Perspectives on Mental Health Information and Program Development Needs Among Canadian Newcomer Parents

by

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Abstract

Children who are newcomers to Canada comprise a rapidly growing portion of the population and face numerous unique mental health risk factors and barriers to care. Mental health literacy (MHL) is a common target for mental health promotion and prevention, and a valuable set of skills for parents as caregivers for their children. However, several aspects of settlement complicate solutions to these challenges, requiring a transformation of our conceptualizations of MHL and effective care. Through two qualitative studies, this dissertation critically evaluated application of MHL in diverse sociocultural contexts, given its non-integration of cultural differences in mental health and information needs. Study 1 (n = 10) explored how MHL aligns with newcomer parents' unique lived experiences and perceptions of information needs surrounding child mental health through individual qualitative interviews. Data was collected and analyzed according to constructivist grounded theory. Findings suggested that the conventional framework of MHL appears to have limited applicability to the newcomer context, due to distinct sociocultural experiences that complicate how presentations of mental health and MHL can be understood (e.g., cultural definitions of mental health, sacrifices and losses during immigration). Findings also highlighted barriers that can limit access to relevant resources (e.g., language, discrimination, settlement stressors). Study 2 (n = 13) evaluated the need for and feasibility of developing a MHL program for newcomer parents via participatory focus groups with newcomer parents and settlement sector professionals. Data was collected and analyzed in line with reflexive thematic analysis. Findings yielded a thematic framework that was organized into program development recommendations for important content areas (e.g., impact of settlement and acculturation on child mental health) and community-based principles in MHL program development (e.g., integration into community settings, focus on family empowerment).

This dissertation's findings offer novel contributions regarding how newcomer families may interface with different perspectives on mental health and psychoeducational resources in central Canada, as well as directions for future settlement sector collaboration and program development for specific newcomer contexts (e.g., cultural groups, immigration categories). Foundations for future research and program development are also provided through a theoretical model and program development recommendations produced in this work.

Keywords: newcomer, immigration, mental health literacy, parenting, child mental health

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Chapter 1: Dissertation Introduction

Childhood and adolescence are critical stages of neurodevelopment, including the formation of foundational social-emotional and cognitive skills (World Health Organization, 2025). However, development of these skills in youth can be disrupted by mental health problems that result from adverse psychosocial experiences and/or biological factors (Patel et al., 2007). This can often contribute to isolation, stigma, and discrimination (Flouri et al., 2014), as well as long-term negative consequences including lower life satisfaction, functional challenges, and onset of other difficulties (e.g., substance use and personality disorders) in adolescence and adulthood (Groenman et al., 2017; Kessler et al., 2009). Unfortunately, mental health problems are highly common and one of the leading sources of illness and disability among youth (Stockings et al., 2016). A recent meta-analysis of 192 global epidemiological studies suggested that approximately 35% of mental health problems develop before age 14 (Solmi et al., 2022). Estimates regarding the international prevalence of child and adolescent mental health problems have varied, but have ranged from 10-20% (Barican et al., 2022; Kieling et al., 2011; Polanczyk et al., 2015). A recent large-scale meta-analysis identified global prevalence estimates of 25.2% for clinically elevated depression and 20.5% for clinically elevated anxiety, suggesting that the prevalence of these symptoms had potentially doubled during the COVID-19 pandemic (Racine et al., 2021). Considering all of this information, early and proactive intervention is conducive to healthier development and prevention of more pervasive challenges (Castagnini et al., 2016; Copeland et al., 2015).

Given worldwide increases in the prevalence of mental health problems, it is also important to consider the complexities of supporting youth who experience these difficulties in the context of foreign health and social systems. In Canada and other nations with high immigration and settlement targets, the national population has increasingly diversified. The Canadian census documented that over 1.3 million new immigrants settled in the country from 2016 to 2021 (Statistics Canada, 2022a), with annual settlement numbers nearly doubling in the past few years (Immigration, Refugees And Citizenship Canada [IRCC], 2024). In 2021, approximately one quarter of the Canadian population was comprised of immigrants (i.e., those who had ever held permanent resident status) and non-permanent residents (e.g., refugee status, holders of a work or study permit). Nearly 60,000 new permanent residents settled in Manitoba from 2016 to 2021, accounting for 4.5% of the province's total population by the end of this period (Statistics Canada, 2022b). Further, 19.7% of the total provincial population in 2021 were immigrants and 2.6% were non-permanent residents. This information reflects that Manitoba is a multicultural province, as well as the importance of effectively addressing the health and social service needs of different cultural communities.

