations. Below, a service provider describes the significance of developing partnerships,

"The key point is to have trust there. If there is no trust, how are we going to develop relationships in order to develop ongoing partnerships? So I do see that different organizations are coming together and collaborating and working together" [Participant 10, Community Professional].

Beyond cross-organizational collaboration, partnerships with parents were often seen as another central component in supporting immigrant and refugee children. Community professionals recognized the value of cooperation and attempted to incorporate it as a practice, as seen here,

"Parents are expected to be far more involved in their children's mental health care, and they are seen as a solution to that. So in a lot of cases best practice demonstrates that the role of family in mental health care is really vital to outcome" [Participant 9, Community Professional].

The final form of collaboration involved the inclusion of children directly in service development. Some community professionals encouraged stronger involvement of target populations in order to promote the relevancy and efficiency of services. Overall, many professionals thought collaboration was a strong suit of the Waterloo Region, with frequent references to thriving partnerships, passionate staff, and involved community members.

Provision of Activities and Resources

As opposed to community professionals' focus on collaboration, this study found that parents focused more on the tangible benefits gained from service provision. Parents adamantly discussed the use of external resources for more informal, recreational, and community-based activities. Such activities were seen as essential resources for promoting the inclusion and socialization of children in a Canadian context, and as a result, parents frequently expressed their gratitude for the provision of such programs. Parents directed their praise at two types of institutions in particular: schools and community centers. Schools were often portrayed in a positive light by parents, and were described as 'open and inclusive', 'supportive' and

'accessible'. Similarly, community centers arose as a central resource for many newcomer families, whom largely felt they had the most convenient and immigrant-friendly programs available. However, some exceptions were made, which will be discussed in subsequent sections.

<u>Flexible and Comprehensive Services</u>

Both groups of stakeholders highlighted the importance of individuality, flexibility, and comprehension of newcomer issues within services. Creating a truly adaptable, needs-based system of care remains a prominent challenge; however, stakeholders felt some progress had been made towards this goal. Several professionals discussed the utilization of a 'community approach', in which services were client-centered. Although widely defined, the concepts of 'cultural competency' or 'cultural sensitivity' were also seen as central to creating adaptable services for diverse, newcomer families. Many community professionals discussed the positive outcomes of adopting such approaches, which is evidenced in the following excerpt,

"Focusing on the populations, and not looking at it as a general group but really breaking it down and looking at the roles in each community, that is when the cultural sensitivity part is important. Being aware of the differences…then you need to adapt and adjust some of the services and programs to connect with them" [Participant 10, Community Professional].

Parents similarly highlighted the importance of attention to culture and personal contexts. Peers with analogous immigration experiences and cultural backgrounds were seen as the prime implementers of this approach. One recent immigrant unpacked this idea below,

"I would say people from our own culture can understand our problems very easily. And they can go into our shoes very easily. [They] understand where I am right now and where I can go in the next few years, 5, 6 years, what I can achieve" [Participant 5, Parent].

Ultimately, programs run by peers were largely seen as preferable by immigrant and refugee parents and community professionals alike. Programs run in this fashion were described as more successfully promoting accessibility and generating positive outcomes for clients.

Challenges within Service Provision

Throughout interviews stakeholders also provided critical feedback on the challenges observed within community and mental health services. Overall, this study revealed widespread recognition of a large gap in services for both immigrant and refugee children and parents. All stakeholders agreed that better services and supports could and should exist for these populations. All but 2 community professionals admitted to the struggle of incorporating services for newcomer children into their organizations; addressing the combination of mental health, cultural diversity, and age-specific needs was seen as almost impossible in the current context. Consequently, this section examines the elements of service provision that stakeholders felt were impeding the construction of a strong system of support for newcomers and their children.

Ineffective Collaboration and Coordination

Remarkably, from the viewpoint of community professionals, the most highly discussed success of service provision also emerged as the number one challenge. Collaboration and coordination among service providers, organizations, and clientele was seen as an essential but largely illusive goal. Professionals shared frustrations about the general stagnancy that exists within certain areas of the service sector,

"People don't always want to work together, people don't want to change. Ad again it's based around a lack of understanding, a lack of empathy, but also a lack of incentives. If I have been doing this for 20 years and I have never seen a reason to change why would I? So it's about changing those levers to make that happen" [Participant 9, Community Professional].

Discontent was also expressed regarding the lack of collaboration with family members,

"That's probably a bit of a weakness in the community. Because a lot of our providers will take a more individualized focus on the child, especially with the teenagers. And often a lot of the community providers are really treating the youth as more of the patients and missing the family piece" [Participant 11, Community Professional].

Similarly, although it is unanimously recognized as an important factor, the inclusion of client's

voices was often seen as simply infeasible. One community professional lamented how majority

voices continue to overpower those within minority communities, while another pinpointed the

difficulty of recruiting accurate representation of diverse groups. Thus, although the importance

of coordination is acknowledged, its full implementation was not always realized.

Inaccessible and Inappropriate Services

The second most common challenge was the inaccessibility of services. Stakeholders

from both categories viewed mainstream services as being inaccessible or inappropriate for many

diverse populations. A common response to this problem within service sectors was the

implementation of 'cultural competency' models, which claim to train professionals in delivering

culturally sensitive services to meet diverse needs. However, professionals often held opposing

views on such approaches, as evidenced in the juxtaposition of the following remarks,

*"What we have done here with a lot of providers is what I would call cultural competency
training. So how do you handle the experience of a population where you are taking into
consideration the cultural nuances that are coming at you. And its not just a language issue, it's
a whole person cultural competency issue"* [Participant 9, Community Professional].

*"I would love to meet somebody who is competent in every culture. That kind of stuff drives me
nuts. It is assuming that you can basically teach somebody every nuance of a culture. I mean you
are friendly and respectful to anybody that walks through the door – that's about all you need to
know about everybody's culture. I find it another smokescreen to keep us, and specifically
mainstream services, from looking at why can't you meet those needs"* [Participant 11,
Community Professional].

Such excerpts indicate the degree of tension that exists within the professional realm regarding

which methods to utilize in training and service delivery for diverse newcomers.

Select parents also commented on the lack of cultural sensitivity within services.

However, most parents interviewed focused on the more practical concerns impeding access to

services, such as navigation, language, transportation, location, and finance barriers. Specifically,

each parent discussed the difficulty of finding and then utilizing resources. Here, one parent

discusses the perplexing service landscape for newcomers, which includes 'outreach workers' that fail to establish connections with diverse communities,

"They have outreach worker, and outreach worker is there if somebody goes to them. Who goes to her though, only those few families who know and they are old Canadians and they know who is that lady and they are used to that. But those people who are new, they don't know about that. They are called outreach officer but they are in-reach. There are hundreds of these kinds of services that these new people don't know about" [Participant 4, Parent].

Ultimately, a lack of information, convenience, cultural sensitivity, and tailored services continue to contribute to the low service utilization demonstrated by newcomer populations.

Low Quality of Services

Unfortunately, the services that newcomer populations were able to access were often perceived as lacking in quality; this was particularly a concern regarding services for sub-populations like children. One parent, felt almost all services were flawed and unusable for newcomers and provided a critical opinion on the quality of services,

"I went to many other organizations, but the services they have I could say are useless. Nothing practical, just by name" [Participant 4, Parent].

Comparable to the opinions of parents, community professionals felt an adequate number of organizations existed, but the quality of services was often sub-standard and failed to meet the complex needs of newcomers. Specific areas such as children's mild to moderate mental health issues, trauma, interpretation and translation, multicultural education, and social inclusion were highlighted as issues that continue to lack focused attention and effective programming.

Lack of Knowledge and Training

Community professionals identified a lack of understanding and training about newcomer needs and challenges within mainstream organizations. Particularly prominent for those working at the systems level of service delivery, professionals described a sense of inexperience with immigrant and refugee populations. As revealed below, the low frequency of interactions was

perceived as inhibiting both the quantity and quality of relevant services,

"I could not tell you what the major challenges are that are faced in a very articulate or really informed way. Based on our experience working with them, we just do not have a large enough sample size. Its not that we do not work with them, we just do not have a lot of them walking through our doors" [Participant 8, Community Professional].

The development of accessible and effective programs was perceived as a difficult task without proper representation and information about clientele and their needs. Newcomer parents also noticed the inexperience of mainstream organizations. Academic progress, suitable employment, and social integration were examples of goals inhibited by unprepared or unsuitable services.

Service Organization

This research also looked to explore stakeholders' opinions on the best strategic approach regarding the organization of newcomer services. Four possible methods for service organization emerged: 'separate streams' for immigrants and refugees, one 'combined stream', incorporation with 'mainstream services', and 'conditional' upon the issues being addressed. The vast majority of parents were supportive of separate service streams for refugee and immigrant populations, whereas community professionals were split between supporting separate streams and converging all services with mainstream programs. An interesting result was the lack of support for the combination of populations into umbrella newcomer programs. Despite its prominence in the field, only one single informant, a direct service provider, believed integrating immigrant and refugee services together was the most appropriate strategy.

Arguments in favour of the separation of immigrant and refugees into distinct service streams largely focused on the diverse needs and issues that different types of newcomers have within Canada. Here a professional explains the logic of separation,

"There is clearly a difference between someone who arrives as a refugee and someone as a landed immigrant – very clear differences. I can't assume at all that there wouldn't be a big difference in terms of their outcomes in mental health as a result of that too…So as a result of

that maybe there are some ways that we can best direct services based on those distinct populations" [Participant 9, Community Professional].