"Newcomer" is a term that describes individuals who have recently settled in a country with either immigrant or refugee status. The Canadian government does not define newcomers in the context of a specific period of time spent living in Canada, although the most common criterion in academic and gray literature includes those who have settled within the past five years (e.g., Shakya et al., 2010; Sim et al., 2023). However, some articles have adopted a broader approach to this topic, such as six to ten years (e.g., Beiser et al., 2015; Crooks et al., 2011), while several do not outline any specific time period (e.g., Caxaj & Berman, 2010; Hirani et al., 2024; Selimos & George, 2018). This dissertation adopted an intermediary approach to defining

this term. In this research, the discussed concepts and research findings relating to newcomers are conceptualized as often being most directly relevant to immigrants and refugees who have settled in the past five years (i.e., the common definition of newcomer); however, a more flexible view was adopted (up to 15 years) to promote recruitment and because these discussions are also likely applicable for many individuals who have lived in Canada for a longer period. Notably, the psychosocial aspects of settlement are complex and indefinite because they can require adjustment to major changes in several life domains, which can extend well beyond a five-year period depending on factors such as resources available and one's sense of integration in the host country and culture (Crooks et al., 2011).

Despite their significant makeup of the population, children who are newcomers and experiencing mental health challenges are an underserved population in Canada (Guruge & Butt, 2015). For instance, language barriers frequently create challenges such as a disconnect between behaviours observed by parents and teachers, a need for interpreters and/or bilingual service providers, and limited access to timely services such as family therapy (Tulli et al., 2020). This and several other aspects of the immigration and settlement landscape require a transformation of our conceptualizations of mental health and effective care to adapt to the needs of this substantial portion of the Canadian population. The remainder of this introductory chapter reviews unique and important determinants of newcomer mental health, as well as one of the most common concepts underlying mental health promotion and prevention research (mental health literacy), prior to outlining the objectives of this dissertation.

Newcomer Mental Health: Risk Factors and Barriers

Among the general population, there are numerous barriers towards accessing mental health-related information and help resources. These include structural barriers (e.g., high costs,

long waitlists, transportation and location-related challenges, not knowing where or how to access resources), attitudinal barriers (e.g., believing a problem is not severe enough to access help or will improve on its own, wanting to handle problems independently, believing resources will not help, concerns about negative social evaluation or hospitalization), and a general low perceived need for external support (Andrade et al., 2014). In addition to these general barriers, there are also distinct sociocultural factors that can negatively impact mental health outcomes and access to resources for newcomer families.

Sociocultural Determinants

Several pre-migration, peri-migration, and post-migration stressors have been demonstrated to have major implications for the wellbeing of newcomer families and their likelihood of accessing mental health-related information and help. Common pre- and peri-migration stressors include separation or loss of family, instability of needs such as food and shelter, and experiences of war-related trauma; common post-migration stressors include reduced size of support networks, language and communication barriers, systemic and social discrimination, new school and social environments, and reduced access to health information and care for the family (Guruge & Butt, 2015; Islam et al., 2017; Khan et al., 2018; Selimos & George, 2018; Tulli et al., 2020). Certain stressors that are not wholly unique to newcomers (e.g., discrimination, poverty) can nonetheless present a more pronounced risk for mental health challenges, such as in low-resource refugee contexts (Ekblad, 2020). For instance, some poverty reduction measures can be inaccessible for newcomers with a precarious immigration status, and they may not be able to provide timely applications due to limited information, help, or available documentation (Li & Neborak, 2018; Mehdi et al., 2024). Newcomers frequently identify such immigration and settlement-related stressors as a primary or overarching cause of mental health

problems (Cha et al., 2019; Sim et al., 2023), suggesting the complicated and entangled nature of settlement with mental health presentations and support needs in this population.