From a similar framework, parents overwhelming argued for separate, targeted services based on

the distinct experiences of immigrants and refugees,

"I think having it separately, maybe same physical location and so on, but immigrants and refugees separate because it's a big difference when people come as a refugee and an immigrant. Refugee is a whole different story" [Participant 3, Parent].

The next most common response was for the integration of services for immigrant and

refugees into mainstream systems of care. A community professional working with refugee

populations explains the frustration often felt within the sector on this topic,

"Why do we always want to keep especially kids separate? They are much more adaptable, they can get along with people more easily from all different backgrounds and walks of life, so why do we want to set up a program that is just for immigrant and refugee kids?...Why not see how to bring in kids from mainstream, and maybe that would be helpful to the refugee kids to know I am not alone feeling this stuff, even kids born in Canada go through similar things" [Participant 11, Community Professional].

A few parents and professionals advanced the idea that newcomers may benefit from initially

receiving specialized services, but then should transition into mainstream systems of care;

beyond the resettlement phase, they were seen as all 'permanent residents' and should not be

treated differently. Overall opinions on service organization were mixed, but regardless of their

recommended approach, all stakeholders agreed that services should ultimately focus on the

individualized needs of each client. Stakeholders all reiterated the following rhetoric,

"A migrant family from China is going to be very different than a migrant family from the Middle East, or a family from England. They're all migrant families, but they will have radically different experiences and needs. Which really gets back to my point about being responsive, being flexible and responsive to the range of different experiences and needs. That's the key there. How do you make everything so flexible in order to address the breadth of experiences that you are going to have coming through your door?" [Participant 8, Community Professional].

Macro-Level Factors: The Impact of the Sociopolitical Context

The most abstract level of influence is referred to as the 'macro-level' and includes structural ideologies and systems. In the current study, contextual factors such as neoliberalism, biomedicalization, multiculturalism, and the immigration system were found to strongly influence the perspectives and lived experience of stakeholders. Such concepts emerged as manifest themes within community professional interviews, whereas parents' responses required a higher degree of interpretation to uncover the presence of more latent, macro themes.

Neoliberalism

The most prominent force identified within the current sociopolitical context was neoliberalism. Within the present study, both stakeholder groups discussed the impact of the neoliberal policies and practices that dominate the current political sphere; such powerful ideologies subsequently dictate the responsibilities of families and the nature of social service provision. Neoliberal themes emerged around the shifting of responsibility for newcomer populations, the financial cuts and costs of services, and the degree of accountability within highly bureaucratic systems.

The Shifting of Responsibility

The neoliberal strategy of decreasing social support from government strongly impacted the experiences of stakeholders. Both parents and professionals witnessed firsthand the responsibility for immigrant and refugee children being transferred away from the federal and provincial level onto local organizations, community leaders, volunteers, and families themselves. Almost all participants expressed the difficulties of such reliance, which was particularly problematic within the settlement sector. Professionals discussed the challenges of

having tiered systems of support, in which newcomers begin to rely on settlement rather than

mainstream services. Related concerns included the following,

"The settlement sector does form a barrier to people actually accessing the mainstream services…we are not pushing hard enough on mainstream services to actually recognize that they are not doing their job probably if somebody can't walk through the door and get served by the person behind the desk, and they are being told to go back to your settlement counselor, that's not working." [Participant 11, Community Professional].

Ultimately, responsibility for newcomer service provision was perceived as being unethically

shifted from the government onto community services, and then further displaced from

mainstream services onto the settlement sector. However, not all stakeholders viewed neoliberal

governance as inherently problematic. A single informant discussed the potential benefits of

making health a more private rather than public matter,

"You probably just need to be working on your own self care as well as with a team around you, this tends to have better outcomes and tends to be cheaper. And in an environment where we cannot sustain the current health care dollars we are moving things out of hospitals into the community" [Participant 9, Community Professional].

Such statements demonstrate the rationale behind neoliberal policies and regulations, which

position individuals as their own primary caregivers. However, the vast majority of stakeholders

opposed the dominant sociopolitical discourse and communicated a strong belief in the important

role of government action and community intervention.

Financial Cuts and Costs

Community professionals also expressed frustration with the lack of financial assistance

from the government. Embodying neoliberal principles, both federal and provincial levels were

perceived as simultaneously downloading responsibility *and* decreasing funding. One

professional articulated the demanding context produced for non-profits as a result,

"I feel that there is a reliance from the general community and maybe the hospitals and whoever else, to just let the nonprofits do their role. 'Nonprofits are here they're doing so much work – let's let them do it'. There's so much pressure on them when there is reduced funding and lack of

resources, or reduced resources that are available, but we still expect them to do so much. So I think there is a lot of pressure on the community agencies to do a lot that is sometimes beyond their scope but their passion and their heart is there at that level that they don't say no" [Participant 10, Community Professional].

Professionals described the subsequent experience of 'system overload', in which populations most in need become the most challenging to provide for. One professional described the results of the extensive discrepancies between service costs and available funding,

"What happens are things like that some cultural communities will never come through the doors of our office. We need to go out and meet them where they're at, right. But outreach is going to be the first thing that we say we don't have time to do anymore because we don't have the time and money to do that and still run the services that we are contractually obligated to deliver" [Participant 8, Community Professional].

Professionals discussed additional consequences of funding cuts, including the challenges associated with shorter programs, staff shortages, lack of language interpretation, and competition for funding. Alternatively, parents were less aware of the intricacies involved within funding requirements, but were directly impacted by practical barriers such as fees for services and cuts in budgets for crucial programs like interpretation and community outreach. The experiences of parents and their families demonstrate the indirect impact of neoliberal reductions on vulnerable populations.

Accountability and Bureaucracy

Stakeholders within both categories noted the increasing levels of accountability, evaluation, and bureaucracy inherent within service provision. Similar to the perspectives on neoliberal reductions, the majority of stakeholders perceived the institution of strict regulations as hindering effective and efficient delivery of services,

"They put in rigid programs because they are concerned about accountability and they want to be able to justify the dollars being spent…Nobody has intentionally done it, and everybody would say everything we have done is to try and ensure that these things remain open to people at a high quality of care, however the way that they have come together has inadvertently created a system that puts up a lot of barriers" [Participant 8, Community Professional].

Parents, who have lived experience navigating such complex systems, reinforced the existence of strong barriers. Parents felt they spent an irrational amount of time attempting to navigate the settlement, health, education, and immigration systems. Multiple parents expressed the belief that resources were often wasted within community organizations, who appeared to be more concerned with reporting and accountability than actually assisting clients. Overall, a complex, bureaucratic system that demands accountability was largely seen by both stakeholder categories as detrimental to the establishment of practical and effectual systems that are user-friendly.

Alternatively, a few select community professionals promoted the importance of accountability within service development and research. Below, a community professional outlines their perspective on the essential role of program evaluation,

"We have to be able to measure the work that we are doing, so we are trying to work towards developing a way of measuring and seeing tangible results that we can say and compare each year to say you know we are making progress. How else do we check things off and say we have achieved them, or these needs are no longer there?" [Participant 10, Community Professional].

The remaining professionals disparaged this requirement as creating barriers to effective service provision. Issues cited include inflexible service standards, unreasonable funding requirements, immeasurable outcomes, and the time and resource intensive nature of reporting to officials.

Biomedicalization

Within the current fields of mental health and community support for newcomer families, evidence was found for particular aspects of the theory of biomedicalization. The following sections will contribute to a more nuanced investigation of this sociopolitical trend, examining findings that both demonstrate and contest its existence in the current area of study.

<u>Individualism</u>

First and foremost, biomedicalization promotes self-regulation and self-discipline, which in turn shifts the responsibility for health onto individuals (Clarke et al. 2003). In this way biomedicalization reinforces the strategies of neoliberalism and the downloading of responsibilities. The existence of this approach within the mental health field is demonstrated by the following comments made by a community professional,

"When the transfer occurs from a medical model to a more community-based model there is a huge transfer of ownership of one's health to self care. It's less the idea that I'm a doctor and I'm going to take care of you and I know best and you should do what I tell you. It's more about this kind of consultative type of health care. So because of this parents are expected to be far more involved in their children's mental health care, and they are seen as a solution to that. So in a lot of cases best practice demonstrates that the role of family in mental health care is really vital to outcome" [Participant 9, Community Professional].

From such frameworks, citizens are convinced to monitor and govern themselves in pursuit of the health goals and values promoted by social institutions (Lupton 1995). In the case of children's health, parents are expected to take up the role of surveillance, which was demonstrated by the expectations of parents' heightened involvement following immigration. The focus on individualized bodies is further evidenced by the increasing presence of customization within service provision. As discussed previously, stakeholders jointly encouraged services to understand, monitor, and address the individual health needs of each client.

<u>Western Models of Care</u>

Stakeholders indicated the continued dominance of Western biomedical models over the incorporation of diverse cultural practices and beliefs within community services. Despite claims of increasing attention to 'cultural competency', stakeholders from each category recognized the perpetuation of Western, biomedical diagnoses and treatments. Below, one professional discusses the inappropriate models that result from non-diversified mental health strategies,

"I think the multicultural community is still getting dismissed in some ways. People are aware of racism and prejudice, I'm not going to say they're not. But the approaches being taught are still more mainstream – the definition of mental health, what approach do you use, attachment stuff. But this language and the ideas are still very Western at the core of it. A lot of white people from Austria and America started this…still very white" [Participant 14, Community Professional].