It is also noteworthy that newcomers, particularly refugee families, commonly experience a pervasive sense of upheaval and disrupted identity before, during, and after settlement (Marshall et al., 2016). These adverse and often traumatic experiences can result in clinical symptoms of depression, anxiety, and posttraumatic stress disorder (PTSD), which may be experienced collectively by families (e.g., those who have fled their country due to war or other humanitarian crises, or have lived in refugee camps) and/or intergenerationally (e.g., parents' experiences impacting children indirectly; Giammusso et al., 2018; Hirani et al., 2024; Pfeiffer et al., 2022). For example, one mixed methods study examined traumatic and depressive symptoms among refugee mothers and their children who had recently moved to Canada (Barnes & Theule, 2023). The findings demonstrated that child internalizing and externalizing behaviours were positively correlated with maternal trauma symptom severity and negatively correlated with child attachment security. The findings additionally suggested that child attachment security may protect against the effects of maternal trauma in this population. More broadly, newcomer families can also experience a great deal of loss during migration, including interpersonal (i.e., family and friends), material (i.e., a home, status of living, income), and more abstract losses (e.g., social role and status, identity, sense of stability or future plans; Renner et al., 2024).

Acculturation

Unlike their non-immigrant peers, children who are newcomers often experience stress about leaving their home country, as well as adapting to a new country and lifestyle (Tulli et al., 2020). Acculturative stress is a term that describes stress resulting from the challenges of integrating new societal systems, norms, values, and customs with pre-existing ones in an

adaptive and balanced way, and is common among newcomers (Burgos et al., 2019). As a result of this tension, many newcomers can experience a sense of confusion, disempowerment, and/or segregation when arriving in the Western world. Difficulties with acculturation have been linked to multiple adverse mental health outcomes, such as depression, anxiety, and low self-esteem, while ease of acculturating has been linked to positive mental health factors such as positive affect and life satisfaction (Yoon et al., 2011, 2013).

During this process, the family unit is often a crucial source of security, resilience, and wellbeing (Burgos et al., 2019). However, pre- and post-settlement experiences can bring on significant pressures for families that are likely to increase children's needs for adaptability within the family unit, but also lower parents' own levels of adaptability, such as their responsiveness to additional stressors (Lewig et al., 2010). Relatedly, newcomer parents compete with multiple influences on their children's orientation to the host culture. Whereas most parents will have reached maturity in their culture of origin, their children will have been socialized exclusively in the host culture or a combination of each (Costigan & Dokis, 2006). As a result, differential acculturation can occur, where parents and their children adapt to the host culture at different rates, leading to intergenerational differences in cultural values and experiences (Khaleque et al., 2015; Telzer, 2011; Yoon et al., 2013). These parent-child acculturation gaps can lead to stress or conflict in the family system, maladaptive behaviours in youth, and parent-child communication barriers (Buki et al., 2003; Telzer, 2011).

Stigma

Stigma is another major factor that can be implicated in the mental health of newcomer families. There is evidence of significant stigma towards mental health problems in the general population, including towards child mental health problems (Mukolo et al., 2010; Pescosolido et

al., 2008). This can lead to avoidance of seeking information and help to reduce shame and stigma for both parents and their children (Tully et al., 2019), as well as self-stigmatization by parents as a failure in their parenting (Pescosolido et al., 2007). There are also notable cultural considerations regarding stigma. Misra and colleagues (2021) conducted a systematic review of cultural aspects of stigma and mental health problems among racial and ethnic minority groups in the United States. Their review identified several different forms of stigma that are relevant to the sociocultural contexts of newcomer families: Affiliative stigma (concealment for family's sake, fear of being a burden, and stigma extending to family); public stigma (limited knowledge about mental illness and specific cultural beliefs); self-stigma (negative emotional responses and coping); and structural stigma (service barriers including access and quality). Affiliative, public, and self-stigma are well-recognized components of mental health stigma research that has evolved over the past several decades. Labelling theories of mental health propose that stigma plays a significant role in maintaining and worsening mental health problems at both the individual (i.e., self-stigma, social avoidance) and social levels (i.e., rejection, discrimination; Link et al., 1989). As a result, concealment and avoidance of help-seeking is exceedingly common to minimize stigma associated with diagnosis or labelling (Corrigan, 2007). Similar forms of stigma have been identified as a common occurrence in past research with newcomer populations (Dixon De Silva et al., 2020; Montgomery & Terrion, 2016; Salami et al., 2019; Tulli et al., 2020; Umpierre et al., 2015; Wang et al., 2019).

Systemic Barriers

The concept of structural stigma identified by Misra and colleagues (2021) bears unique considerations for the contexts of newcomer families. Unfortunately, there are limited psychosocial interventions in Canada that are concentrated towards newcomer families' mental

health (Hirani et al., 2024). With increasing cultural diversity in the Western world, disparities in accessing of mental health services have become evident across many newcomer groups (Na et al., 2016). Despite universal healthcare coverage and select free community-based services that are available in some regions of Canada, newcomers and other racialized groups such as Indigenous peoples and ethnic minorities experience significant structural barriers and inequities towards services they may need (Kalich et al., 2016; Kirmayer & Jarvis, 2019). These barriers can involve interrelated socioeconomic issues such as financial strain, poor employment conditions, lack of access to childcare, geographic location, transportation, and language barriers (Tulli et al., 2020). Further, cultural differences in knowledge acquisition and help-seeking can conflict with available pathways to information and care in the host country (Kirmayer & Jarvis, 2019). It is also common for newcomers to distrust authorities after experiencing mistreatment, neglect, and/or victimization by governmental, social, and health systems (Ellis et al., 2011), which can sometimes result from these cultural differences. Thus, due to these difficult experiences and perceived power imbalances, newcomers may hesitate to access health and social services, even if accessing them is possible (Marshall et al., 2016).

Mental Health Literacy

Because of these prominent factors that can be implicated in the mental health of newcomer families, it is critical to assist newcomer parents with promoting the mental health of their children and navigating information and help options (Guruge & Butt, 2015). In response to the high global prevalence of mental health challenges and need for proactive psychosocial approaches, several recent research reviews have called for continued initiatives to better understand and improve public mental health literacy (MHL; Amado-Rodríguez et al., 2022; Cresswell-Smith et al., 2023; Johnson et al., 2023; Reavley & Jorm, 2024; Tully et al., 2019).

The Canadian Alliance on Mental Illness and Mental Health (2008) identified newcomers as a priority group for promoting MHL. Recent research with representatives from Canadian health, education, settlement, and social service sectors also identified MHL as a notable barrier for newcomer families to access mental health support (Sim et al., 2023).

MHL has often been defined as "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" (Jorm et al., 1997). The concept of MHL was originally derived from health literacy literature, which focuses on personal and cognitive skills that mediate effective and autonomous control over health and clinical decision-making (Nutbeam, 2008). In their seminal paper, Jorm and colleagues (1997) first proposed that health literacy researchers had underemphasized the impact of mental health on daily functioning, and had thus neglected investigation of the knowledge, skills, and behaviours required for one to attain good mental health. In doing so, this Australia-based research group launched a new subset of health literacy and mental health literature which has focused on understanding and strengthening MHL in the public. They additionally developed a framework for MHL comprised of several core skills: (a) ability to recognize specific mental health problems, (b) knowledge of how to seek information on mental health, (c) knowledge of risk factors and causes, (d) knowledge of available professional and self-help options, and (e) attitudes that promote recognition and appropriate help-seeking (Jorm et al., 1997). Later revisions to this MHL framework included: (f) knowledge of how to prevent mental health problems, (g) recognition of when a mental health problem is developing, and (h) mental health first aid skills to support others with a mental health problem (Jorm, 2012).

The Jorm research group's definition has since been employed in this field of research as a common framework for the evaluation of MHL skills (Spiker & Hammer, 2019), although

other frameworks have been developed to consolidate the Jorm group's definition or propose additional components (e.g., Kutcher et al., 2016). For instance, several researchers have suggested that knowledge of how to achieve and maintain positive mental health (i.e., 'positive mental health literacy') is another important and overlooked aspect of this concept (Bjørnsen et al., 2017; Carvalho et al., 2022; Cresswell-Smith et al., 2023; Kutcher et al., 2016). Overall, research in this field has brought about programs aimed at strengthening mental health knowledge and awareness among the general public, select governmental policy developments, social awareness campaigns, and funding for psychoeducational MHL programs in several countries (Jorm, 2015; Kutcher et al., 2016). Reviews of population-level data since the emergence of this field have also demonstrated that MHL campaigns and programs can be successful at strengthening MHL skills, such as recognition of key symptoms, over time (Furnham & Swami, 2018; Goldney et al., 2009; Jorm, 2012; Reavley & Jorm, 2011).