In the context of such Westernized biomedical models, stakeholders identified language, culture, residency status, and race as characteristics that negatively influenced their level of care. Both parents and professionals unanimously criticized mainstream organizations for sustaining multicultural barriers and providing inequitable services for diverse populations.

Mental Health Diagnoses and Treatment

Paradoxically, themes that emerged within service provision and health diagnosis also indicated a *lower* presence of biomedicalization than previously theorized. Interestingly, medicalized diagnoses and treatments for mental health concerns did not emerge as a strong concern for immigrant and refugee children. In contrast, the discussion of children's wellbeing largely steered clear of mental health terminology. Only one parent indicated their child had been diagnosed with mental illness (depression and obsessive-compulsive disorder), whereas others refrained from using any medicalized descriptions of their children's emotions and behaviours. Similarly, professionals rarely spoke of mental illness as a particular challenge for newcomer children, with the only exception being the topic of war and violence-induced trauma.

Decentralization and Deinstitutionalization

From the biomedicalization perspective, services are projected as increasingly undergoing convergence and centralization (Clarke et al. 2003). However, within the current study community professionals observed the service sector as moving towards further *de*centralization and *de*institutionalization, creating a diffuse network of community-based services. In fact, one professional highlighted decentralization as an ideal to actively pursue,

"We're trying to decentralize this to make it more accessible, make it cheaper, but make it better – the outcomes are usually better if you can get to people better. And that will go a long way for access too. If there was after school basketball and also an after school counseling session for families, its okay and it almost kind of de-stigmatizes, its not as big of a fear as going to a big sanitized place to get care" [Participant 9, Community Professional].

From a similar perspective, the following community professional argues against the existence of

growing biomedicalization and hospitalization within the mental health field,

"I would actually argue that, especially in Ontario, mental health is being pulled away from the hospitals and back into community organizations…There is a move a foot on community-based mental health care and not hospitalization. There is a radical move away from hospitalization. Whether that is a move away from the medical model or not, I don't know. It's one step away from the medical model, you may still be medicating people but you've moved away from medicalizing them or institutionalizing them" [Participant 8, Community Professional].

Thus, from the perspective of community professionals, the biomedicalization tendency to

centralize services was not evidenced within the settlement and mental health sectors.

Alternatively, organizations were perceived as frequently integrating diverse community-based

services into support plans. Beyond highlighting the frustrations involved in navigating dispersed

community-based services, parents did not express opinions on the trends of de/centralization.

Multiculturalism and Stigmatization

A third macro-level trend that emerged concerned the stigmatization of mental illness and

treatments within multicultural communities. Several stakeholders discussed how within diverse

cultures, mental health is often either highly stigmatized or completely disregarded.

Consequently, the stigmatization surrounding mental health is often amplified for newcomers.

Below, a professional discusses how mental health is interpreted differently across cultures,

"From the immigrant point of view, when you mention mental health it might mean something different. Sometimes terminology has a different meaning and it is hard to understand fully from an immigrant point of view, as soon as you mention mental health it is different than what here society is trying to perceive it is as. Whenever it is mental health it is connected to some problems. And from an immigrant point of view it would have more of a stigma, it is seen as a problem" [Participant 12, Community Professional].

As a result of widespread cultural discrepancies within mental health beliefs and approaches to treatment, newcomers were observed as often feeling uncomfortable accessing formal support systems in Canada. The below excerpts from both stakeholder groups demonstrate the concerns that frequently arise when navigating new mental health systems,

"Even our society is struggling with that, yet along other cultures. They also might have never had mental health organizations or services that could have helped, even if they wanted help. So for them it is kind of two-folded, it's a totally new situation that these resources are even available, yet alone accessing them" [Participant 13, Community Professional].

"Mental health services are quite alien and not familiar topics. The parents have never used them before; their grandparents have never used them before. If they don't know what it is, how are they going to use it? They need to trust. Not to mention using different languages, if you talk to me in English, then I am already not good at English, so how am I going to explain it and be heard?" [Participant 2, Parent].

Additional problems can surface on account of the asymmetrical acculturation rates that commonly occur between the parents and children of newcomer families. As children tend to assimilate faster than older generations (Stevens & Vollebergh, 2008), stigma related to mental health and the use of Western services might diminish more quickly and easily for younger populations. Below a community professional describes this experience,

"The kids for the most part are reaching out, and the parents aren't all the time, because they are often uncomfortable with that…the kids are growing up in westernized society, and they are at school meeting friends and hearing this. And they see that in Canada if we have depression we go to our family doctor and talk about that. That is a fairly accepted norm in Canada. But the families might have a real hard time with that concept. It's the cultural piece" [Participant 15, Community Professional].

To counteract the higher levels of stigmatization, all stakeholders discussed how successful service provision for newcomer populations requires the use of additional outreach and educational strategies. Both parents and professionals strongly believed that without the removal of such obstacles, the health inequity between diverse demographics in Canada would continue to grow. Stakeholders provided countless examples of the negative consequences of

mental health stigmatization, which include the delayed diagnosis and treatment of mental illness, amplified suicide rates, family conflict, and employment difficulties. However, recommendations for the best way to reduce barriers to service utilization varied drastically both within and between stakeholder groups. Polarities in opinions emerged on issues such as the use of cultural competency strategies, the importance of language, and having professionals from either the same ethno-cultural background or not. However, stakeholders generally agreed on the importance of outreach and the implementation of informal services such as school workshops to increase the education and awareness of all newcomer parents.

Level of Assimilation

An additional finding linked to multiculturalism concerned the level of assimilation encouraged for multicultural families arriving in Canada. The two stakeholder groups were clearly divided on this issue. Parents felt strongly about their children assimilating into Canadian culture. Some parents discussed attempts to still teach children about their native culture, but surprisingly most valorized the acquisition of Canadian customs and beliefs to a higher degree. A strong sentiment for assimilation is evidenced in the following parent's statement,

"I think being Canadian here will be the best thing for her because she was born here and we are adapted to the Canadian way. I think it is important for people to adapt to the Canadian way. I don't think you need to change who you are but once you step out of home you need to have some openness because the fact is that you accepted Canada and you have to be fair, you have to accept in Canada that we have different people" [Participant 3, Parent].

In contrast, community professionals fervently believed in the importance of maintaining native cultural values and were more likely to stress integration for newcomers. Professional stakeholders were more likely to discuss the difficulties of 'parenting in two cultures' and the importance of organizations incorporating diverse cultural beliefs into their practice. Thus, in an attempt to foster a sense of belonging and normalization for their children, parents often

emphasized assimilation strategies, whereas professionals idealized the balanced integration of multiple cultural identities.

Immigration System

The aspect of the sociopolitical context that was found to be most pertinent to newcomer populations directly was the immigration system and its related policies. Although Canada is heralded as maintaining one of the top immigration systems worldwide, the individual experiences and perceptions of stakeholders were not always supportive of such claims.

Unmet Expectations

Both parents and community professionals highlighted the detrimental policies and practices inherent within the Canadian immigration system. These included long application timelines, the high costs of immigration, barriers to health care support, and strict international accreditation standards. Below a community professional discusses the confusion of many newcomers that face extensive barriers without adequate assistance,

"If you are a community member and you have lived through this, it's going to be different. You want to see everything improve, it's hard for you to comprehend why is it even like this? If Canada is bringing immigrants and refugees into the community and country, then why aren't you equipped to deal with our issues and needs?" [Participant 10, Community Professional]

Parents and community professionals alike recognized the vast discrepancy between newcomer families' expectations and realities. Many parents, such as the one below, told stories about being accepted into Canada, the high expectations generated, and their subsequent unfulfillment,

"I remember my time, the day, I was like up in the cloud, and I was really happy and I was young. I got my citizenship and I talked to this lady to evaluate my BA degree and she said now that you're a citizen you'd be able to do any kind of job. And I said like your job, and she said yeah like this job. And I have been waiting for that time, it still hasn't happened" [Participant 7, Parent].

The marketing efforts of Citizen and Immigration Canada were seen as often leading to the disappointment and frustration of immigrants and refugees once they arrive in Canada. However,

motivated by the desire for their children to achieve the idealized 'American or Canadian

Dream', parents were perceived as risking everything and often struggling as a result,

"Their parents bring them here mostly because they want a different life for their kids, and they leave a lot behind. They leave their comfort, a lot of them are very skilled and professionals in their own country. But because of strife, war, and so forth they want their children to have a better outlook for their future, so they bring them to Canada in the hopes of a better life. The 'Canadian Dream' as they call it, but they struggle themselves" [Participant 13, Community Professional].

Excitement was often further diminished by the negative reception of new immigrants and

refugees by the community at large. A consistent theme across interviews was the continued

experience of discrimination and negative societal perception of newcomer populations.

Particularly during times of economic difficulty, stakeholders perceived the general population

as unwelcoming and even directly hostile towards newcomer families.

Advocacy for Change

Despite widespread recognition of the inherent concerns and obstacles within the

Canadian immigration system, generating change was seen as an almost impossible task.

Stakeholders believed in the importance of voicing their concerns; in fact, this was frequently

mentioned as a motivating factor for participation in this study. However, stakeholders from

both categories recognized the improbability of short-term change due to the bureaucratic nature

of governmental systems. Below a community professional conveys the difficulties of advocacy,

"I'm not dismissing our service providers from searching for how to do things better, they still need to keep searching. But there are systems that need to be improved as well. Service providers can help people navigate the systems and provide some support, but they can't change systems. We can try to do some advocacy work and we do try, but somebody needs to listen" [Participant 14, Community Professional].