Parent Mental Health Literacy

Early recognition and intervention for mental health problems in children are often vital for reducing the impact on their quality of life and development (Flouri et al., 2014; Groenman et al., 2017), as well as emotional burden for their parents (Hurley, Swann, Allen, Ferguson, et al., 2020; Tambling et al., 2023). A parent or family's ability to identify challenges with mental health in their children, as well as seek help, have often been conceptualized as key indicators of their MHL skills (Lawrence et al., 2015). Due to their proximity to their children, parents are positioned to recognize early symptoms of mental health problems, and often are gatekeepers for children's access to help and treatment (Bonanno et al., 2021; Johnco et al., 2019; Tambling et al., 2023; Tully et al., 2019). However, research conducted in this area thus far has indicated that MHL skills may be limited among parents (Frauenholtz et al., 2015; Hurley, Swann, Allen,

Ferguson, et al., 2020; Johnson et al., 2023; Jorm et al., 2007; Mendenhall, 2012; Yap & Jorm, 2012), similar to findings in the general public (Furnham & Swami, 2018; Tay et al., 2018).

Building parents' capacity for identifying signs of common child mental health problems can aid them in differentiating these problems from developmentally common emotional and behavioural difficulties (Abera et al., 2015; Cormier et al., 2020). However, some research has suggested that many parents find it difficult to recognize symptoms of common child mental health problems such as anxiety, and often have low confidence in their ability to do so (Cormier et al., 2020; Davidson et al., 2022; Frauenholtz et al., 2015; Royal Children's Hospital, 2017). Our research (Davidson et al., 2022) surveyed 128 parents and found that 56.3% of those who read a vignette depicting a child with anxiety were able to correctly recognize the problem, and 51.6% of those reading an ADHD vignette correctly recognized the problem. They also self-rated their familiarity with the symptoms of child mental health problems on a 5-point scale (M = 2.81/5), which suggested they believed they had limited familiarity in this area. In another recent study, Cormier and colleagues (2020) found that 41.1% of parents they surveyed were able to accurately recognize ADHD, 64.9% recognized autism spectrum disorder, and 19.1% recognized separation anxiety disorder, while only 14% were able to recognize all three problems. Considering the rising rates of mental health problems in youth (Racine et al., 2021) and greater likelihood of more complex and comorbid presentations, it is increasingly important to help parents strengthen these recognition skills.

Further, parents' ability to effectively recognize symptoms of a mental health problem in their children is often a first step towards seeking external information or support that may be needed to better understand and address the problem (Gulliver et al., 2010). However, the potential benefits of seeking professional mental health treatment for one's children are not

universally recognized among parents (Jorm et al., 2007). Despite evidence supporting the effectiveness of clinical treatment, treatment services are rarely accessed, and prevalence of child mental health problems such as anxiety and depression remain high (Tully et al., 2019). Rather than seeking out dedicated mental health services for children, prioritizing informal help and advice (e.g., from family and friends) is common, as is addressing problems without external help (Jorm & Wright, 2007; Lawrence et al., 2015; Mendenhall & Frauenholtz, 2015; Tapp et al., 2018; Wright et al., 2007). In addition, some research has shown that parents often prefer to access generalized rather than specialized services for child mental health problems (Dey et al., 2015; Hurley, Swann, Allen, Ferguson, et al., 2020; Jorm & Wright, 2007). Similarly, our research (Davidson et al., 2022) found that, in response to vignettes depicting a child with anxiety or ADHD, parents generally rated accessing a general practitioner as more helpful than a psychologist or psychiatrist. Their self-ratings of their familiarity with treatment options on a 5-point scale ($M = 2.67/5$) also suggested limited confidence about their familiarity with this information. These findings are attributable to numerous factors, such as limited public knowledge regarding service options, stigma, and service availability and affordability (Boulter & Rickwood, 2013; Mendenhall et al., 2009; Mendenhall & Frauenholtz, 2015).

Overall, the literature base on MHL skills in parents suggests a value in continued efforts to arm them with information about common problems and treatment options, as well as additional research to better understand factors and barriers associated with these skills. Research regarding these skills among parents has generally been limited, particularly in the context of younger children rather than adolescents (Hart et al., 2023; Johnson et al., 2023; Tully et al., 2019). Potential reasons for the relative underdevelopment of this literature area may include concerns about stigmatizing children and/or parents, the complexity of differentiating mental

health problems from developmentally normal and transient emotions and behaviours, potential for fostering anxiety and unwarranted help-seeking in parents, and scarcity of community services which could even accommodate increased help-seeking (Tully et al., 2019). Recently, because of differences in epidemiology, treatment strategies, and help-seeking pathways for child mental health, researchers have called for a focus on "mental health literacy for supporting children", referring to adults' knowledge and beliefs that support actions that prevent or manage mental health problems in school-aged children (Hart et al., 2023; Johnson et al., 2023).

Sociocultural Contextualization of Research

This discussion and research findings relating to parent MHL are even more complicated within the sociocultural contexts of newcomer families. Due to a wide range of unique stressors that are often faced by newcomer families, the very nature of mental health, and thus the qualities and needs for certain MHL skills, must differ. Furthermore, while progress has been achieved in the past few decades to better understand several factors that can be implicated in newcomers' mental health, most mental health policies and practices are geared towards generic approaches that may be less relevant or unable to address their unique needs (Na et al., 2016). Thus, it is important to consider how initiatives to strengthen MHL can become more culturally responsive broadly, and specifically in the context of newcomer parents. Tailoring information dissemination and services to this context is also necessary for reducing barriers to accessing them (Burgos et al., 2019; Tulli et al., 2020). Overall, in light of increasing immigration numbers and families displaced by global emergencies, a paradigm shift in delivery of mental health information and services is required to adapt to the large numbers of newcomer families who are and will be in need (Ekblad, 2020; Sim et al., 2023). Given Canada's avowed values and policies regarding multiculturalism, Canadian mental health researchers and practitioners are in one of

the most suitable positions to investigate culturally responsive mental health prevention, promotion, and intervention strategies that can meet these diverse needs (Kirmayer & Jarvis, 2019).

Dissertation Overview

My dissertation aims to expand on these needs for sociocultural responsiveness in MHL research through two exploratory and participatory qualitative studies with newcomers to Manitoba, Canada who were parents of children ages 2-12.

Qualitative Focus

While quantitative research methods are valuable for many purposes such as evaluating population-level patterns and statistical relationships between variables, qualitative approaches are likely to be more suitable for elucidating parents' perceptions and behaviours surrounding child mental health (Hurley, Swann, Allen, Ferguson, et al., 2020), because they enable a more in-depth and personal understanding of their experiences (Atilola, 2015). It has additionally been argued that qualitative methods are more suitable for understanding and empowering the voices of members of marginalized communities, which have often been suppressed, underexplored, or misunderstood (Liamputtong, 2015; Ponterotto, 2010; Stein & Mankowski, 2004).

This dissertation research was conducted through the epistemological lens of constructivism. This research paradigm emphasizes that meaning and reality are largely a product of subjective experience, and the world thus consists of multiple individual realities influenced by context (Lincoln & Guba, 2013; Mills et al., 2006). Relatedly, under this paradigm, knowledge and meaning derived from qualitative data are viewed as inevitably being co-constructed between the participant and the researcher, such that the "humanness" of the researcher will influence interpretation and description of the findings (Mills et al., 2006).

Reflexivity and Research Context

Consistent with this constructivist view, reflexivity is an important consideration in this research. Reflexivity entails the researcher's reflection and discussion regarding the influence of their personal experiences, beliefs, and judgments on data collection and analyses (Pillow, 2003). Effective practice of reflexivity is conducive to closer representation of participants' experiences within the study context. Thus, it is critical to consider the influence of my identity, social status, and background experiences on social dynamics with research participants, as well as the organization and interpretation of the data. Some of these factors include being a White, male, Canadian-born, non-parent, Ph.D. candidate in clinical psychology, with clinical training in psychological assessment and treatment. In addition, several personal values motivated my development of this research, including personal experiences with anxiety, as well as beliefs that mental health information and psychological supports should be more accessible to those in need (particularly from a young age). Although my intention in conducting this research is to capture participants' experiences and perspectives as accurately as possible, it is through this lens of personal experiences that I conducted this research and interpreted its findings.