The challenges of promoting newcomer concerns were also emphasized by parents. The

following quotation reveals a parent's disappointment with the inaction of the municipal mayor,

"He was very honest and good but I know it's not in his hand. It's a kind of provincial government thing concerning the loans and that kind of stuff, so he doesn't have anything to do. He said he is sorry, and I said I know but I just want to see if this problem is really reaching them or not. If they know about it" [Participant 1, Parent].

Despite the common sentiment of frustration, stakeholders remained optimistic about the future for newcomers and the immigration system. Recognizing that the institution of structural changes takes time and effort, stakeholders still maintained a relatively positive outlook,

"I am encouraged by the fact that I have been able to see growth and change over the years. And to see that we have moved in the right direction. And I don't want to see it take a step back. So I can only hope that it will move forward" [Participant 13, Community Professional].

DISCUSSION

The findings reveal the complexity involved in supporting immigrant and refugee children and their families. Breaking down factors into their appropriate micro, meso, and macro spheres demonstrates both the distinct role and the interconnections of each level of influence. The following section works to expose how elements of the larger-scale context impact more immediate experiences, and vice versa. By shifting discourse away from the micro issues experienced by newcomer families and towards a more nuanced understanding of the environment surrounding such populations, this study contributes both breadth and depth to previous literature. Ultimately, the current study illuminates the multidirectional relationship between sociopolitical trends, community and parenting roles, and the wellbeing of children.

Macro Level

Surprisingly, past research has largely failed to examine the impact of dominant sociopolitical ideologies and practices on the experiences and services for newcomer populations. However, in the current study, macro-scale systems and trends such as neoliberalism, biomedicalization, multiculturalism, and the immigration system, were evidenced as key contributors to smaller scale individual, familial, and community issues.

Unethical Neoliberal Strategies

The foundational feature of neoliberal governance is the diminished involvement of government in the public regulation of the market economy and social services (Ayo, 2012). In regards to the provision of support to immigrant populations, the federal government has begun to download power over policy and resource distribution to provincial and municipal governments (Bhuyan, 2012). While the federal government maintains the majority of control over immigrant selection policies, responsibility for immigrant integration and health services are transferred to local authorities (Ibid). These changes reflect the political shift from the welfare to the neoliberal state, in which "programs/services once under national purview [are] devolved to local levels, without the funding structures to support them" (Ibid, p. 215). Thus, in recent decades federal actors have begun to to reduce funding contributions and their level of responsibility for the wellbeing of citizens, shifting the onus onto lower branches of government, community-based organizations, and individuals (Ilcan & Basok, 2004).

The current study demonstrates the problematic nature of such transference and its impact on parents and community organizations. Stakeholders described a relentless cycle of devolution that shifts the provision of social and health services from federal to provincial and municipal governments, government bodies to community organizations, mainstream sectors to settlement sectors, settlement sectors to parents, and then back again. This process is particularly prominent for vulnerable populations like newcomers, who are widely impacted by the privatization and devolution of social services resulting from neoliberalism (Bhuyan, 2012). In the end, parents and communities shoulder the bulk of the responsibility for the provision of newcomer children's physical, social, and emotional support. This cycle of responsibilization represents what Brodie (2002) designates the "reterritorialization of governance in community" (p. 392), in which

services are devolved and diffused among the non-profit sector, community groups, and families. However, without the transference of matching financial resources, stress and frustration builds for organizations and parents whom are "positioned as ultimately responsible for but incapable of ensuring their child's optimal development" (Shirani et al., 2012, p.26). This is particularly problematic for newcomer parents, whom are pressured to uptake full childrearing responsibility without the necessary cultural capital, social support, emotional stability, and financial resources needed to succeed. Ultimately, neoliberal devolution pressures parents to ensure children are socialized into social ideals with little government assistance (Lister, 2006).

Alongside the downsizing of community and governmental support, neoliberal regimes have increased the degree of evaluation, reporting, and eligibility requirements for non-profit organizations. These 'technologies of government' include the creation of an 'audit culture', 'report culture' and general incorporation of private sector principles into non-profit management (Townsend & Townsend, 2004; Evans & Shields, 2005). Both parents and community professionals recognized this phenomenon, elaborating on both the positive and negative repercussions of increasing accountability. In alignment with Townsend and Townsend (2004), stakeholders predominantly identified the encroachment of private sector practices as an unethical movement, which compel non-profits to serve the interests of funders and governing bodies instead of communities in need. Some stakeholders viewed accountability and evaluation as necessary developments; however, viewpoints generally reflected the desire for a *balance* of rigor and flexibility within accountability mechanisms (Phillips, 2003). Overall, the three major elements of neoliberalism – devolution, financial cuts, and increased accountability – were seen as creating difficult and inadequate systems of support for newcomer families and professionals.

Variations of Biomedicalization

The political climate of neoliberalism is intricately linked with the advancement of other social movements, including biomedicalization. Mirroring neoliberalism in the promotion of individualism, devolution, and rationalization, biomedicalization is a more recent sociopolitical force that fluctuates highly depending on the situation under analysis. As a result, Clarke et al. (2003) have called upon other researchers to expose the heterogeneities that are inherent within its practices and effects. The current study contributes to a more nuanced understanding of the impact of biomedicalization on the populations of children, newcomers, and community organizations.

The current study indicates that there are several ways in which biomedicalization is guiding the context of service provision for newcomer families. Similar to neoliberal logic, biomedicalization responsibilizes individuals for the management of personal and familial wellbeing (Rose, 1989). Social institutions such as community organizations play a key role in disseminating the logic of 'healthism', in which individuals are encouraged to become active participants in the pursuit of idealistic health goals (Crawford, 1985). The present study reiterates the shared governance of newcomer children's health in particular; self-care and intensive parenting techniques act as mechanisms of healthism and biomedicalization, which prioritize individualized efforts and familial care over structural changes. Overall, biomedicalization assists neoliberalism by further downloading responsibility away from governing bodies and replacing the large, structural social determinants of health with individually based behavioural strategies. This is particularly detrimental for the wellbeing of newcomers, whom are disproportionately affected by structural systems and policies (Mwarigha, 2002).

The biomedical restructuring of services was also found to have a strong impact on newcomers. Centered on Western, biomedical models of health care, many programs within community organizations embrace ethnocentric approaches that fail to integrate the concerns of diverse populations (Capell et al., 2008). Stakeholders in the current study witnessed the continuation of unapproachable and inappropriate services for recent immigrants and refugees. Such Westernized, biomedical interventions may be convenient for professionals, but they may also be inappropriate, self-defeating, or even detrimental to clients (Fong, 2004). Thus, the focus on Western models of care sustains what Clarke et al. (2003) label 'stratified biomedicalization', in which acts of 'exclusionary disciplining' (p. 184) continue to erect information, access, and treatment barriers for particular populations. Alongside the bureaucracy and financial inequality promoted by neoliberalism, these processes further contribute to what Abate (2000) labels the 'medical divide'. By elevating barriers to culturally appropriate resources, recent health care trends reinforce inequality between the biomedical 'haves' and 'have-nots' (Ibid). As Clarke et al. (2003) summarize, in Western society biomedicalization is unevenly distributed as "some protest excessive biomedical intervention into their lives, [while] others lack basic care" (p. 170).

Thus, the current study also demonstrated situations where newcomers experience *less* of an impact from biomedicalization than other populations. Interestingly, the level of 'cooptative medicalization', which refers to "the jurisdictional expansion of modern medicine into areas of life previously not deemed medical" (Clarke et al., 2003), did not emerge as a strong concern for immigrant and refugee children. In other words, discourse was not presented in a medicalized, mental illness framework; this finding contradicts the dominant cultural tendency to medicalize children's lives (Whitaker, 2010). Rather than applying an acute biomedical lens, the concerns of newcomer children appear to be interpreted through a moderate life stress paradigm. This may,

among other reasons, be the result of different interpretations of children's issues across cultural groups, inattention to emotional and health issues, stigmatization of mental health diagnoses, or a further demonstration of stratified biomedicalization and the inaccessibility of resources. Similarly, the centralization of services that often results from the biomedical focus on rationality (Clarke et al., 2003) was not evidenced in the current study. Instead, stakeholders advocated the growing implementation of a community approach of deinstitutionalization and decentralization. Stakeholders were undecided whether diffusion of services into the community would improve access, or further complicate the navigation of systems. Overall, biomedicalization did not appear as a ubiquitous force within the immigration and health care contexts; further analysis demonstrates its multifaceted nature and discontinuous presence.

The Interface between Multiculturalism and Stigmatization

In alignment with neoliberalism, biomedicalization, and the growth of individualized health interventions, public discourses surrounding mental health education, diagnosis, and treatment have grown exponentially in recent years. Such widespread expansion is evidenced in the Canadian context by the development of countless new mental health positions and organizations; the most powerful exemplar was the institution of Canada's first official Mental Health Strategy (see www.mentalhealthcommission.ca). Although the acceptability and accessibility of mental health diagnoses and treatments appears to be increasing in Canada, newcomer populations continue to face extensive barriers to understanding and accessing mental health resources for their families (Khanlou, 2009; Hansson et al., 2010).