It is my view that several of these experiences, beliefs, and skills benefitted this research by helping me to construct and adaptively frame questions to participants, as well as convey empathy, nonjudgment, and authenticity, thereby promoting openness in participants and the richness of the data. Conversely, my identity and beliefs may have limited my comprehension of participants' experiences at least to some degree. For instance, because I do not have experiences as a newcomer or as a parent, my natural position was to view this research through a lens that is primarily focused on mental health promotion and prevention for a significant and important segment of the Canadian population. However, through its qualitative focus, this research strives

to additionally understand and place equal emphasis on participants' perspectives. Notably, my background and status also had the potential to evoke guardedness in participants or influence what comments and feedback they may share (e.g., those with different sociocultural values and experiences surrounding child mental health and psychological treatment, those who have had negative experiences with researchers and/or mental health professionals). These types of reflections and observations were documented in reflexive notes and memos, which will be discussed in subsequent chapters that focus on individual research studies.

Another important reflexive consideration is to address what may be perceived as an inherent discrepancy in this dissertation. This research creates a juxtaposition between two different perspectives: the notion that MHL is a valuable concept because it presents a unified framework for outlining mental health knowledge and skills that could potentially be applied in different contexts; and the notion that this concept is insufficient and requires a unique approach when viewed through a cross-cultural lens. Because this research is conceptualized as a bridge between Western psychology training and a newcomer participatory perspective, part of its value is to seek pathways for easing this tension, such as aspects of MHL that newcomers perceive to be important for their communities, and necessary qualities in a psychoeducational program for it to have impact in a community. This juxtaposition will continue to be explored in subsequent chapters.

Dissertation Objectives

Considering the discussed advantages of qualitative methods and the aim to elevate participants' voices to enhance our understanding and approach to MHL with newcomer populations, this research comprised two interrelated qualitative studies. Study 1 constitutes an in-depth theoretical exploration of how MHL aligns with newcomer parents' unique perceptions,

lived experiences, and information needs surrounding child mental health. Two objectives of Study 1 were pursued through individual qualitative interviews with parents of children ages 2-12 who were newcomers to Manitoba: 1) Explore the relevance of the Western MHL framework for this population by examining the interrelation of their sociocultural contexts and mental health perceptions and experiences; and 2) Understand key barriers that newcomer parents in central Canada face towards accessing relevant and desired information and supports for promoting mental health in their children.

Study 2 focused on identifying avenues for strengthening parent MHL skills within the sociocultural contexts of newcomer families. This study entailed participatory focus groups with settlement sector professionals and newcomer parents. In the focus groups, participants engaged in feedback and discussion regarding the need for and feasibility of a hypothetical MHL program that was outlined in a program logic model. Study 2 thus addressed the following objectives through these participatory focus groups: 1) Understand how a MHL program about child mental health could be effectively situated within the sociocultural contexts of newcomer parents; and 2) Determine key revisions to the program logic model to enhance the utility of the program.

Further information on study rationale, relevant literature, research methods, findings, and implications of Studies 1 and 2 are discussed in the following chapters. The ultimate goals of this dissertation are to expand researchers' considerations regarding how MHL can be conceptualized and addressed in the immigration and settlement context, as well as to help advance mental health promotion and prevention strategies for a significant and actively growing population in the Canadian mental health landscape, through participatory research methods that empower their voices. Joint implications of the two studies, and their relevance to these objectives, are discussed in Chapter 4.

Chapter 2: Study 1

Introduction

Improving public awareness and understanding of mental health problems has been argued to be crucial for preventive action, reducing stigma, identifying any need for additional support, and encouraging help-seeking behaviours (Bonanno et al., 2021; Hart et al., 2023; Kelly et al., 2007; Reavley & Jorm, 2024). MHL is a prevalent concept and approach to encapsulating these and other skills in mental health research. It is often conceptualized as a target of public mental health awareness campaigns and psychoeducational programs, some of which have shown to be effective for strengthening skills among the general public, such as recognition of key symptoms of mental health problems and knowledge about different treatment options (Furnham & Swami, 2018; Goldney et al., 2009; Jorm, 2012, 2015; Reavley & Jorm, 2011). However, research in the past decade has also introduced some constructive questioning of how MHL is defined (Atilola, 2015; Kutcher et al., 2016; Spiker & Hammer, 2019), its validity and reliability as a psychological construct (Hurley, Swann, Allen, Ferguson, et al., 2020; O'Connor et al., 2014; Reardon et al., 2017; Wei et al., 2015, 2016), and its generalizability to and representation of different cultural and ethnic groups (Furnham & Hamid, 2014; Kutcher et al., 2016; Mendenhall & Frauenholtz, 2015; Na et al., 2016; Reardon et al., 2017).