Stakeholders described how these barriers are often created by the interpretative nature of concepts like mental health. Many academics such as Beiser (2005) have investigated the perceptions of mental health across cultures, and have demonstrated the western and ethnocentric

nature of diagnoses like depression. Moreover, cultural relativists argue that because the experience of illness diverges drastically across cultures, universalistic interpretations of emotions, thoughts, and behaviours are impossible (Ibid). The continued dominance of Westernized, biomedical interpretations and models has been shown to depreciate alternative cultural approaches and contribute to stigmatization, underutilization of services, inadequate treatment, and misdiagnoses (Capell et al., 2008).

Stakeholders largely disagreed on the best means of action for the improvement of interventions across cultures. Discrepancies over the use of peers or experts, ethnic matching between staff and clients, and the use of cultural competency techniques were found. On the topic of acculturation support, both the community professionals in the current study and previous literature focus on the importance of balancing native cultural traditions and values with Canadian ones (Berry, 2006; Fantino & Colak, 2002). However, this advice may not be in alignment with the actual desires of many immigrants and refugees; the current study revealed a much stronger desire for the integration of newcomers into Canadian culture, particularly for children. Realizing this need may explain why the majority of stakeholders resisted the growing trend of 'cultural competency'. Despite its popularity, critics have categorized such strategies as extremely reductionist in the assumption of culture's centrality in the treatment of visible minorities (Gregg & Saha, 2006). In reality, cultural competency approaches have been shown to actually hinder a more practical reading of challenges (Kleinman & Benson, 2006) and have been theorized as unethical mechanisms of biomedicalization for the 'management' of cultural differences (Clarke et al. 2003). Consequently, the role of multiculturalism within service models may be overstated, resulting in unnecessary investment in complex 'multicultural' strategies.

Outside of increasing the desirability of Canadian immigration, the promotion of 'multiculturalism' may not be as paramount to newcomers as previous studies have suggested.

Disenchantment with the Immigration System

Overall, despite the portrayal of a national focus on multiculturalism and immigration within Canada, the current study revealed a sociopolitical climate that is unprepared and unqualified for the task of managing and addressing immigrant and refugee concerns. Instead of providing strong support for the emotional difficulties involved in resettlement and integration, immigration policies have largely been concerned with forwarding national interests; governmental resources have been funneled primarily into the implementation of selection criteria and economic integration (Hochschild & Cropper, 2010). Particularly for young populations outside of the workforce, this approach systematically fails to redress the settlement, integration, and health issues that are closely tied to immigration (Beiser et al., 2011).

Without adequate post-settlement support, it is difficult for newcomer families to successfully realize the fruitions expected of immigration. Current findings revealed the existence of vast discrepancies between immigrant and refugee's positive expectations preceding immigration and the feelings of disappointment afterwards. Within the current immigration system a large gap exists between "the promise of citizenship and the reality of exclusion" (Galabuzi, 2004, p.262). As public policy and national sentiments reflect, Canada clearly valorizes immigration as the means to positive social and economic development. However, fulfillment of these ideals is unlikely in the current context due to political inattention to newcomer health and wellbeing (Beiser, 2005).

Thus, although international discourse implies the existence of a 'utopian migration system' in Canada (Simmons, 2010), the experiences of recent newcomers and community

professionals are much more dystopian in nature. Newcomers across studies have demonstrated the incredible amount of bureaucratic 'red tape' that exists before, during, and after immigration; documented concerns include international accreditation requirements and health care coverage (Boyd & Schellenberg, 2007; Asanin & Wilson, 2008). The obstacles within the system are only exacerbated by the accountability regulations and reduction of services instituted under neoliberal regimes. However, in contradiction to current political agendas, the success of immigration depends on the creation of policies that are informed by lived experience and actively increase support for newcomer transitions. Until the immigration system is improved, newcomers will continue to face structurally induced barriers to equitable health conditions.

Meso Level

Demonstrating their pervasive nature, neoliberal, biomedical, multicultural, and immigration trends greatly influence many other macro, meso, and micro-spheres. In the current study, the larger sociopolitical context was found to directly influence the type of support demanded from parents and the community within the meso-level. This study contributes further verification of the importance of support systems in counteracting the negative effects of unsupportive contexts (Ma, 2002; Hoy & Ikavalko, 2005; Janzen & Ochocka, 2003). However, stakeholders held divergent opinions on the best type and level of involvement of parents and communities. Overall, findings demonstrate the dynamic interrelation of sociopolitical, family, and community spheres and their combined impact on the wellbeing of newcomer children.

Intensive and Scaffolding Parenting Styles

Despite their important function, a limited number of previous studies have closely examined the role expected of caregivers during and after immigration. In response to this gap, the current study investigated perceptions on the function of parents as supports for newcomer

children. Ultimately, the study revealed strong attention to the role of parents by both groups of stakeholders; such findings reflect the paternalistic nature of child development, in which young populations are viewed as vulnerable and dependent beings who require the intervention of adults (Sadoway, 2002). However, the degree and type of parent involvement expected differed drastically across stakeholder groups, with a much stronger emphasis made by community professionals. This discrepancy may be explained by different cultural approaches to parenting, particularly the dominance of more 'intensive' styles within Westernized contexts (Clarke, 2013). Intensive mothering is defined as "an approach that is child-focused, with the mother having the responsibility to care, both intensively and extensively, for all aspects of the child's physical, moral, social, emotional, and intellectual development" (Vincent, 2010, p. 110). Growing in precedence throughout Western societies, this concept has been expanded to also encompass fathers under the broader label of 'intensive parenting' (Shirani et al., 2010). Both concepts reflect the expectation for contemporary parents to have a heightened awareness of their children's wellbeing, govern every aspect of their life, and shield them from all potential risks (Ibid). Parents adopting intensive strategies often sacrifice their own emotional and physical health in order to forward their children's interests (Hays, 1996; Rizzo et al., 2012). The views of community professionals in the current study were aligned with this intensive approach.

However, newcomer parents interviewed did not communicate the same affinity for such highly involved parenting strategies. They acknowledged the importance of parent's presence and facilitation during the initial resettlement phase, but largely reduced their subsequent level of involvement; newcomer parents were found more strongly encouraging their children's ability to be independent and resilient. This parenting style mirrors 'scaffolding' parental approaches that have been advocated in the literature as healthier for child development (Pratt et al., 1988; Bibok

et al., 2009). Typically applied to children's learning processes, scaffolding approaches involve the establishment of an emotionally and cognitively supportive environment in which parents gradually reduce support to develop children's independence (Ibid). In stark contradiction to intensive parenting, this alternative approach highlights the reduction of parental involvement over time, as children become more capable of solving personal issues on their own. Overall, this study revealed newcomer parents as only temporarily increasing their involvement when necessary, whereas professionals advocated a consistently high level of intensive childrearing.

The professional advice given to parents was found to be largely paradoxical in nature. Following the logic of neoliberalism and biomedicalization, parents in this study were expected to both engage in intensive parenting techniques, while also taking care of themselves post-migration. However, particularly in the context of resettlement, the tasks of self-care and intensive child development become opposing forces. Within the intensive parenting approach, childrearing becomes a ceaseless task that is prioritized above the health and wellbeing of parents (Hays, 1996; Clarke, 2012); as a result, intensive parenting has been linked to mental health issues such as parental depression and elevated stress (Rizzo et al., 2012). However, this study also demonstrated the need for *increased* self-care as newcomer parents undergo their own hardships following immigration. Thus, being a caregiver *and* a newcomer is difficult to balance; parents are often overwhelmed with their own challenges and consequently are unable to fulfill the high expectations associated with intensive parenting.

The Family-Responsibility Paradigm

Although the development of strong community support systems has been emphasized across prior research (Raphael, 2006; Ma, 2002), the method of community intervention endorsed within the current study is fairly unique. In the pursuit of children's wellbeing, both

parents and community professionals identified *parenting skills* as the best target for community intervention. As a result, parents were encouraged by all stakeholders to engage in community services and programs that would improve their parenting ability. This approach further reflects the concept of intensive parenting in which parents are expected to be actively engaged in all elements of childrearing, utilize expert advice, and prioritize their children (Hays, 1996).

The focus on family systems within government policies and community programs is not a new phenomenon. Jensen (2004) categorizes the two policy frameworks that have dominated Canadian social services as the 'family-responsibility' and 'investing-in-children' paradigms. Closely connected to neoliberal governance, Jensen (2004) theorizes that society has shifted from the former to the latter, institutionalizing the shared responsibility of child development within the community. However, this study demonstrates a continued emphasis on 'family-responsibility', as parents clearly remained the focus of interventions. Stakeholders described the role of community services as providing parents with the skills required for intensive parenting. Thus, this study demonstrates how the development of policies and services claiming to support children directly merely obscure the work expected of parents (Butler, 2010). Thus, services may have superficially adjusted their target population to children, but parents remain the primary providers of care. As Butler (2010) observes, "moving away from a family responsibility model might look as though the community is taking a larger role in raising children, but in reality, it just opens the door for further regulatory measures [of parents]" (p. 252).

This study revealed widespread agreement with this model of service provision amongst professional stakeholders; almost all community professionals espoused neoliberal ideologies and framed children's health in intensive parenting and family-responsibility frameworks. Alternatively, the hopes of newcomer parents for community support and collaborative

childrearing were more closely aligned with the investing-in-children paradigm. Sensing that systemic improvements were unlikely to occur, most community professional stakeholders encouraged the neoliberal shift of responsibility onto parents. Consequently, despite the prominence of structural barriers and desire for support, the pressure for newcomer parents to meet their children's individualized needs was applied from the professionals interviewed.

Inadequate Service Landscapes

Verifying past research that had been conducted within the local context (Immigration Partnership, 2010) and on a national scale (Hansson et al. 2010), the current study revealed an overwhelmed and under-funded service landscape. Surprisingly, predominant issues were not the quantity of services as emphasized in other studies (Shakya et al., 2010; Anisef & Kilbride, 2000; Chuang, 2009), but rather were regarding their quality and degree of accessibility. In alignment with the sociopolitical effects of neoliberalism, biomedicalization, and the current immigration system, understanding and accessing appropriate services have consistently remained the most widely cited obstacles (Khanlou et al., 2009; Ngo, 2009; Lai & Hynie, 2010).

In an attempt to address the perpetuation of cross-cultural access barriers, the service sector has developed 'cultural competency' models of care. Despite their growing popularity, stakeholders held wide-ranging opinions on their use. Past research on the topic is similarly controversial, with some viewing culturally competent care as a cornerstone in modern service provision (Betancourt et al., 2003; Kirmayer et al., 2003), and others denying its relevance completely (Kumas-Tan et al., 2007; Beach et al., 2005). In the current study a dichotomy emerged, in which some stakeholders supported strategies such as hiring diverse staff and providing appropriate educational training, and others condemned the essentialism of cultures, assumption of expertise, and lack of conceptual consensus. Many stakeholders downplayed the

formality of cultural competency training programs and instead stressed the importance of simple techniques such as remaining open, humble, and flexible. This alternative approach aligns with the ideology of 'cultural humility', which avoids some of the pitfalls frequently associated with cultural competency (Tervalon & Murrary-Garcia, 1998). Most stakeholders believed health inequities could be more efficiently reduced by opening up mainstream services, hiring peers with lived experience, and directing resources towards more practical and universal barriers such as deficiencies in interpretation services, transportation, and financial assistance.

In corroboration of past research, obstacles to coordination and collaboration also hindered the development of a strong, united system of support (Kilbride & Anisef, 2001; Kirby & Keon, 2006). Community professionals demonstrated a lack of what Isaacs et al. (2012) label 'competence trust', in which organizations trust one another to provide adequate services and feel confident making referrals. Studies have shown the power of competence trust to improve partnerships, access to services, and health outcomes for culturally diverse families (Ibid). Community professionals appeared to uphold this goal, but were discouraged by its infeasibility. In its absence, the settlement sector felt immense pressure from the government and mainstream organizations to meet all the needs of newcomers. Stakeholders identified the development of a tiered system of support that displaces the urgency for change within mainstream systems of care onto settlement and ethno-specific organizations (Kirmayer, 2012). Furthermore, the propensity to combine refugee and immigrant populations within the same services was not encouraged in the current study. In direct contradiction to its high prevalence, almost all stakeholders disagreed with this organizational approach. Overall, it is clear that without a solid understanding of population needs or the ability to implement identified best practices, the settlement and mental health sectors are still struggling to adequately support newcomer populations.

Micro Level

As a consequence of unjust social contexts, racial and cultural disparities in quality of healthcare and health outcomes continue to be extensively documented across Canada (Beach et al., 2005; Beiser, 2005). The present study reiterates the presence of heightened health inequities, focusing specifically on the sub-populations of newcomer parents and children. Discussion on the specific experiences of newcomer populations represents the final level of an ecological paradigm, demonstrating the impact that more distant factors have on daily, lived experiences.

Triple Jeopardy of Parents

Unlike the majority of previous literature on newcomer children, the current study ultimately focused on parents. The challenges found for parental figures confirmed the large body of research that exists on the experiences of adult immigrant and refugee populations; essentially, the most common difficulties of immigration for parents – language barriers, discrimination, isolation, acculturation stress, and unemployment – are in line with prior research (see Hansson et al., 2010). However, this study revealed the significance of language concerns; communication issues were perceived as causing and exacerbating additional challenges. Other academics have highlighted the importance of language competence for such populations (Chuang, 2009, 2010; Shakya et al., 2010); however, few have recognized the hierarchal nature of newcomer challenges that was found in the current study, which positioned language as the central cause of many subsidiary issues (see figure 1).

**Figure 1: Major Challenges for Immigrant and Refugee Parents**
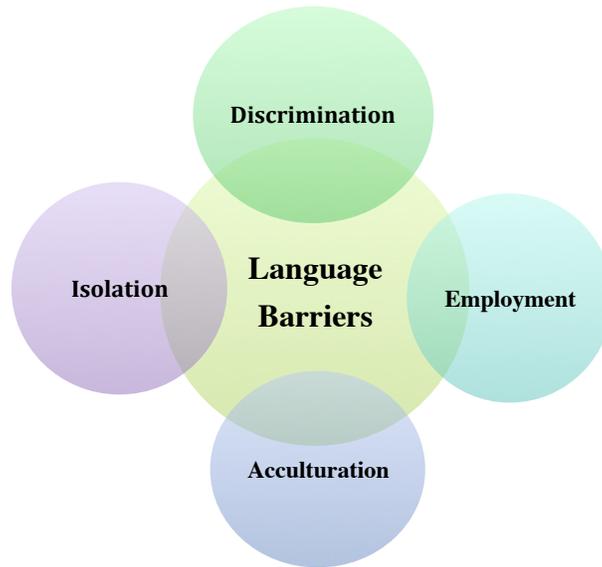
Although some commonalities exist between newcomer and native-born caregivers, this study revealed the particular vulnerable space occupied by immigrant and refugee parents. The situational context of immigration was noted as further complicating the already demanding responsibilities of parenthood; language difficulties, cultural and racial differences, traditional gender roles, social isolation, weak social support, and trauma were identified as factors that further exacerbate the challenges of parenthood. Thus, it appears newcomer parents live in a state of 'triple jeopardy', in which parenting challenges, newcomer issues, and structural barriers coalesce to heighten the risk for adverse social conditions and poor wellbeing. This phenomenon reflects the concepts of 'triple disadvantage' and 'double jeopardy' discussed by Rong and Brown (2002) and Beiser (1998) regarding the intersectionality of vulnerabilities; the principles behind both concepts are highly transferable to the current analysis of newcomer parents.

Resiliency of Children

The current study largely reinforced previous findings on the major challenges faced by newcomer children. Stakeholders interviewed similarly focused on the detrimental impact of

language barriers and subsequent issues of social isolation, role-reversal, bullying, and the

acculturation process (Khanlou et al., 2009; Anisef & Kilbride, 2000; Chuang, 2009).

Figure 2: Major Challenges for Immigrant and Refugee Children

Isolation

Acculturation

Language Barriers

Bullying

Role-Reversal
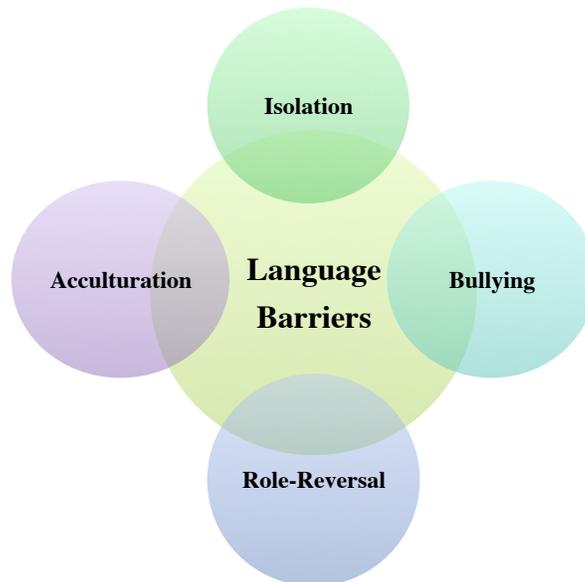
However, within this study the discussion of children's experiences was extremely

limited. Both stakeholder groups seemed to assume the positive wellbeing of children, as issues

connected to adult populations consumed the majority of dialogue. Although certain

psychosocial issues were identified as predominantly affecting children, the severity of their

impact was consistently downplayed; interviews confirmed the expectation of resiliency, in

which children are believed to adapt quickly and are rarely associated with negative emotions or

mental illness (Fantino & Colak, 2001). Thus, despite the presence of acute challenges for

children, stakeholders often perceived them as manageable issues that would not have long-term

impacts. This phenomenon may further reflect the lower assignment of mental health diagnoses

to newcomer children, which indicates a lower presence of biomedicalization and access to

related technoscientific resources (Clarke et al. 2003). These processes contribute to the

categorization of children as an invisible or forgotten population (Tremblay, 2012), in which

support systems are concentrated on the needs of adult newcomers and overlook the experiences of children. Examining previous literature, which has largely failed to analyze the intersectionality of age and immigration, only further substantiates the negligence of young immigrant and refugee lives.

The Healthy Immigrant Effect?

In previous literature, academics have attempted to explain the health status of recent immigrants and refugees through *the healthy immigrant effect*. From this lens, immigrant health is viewed as initially superior to native populations but subsequently declining and converging to a similar level (Beiser, 2005). However, the present study did not find proof of this effect. On the contrary, informants described the quality of both physical and mental health as temporarily decreasing during the initial settlement period, and then slowly rising again during adaptation. This experience may more closely reflect the *resettlement stress model* which predicts an initial decline in immigrant health as they face stressors such as family poverty, weak social support, and barriers to health services (Beiser, 2005). Thus, it appears that newcomer's health may be threatened during the resettlement period but tends to rebound over time (Beiser, 1999). However, it is unclear whether these findings actually demonstrate the improvement of health levels over time, or are simply the result of discounting long-term issues in order to appear resilient. Nonetheless, individual health and wellbeing is clearly shaped by macro factors such as stage of resettlement, social location, and structural barriers.

The Intersection of Micro, Meso, and Macro Factors

In order to draw out the array of factors that interweave to shape the support systems for newcomer families, this study adopted the framework of Bronfrenbrenner's (1979) ecological paradigm. Both the lived realities of community professionals and newcomer families are

influenced by the ways in which micro, meso, and macro levels of the environment interact. A few researchers have recognized this intersectionality (see Khanlou et al., 2009; Beiser, 2005, 2011), but have lacked a critical analysis of stakeholder perspectives and the power of sociopolitical structures. Through the exploration of key factors from each ecological level, this study critically evaluated the context for stakeholders attempting to support newcomer children.

Although all micro, meso, and macro factors interact and influence one another to some degree, this study found the most significant impact emerging between macro-level elements and lower micro and meso experiences. In both direct and indirect ways, the sociopolitical ideologies of neoliberalism and biomedicalization, and the policies and practices of multiculturalism and immigration, were found to simultaneously influence the service sector, parental responsibilities, individual newcomers' experiences, and one another. As two of the most powerful ideologies steering contemporary service provision, neoliberalism and biomedicalization were observed as strongly impacting all other levels. The focus on individualization, responsibilization, and stratification within Western culture strongly shaped the expectations and realities of parents and community professionals. The study also revealed tremendous impacts from the relatively invisible policies and discourses revolving around multiculturalism, mental health, and immigration. Despite their conceptual nature, such factors have a tangible presence within the daily lives and struggles of parents and community professionals, influencing their evaluation of services, interpretation of stakeholder roles, and level of success in supporting children. Children were also impacted directly by the state of social determinants of health, and indirectly through the toll on their support systems of parents and community figures.

Overall, the emphasis on parents within the current study points to the essential role for primary caregivers during immigration. The intersecting, multi-level factors discovered in this

study ultimately lead to the responsibilization of parents for the care of newcomer children. The primary components contributing to this process include the intricate balance of children and parents' challenges, pressures for intensive parenting, dominance of the family-responsibility paradigm, and constrictive sociopolitical ideologies, policies, and systems. However, parents continue to face countless obstacles to managing such expectations, including personal challenges like isolation, unemployment, language barriers, prioritization of basic needs, slow acculturation, stigmatization of mental health, and barriers to service utilization. Within a contemporary Canadian environment, the combined experiences of immigration and parenthood creates a context for newcomer parents that simultaneously responsibilizes them for the care of their children *and* restricts their ability to effectively do so. Thus, without either the provision of sufficient support for parents or compensatory improvement of direct services for children, immigrant and refugee children will continue to experience inadequate systems of support and pervasive health inequities.

Demonstrating the pervasiveness of immigration and parenting challenges, discourse in the current study largely reflected consensus both within and across the stakeholder groups of parents and community professionals. Participants mostly agreed on the micro-level challenges predominantly experienced by children and parents, similarly emphasized the primary and secondary roles of parents and community organizations in supporting children, advocated for the investment of resources in parenting strategies, and described similar structural barriers. However, a few prominent discrepancies emerged. Between groups, opinions varied on the type and extent of parental involvement, reflecting different cultural values regarding intensive and less emotionally involved parenting styles. Interesting differences also emerged between newcomer parents and community professionals regarding the level of acculturation and role of

multiculturalism. As could be predicted, the overall content of interviews differed drastically. On account of their different social locations; community professionals espoused more critical, nuanced opinions on large-scale issues and future concerns, whereas parents were much more focused on the practical, daily challenges affecting them presently. A few major issues also created dichotomies within the stakeholder groups. These included the use of cultural competency models, accountability measures, and the streamlining of services in either a combined, separate, or mainstream way. Ultimately, each stakeholder category provided a unique outlook on the service landscape and experiences of newcomer families. Including both was an invaluable facet of the current study, which looked to achieve a more nuanced and contextualized introduction to the prominent issues affecting newcomer children.

Overall, the inclusion of diverse stakeholder perspectives and the critical analysis of sociopolitical factors give way to different interpretations and recommendations than previously afforded. The vast majority of prior studies conclude with the provision of specific, practical steps that are recommended for the development of new or improved services for newcomer children (see Khanlou et al., 2009; Anisef & Kilbride, 2000; Chuang, 2010). The findings in the current study would confirm many of the top recommendations, such as enhanced collaboration, increased awareness and outreach, and improved flexibility and comprehension of services. Furthermore, it could contribute additional advice on targeting services to parents, cultural competency training, and the adjustment of service streams. However, the current study recognizes the relative infeasibility of implementing practical recommendations in the current context. As demonstrated, a deteriorating immigration system and increasing neoliberalism, biomedicalization, and stigmatization coalesce to generate a hostile environment for the expansion and improvement of any social services. This reality has been demonstrated time and

again by the low degree of follow-through for the recommendations of nationally mandated studies (Hansson et al., 2010). Alternatively, this study exposes a deeper need for researchers, community professionals, activists, and politicians to become actively engaged in the root of the problem, which stems from the broader social, economic, political, and cultural factors that structure the environment (Canadian Institute for Health Information, 2009). Essentially, before specific recommendations can be successfully implemented, a larger social movement is required to shift the ideologies and practices of political systems. Without such progress, the specific suggestions of researchers and academics will continue to be overlooked, divorced from reality, and remain in the 'phantom zone of irrelevance' (Raphael, 2009).

CONCLUSION

This study aimed to contribute to the body of research on newcomer children's mental health and wellbeing by applying a critical lens to the discourse produced by diverse stakeholders. Recognizing the paucity of research, an ecological paradigm was adopted in order to investigate the full range of micro, meso, and macro levels of society impacting immigrant and refugee children's lives. Utilizing such an approach was useful in demonstrating "the interrelatedness and interdependency between individuals and social systems" (Queralt in Waller, 2001, p. 290) that is evidenced for newcomer children and their support networks.

From within a holistic framework, the research process looked to explore 5 main areas of concern: 1) the challenges of newcomer children, 2) the role of parents and the community, 3) the desired types and levels of support, 4) the state of the service landscape, and 5) the impact of sociopolitical processes. Such a wide range of focus allowed for the development of a complete picture of the current context and populations involved. Ultimately, this study revealed an environment that is not prepared to confront the issues related to immigrant and refugee

children's mental health and wellbeing. Instead, a consensus emerged across stakeholder groups

on the precedence of adult newcomer challenges and concerns. This was evidenced by the

primary focus on the challenges of parents and recommendations for services and supports

targeting them. Minimal information was collected on the specific issues and concerns of

children or the gaps in support that predominantly impact young populations. Essentially,

stakeholders believed that if parents were well supported and involved in their lives, newcomer

children would be resilient to the issues of immigration and child development. However, this is

an insufficient response to the experiences of immigrant and refugee children. With extensive

evidence demonstrating the adverse nature of the sociopolitical context and the prevalence of

newcomer children's issues, any assumptions of resiliency, sufficient social support, or parental

capability to manage children's needs should not be made. Support from parents and community

organizations cannot replace attention to the social determinants of health and the related

structural barriers that relentlessly impact newcomer parents, organizations, and children.

Overall, stakeholders in the current study framed interventions with parents as a useful

strategy for improving children's wellbeing. However, the successful implementation of this

approach has not been realized in the current context. Despite receiving higher attention than

children, the issues of newcomer parents clearly remained unresolved. Thus, before the larger

problems of the service and sociopolitical landscapes are addressed, the improvement of support

received by newcomer children will be minimal; parents and organizations will continue to

struggle and feel incapable of adequately supporting even more vulnerable sub-groups. Thus,

policies, services, and systems need to be connected to powerful sociopolitical forces that can

foster more supportive environments. While ideologies like neoliberalism and biomedicalization

continue to dominate, sustainable action and change concerning vulnerable populations will be

difficult to attain. Parents will continue to be disproportionately burdened by the responsibility of navigating post-migration contexts for both themselves and their family, and children will suffer as a result. Until the local and national community steps up and removes the structural barriers impeding the successful transition of newcomers, health inequities for children will remain.

It is noted that a few additional limitations emerged during the course of this study. Primarily, it is recognized that conducting interviews from a social location of racial and class privilege likely influenced the dialogue of participants. However, the researcher attempted to combat this limitation by remaining open and honest about personal information and investment in the topic at hand. Furthermore, on account of time and recruitment constraints, the participant samples were not completely balanced across desired characteristics. The sample of parents ultimately lacked representation of refugee statuses and only one participant had a child with an acknowledged mental health diagnosis. Within participant samples, potential limitations included the unanimous fluency in English and the high prevalence of female participants (11 out of 15). These characteristics are not inherently limiting, but they shape the social location and experiences of respondents in particular ways. Additionally, it would have been beneficial to increase the overall number of participants involved in the study, particularly to ensure more balanced representation of diverse traits and backgrounds. A larger sample size may also have contributed to stronger comparisons across and within stakeholder categories; without more data to compare and contrast it is difficult to interpret internal and external validity of different claims. Finally, this study would have been strengthened by the inclusion of children themselves. Noting the focus of stakeholders on adult concerns, the direct involvement of children's voices would have made a useful third group for comparison. Ultimately, a small and time intensive study is likely to have the above limitations. However, contextualized, qualitative case studies

remain imperative in building deeper insight into the experiences of vulnerable populations like newcomer children.

Acknowledging the aforementioned limitations of the current study, further research into more specific sub-groups would be valuable. Samples in future studies should select and investigate the distinctions created by factors such as gender (of all stakeholders - parents, children, professionals), age of children (young children or adolescents), ethnicity or nationality (of all stakeholders), and immigrant status (of all stakeholders). Deeper insight into the influence that the type of organization or professional role has on community professional's opinions would also be of interest; increasing sample size and allowing direct comparisons between different service sectors (mainstream, settlement, independent professional) and position levels (director, manager, direct service provider) may reveal more complexities related to the social location of community stakeholders. In order to understand the influence of sociopolitical contexts, a comparative case study across different cities, provinces, or even countries would be worthwhile. Contrasting the micro and meso experiences in jurisdictions with different social, economic, and political systems would allow a deeper understanding of the influence of macro-level features of the environment. Finally, delving deeper into the more highly contested issues covered could promote a stronger understanding of topics like cultural competency, biomedicalization, ideal levels of acculturation, and the interpretation and use of intensive parenting techniques across cultures.

Overall, with the relative absence of literature on the topic, more studies that examine both the facilitative and obstructive conditions impacting newcomer populations are required. The execution of a multi-level analysis is a necessary prerequisite to the establishment of more feasible, contextualized, and realistic recommendations for change. Increased attention to both

the intersectionality of the ecological spheres and the inclusion of diverse stakeholders' voices will help foster more constructive insight into the reality of immigration and resettlement. Ultimately, as they significantly influence the wellbeing of vulnerable populations, the development of government policies, community programs, and research reports should always acknowledge structural conditions and be guided by the lived experience of key stakeholders.

List of Appendices

Appendix 1: Interview Guide for Community Professionals

Background

1. Please tell me about your organization.

2. What has been your past and current involvement with the organization?

Mental Health and Wellbeing of Migrant Children

3. What do you see as some of the major challenges faced by immigrant and refugee children in the Waterloo Region?

4. How do you think these experiences impact newcomer children's mental health and wellbeing?

5. In the research literature, many researchers combine the topic of refugees and immigrants. What is your opinion on combining the experiences and services of immigrant and refugee children?

The Role of Parents and Community Support

6. What role do you believe community services have in supporting immigrant and refugee children?

7. What role do you believe parents have in supporting their immigrant or refugee children?

Services and Support

8. What services and supports for migrant children does your organization offer?

9. What other services and supports would you like to provide? Please explain what they would entail and how it would be different from current programs.

10. What is the current state of services for newcomer children? Are there any unmet needs?

Evaluation of Services

11. What do you think works well in the creation and delivery of services for migrant children?

12. What types of challenges emerge in the creation and delivery of services for newcomer children?

13. What do you believe are the causes of the challenges that exist in supporting this population?

14. What do you see for the future in the area of immigration and community services?

Appendix 2: Interview Guide for Parents

Background

1. Please tell me about your family.

2. What has your experience with immigration and settlement within Canada been like for you and your children?

Experiences of Immigrant and Refugee Children

3. Have your children had any difficulties or concerns before or after your arrival in Canada?
- Have your children demonstrated any behavioural problems at home or in school?
- Have your children demonstrated any emotional problems at home or in school?

4. What do you think are the most common difficulties faced by immigrant and/or refugee children in Canada?

The Role of Parents and Community Support

5. What do you feel are your role and responsibilities as a parent when supporting your child's settlement, integration, and health in Canada?

6. What role do you believe community services have in supporting immigrant and refugee children?

Supporting Immigrant and Refugee Children

7. What has helped your child do well in Canada? What kind of strategies have you used as a parent to help them adjust?

8. Have you gone outside of the family to receive community support for your children?
- If yes, what forms of support did you use? What was this experience like?
- If no, what are your reasons for not using outside support?

Evaluation of Community Support

9. What do you think works well in community services for immigrant and refugee children and families?

10. Are there any problems that exist within community services for immigrant and refugee children and families?

11. Are there any additional types of services and supports that you would like the community to provide for immigrant and refugee children? Please explain any gaps that currently exist and what you think could be improved.

12. In other research and in many community services, different classes of refugees and immigrants are often combined together. What is your opinion on combining the experiences and services of immigrant and refugee children? Do you think they are similar or very different?

WILFRID LAURIER UNIVERSITY
INFORMATION LETTER

Exploring Diverse Perspectives On the Mental Health and Community Support Systems for Immigrant and Refugee Children

Researcher: Taylor Marlow, M.A Sociology Candidate
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Department of Sociology, Wilfrid Laurier University

Supervisor: Dr. Juanne Clarke, Ph.D
jclarke@wlu.ca
Department of Sociology, Wilfrid Laurier University

PURPOSE OF THE STUDY
You are invited to participate in a local research study. The purpose of this study is to explore the needs of immigrant and refugee children and the state of current mental health and community services that are available to them within the Waterloo Region.

PARTICIPATION
 I am seeking professionals who currently work within community organizations in the Waterloo Region, which address either mental health and/or immigrant and refugee concerns. Participants are invited to participate in a one-on-one interview, which will be approximately 1 to 1.5 hours in length. The location of the interview is flexible and will be agreed upon by both the interviewer and the participant. All interviews will be audio recorded and later transcribed. Absolutely no deception will be used during the course of this study.

RISKS
The participant may experience discomfort and/or wish to end their participation for various personal reasons. If so, the researcher or the participant may decide to end the interview and their participation in this study at any point in time.

BENEFITS
Participants will gain insight into the challenges and needs of local immigrant and refugee children, as well as information on the status of the programs and services available for this population within the Waterloo Region. The community as a whole will be able to benefit by gaining knowledge on this vulnerable population, while also receiving collaborative recommendations to improve the current state of services and support. On a national level, this research will add to the body of literature on both immigrant and refugee children and on the provision of mental health and community support services.

CONFIDENTIALITY

Please be aware that quotations may be used in write-ups or presentations. However, participants will never be identified by name or title. When quotations are used, the researcher will identify participants by a numerical identifier, such as 'Participant 1'. Only the researcher and supervisor will have access to research data. Electronic files will be encrypted and any hard copies will be kept in a locked drawer. The researcher may keep the data for up to two years before destroying it.

CONTACT

If you have questions at any time about the study or the procedures, you may contact the researcher, Taylor Marlow, at marl2640@mylaurier.ca. This project has been reviewed and approved by the University Research Ethics Board. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in human research have been violated during the course of this project, you may contact Dr. Robert Basso, Chair, University Research Ethics Board, Wilfrid Laurier University, (519) 884-1970, extension 4994 or rbasso@wlu.ca.

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PARTICIPATION
I am seeking the parents or primary caregivers of immigrant or government-assisted refugee children that are currently residing within the Waterloo Region. Participants are invited to participate in a one-on-one interview, which will be approximately 1.5 hours in length. The location of the interview is flexible and will be agreed upon by both the interviewer and the participant. All interviews will be audio recorded and later transcribed. Absolutely no deception will be used during the course of this study.

RISKS
The participant may experience strong emotions, discomfort and/or wish to end their participation for various personal reasons. If so, the researcher or the participant may decide to skip questions or end the interview and their participation in this study at any point in time with no penalties. The participant may experience strong emotions, discomfort and/or wish to end their participation for various personal reasons. If so, the researcher or the participant may decide to skip questions or end the interview and their participation in this study at any point in time with no penalties. In addition, if confidentiality is ever breached it may induce social risks for the participants. However, extensive measures will be taken to ensure confidentiality is protected (see section on 'confidentiality').

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COMPENSATION
For participating in this study you will receive financial compensation of $50.00. You will still be entitled to full compensation if you withdraw from the study prior to its completion.

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INFORMATION
I am seeking professionals who currently work within community organizations in the Waterloo Region, which address either mental health and/or immigrant and refugee concerns. Participants are invited to participate in a one-on-one interview, which will be approximately 1 to 1.5 hours in length. The location of the interview is flexible and will be agreed upon by both the interviewer and the participant. All interviews will be audio recorded and later transcribed. Absolutely no deception will be used during the course of this study.

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PARTICIPATION

Your participation in this study is completely voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time in time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study, every attempt will be made to remove your data from the study, and have it destroyed. You have the right to omit any questions or procedures you choose without question.

FEEDBACK AND PUBLICATION

The data will be used in the write up of a Major Research Paper (MRP) as the researcher's partial fulfillment for the 2014 MA program in Sociology at Wilfrid Laurier University. This paper may be used as the basis for presentations, community forums, and academic publications. This paper will also be made available for viewing in the Sociology Department at the Waterloo campus of Wilfrid Laurier University. The researcher will provide an executive summary report of the findings to participants following completion.

CONSENT

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study.

Participant's signature_____ Date _____
Investigator's signature_____ Date _____

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COMPENSATION

For participating in this study you will receive financial compensation of $50.00. You will still be entitled to full compensation if you withdraw from the study prior to when the transcription of the interview data occurs; after transcription take place it is not possible to withdraw their data.

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CONSENT

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Participant's signature_____ Date _____
Investigator's signature_____ Date _____

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