These challenges are likely to confound how MHL and other psychoeducational strategies translate to diverse sociocultural contexts. Thus, the initial study in this dissertation involved a theoretical and critical evaluation of how the concept of MHL relates to the contexts of newcomer families. This study entailed individual qualitative interviews with parents of children ages 2-12 who were newcomers to Manitoba, with the aims of examining how their sociocultural contexts align with the conventional MHL framework, as well as understanding

barriers to mental health promotion, information access, and help-seeking for this population. A closer review of current challenges in MHL research, and their relevance to the contexts of newcomers, will set the stage for the study's methods, findings, and implications.

Contemporary Limitations of Mental Health Literacy

Despite the value of MHL as a framework for consolidating several mental health-related concepts (e.g., knowledge, beliefs, behaviours), some authors have identified theoretical and methodological limitations across this research landscape in the past decade, suggesting a need to consider other pathways that may lead to better understanding and promotion of MHL in the public (Kutcher et al., 2016; Spiker & Hammer, 2019). For instance, Hurley and colleagues (2020) conducted a systematic review of 21 studies focused on MHL skills among parents and caregivers. They identified poor sample diversity, use of inconsistent and non-validated measures, and limited focus on prevention and psychoeducation compared to evaluation of skill levels, as common issues. They found that quantitative studies in this area were often confined by poor representation in samples for individuals from non-Western countries, as well as fathers and male caregivers. Similarly, father engagement has been consistently documented for several decades as a pervasive challenge in parenting research focused broadly on child development (Parent et al., 2017), child mental health (Schulz et al., 2023), and interventions focusing on child wellbeing (Tully et al., 2017). Hurley and colleagues (2020) also noted that qualitative studies in their review demonstrated minimal practice of reflexivity, which is necessary to highlight key factors of diversity and representation as they pertain to both the researcher and participants (Wasserfall, 1993). These findings provide an overview of other recent critiques regarding definition, measurement, and cross-cultural representation for MHL research that will be detailed below.

Definition

Several researchers have recently identified concerns regarding how MHL is defined and conceptualized. For instance, it has been argued that the Jorm research group's conceptual framework of MHL is not explicit on which knowledge, beliefs, and behaviours constitute 'good' MHL (Atilola, 2015). Further, most investigations of MHL skills, despite being theoretically grounded in this framework, do not evaluate or base psychoeducational resources around all of its components (Kutcher et al., 2016). Some researchers have also proposed revisions to the framework to include other components such as effective help-seeking and low stigma, or to re-concentrate the framework towards a focus on positive mental health factors rather than illness reduction (Bjørnsen et al., 2017; Carvalho et al., 2022; Cresswell-Smith et al., 2023; Kutcher et al., 2016; Wei et al., 2015, 2016). A potential challenge is that further expansion of this framework may simply be a cause for further confusion regarding what should be included under the conceptual umbrella of MHL (Spiker & Hammer, 2019).

Measurement

A related problem pertains to inconsistent measurement of MHL. At least 200 instruments have been developed to measure variables relating to the concept of MHL, only for many of these measures to be unused, altered, and/or not replicated in future research (Wei et al., 2015, 2016). For instance, O'Connor and colleagues (2014) found that 12 out of 13 MHL scales they examined included factors or subscales that diverged from the standard MHL framework. Further, there is a great deal of relevant research that overlaps with different components of MHL but is not explicitly measured or labelled as MHL. For example, Reardon and colleagues (2017) conducted a systematic review of 44 quantitative and qualitative studies focused on barriers and facilitators to accessing child mental health treatment. Some of these studies

included core MHL components (e.g., attitudes towards treatment, knowledge of mental health problems) but MHL was not referenced. This brings into questioning whether conclusions can be drawn from similar research that does not claim to measure MHL. In addition, evaluation studies for MHL-related measures have presented a trend of being psychometrically weak, unclear about robustness and validation, or not reporting these properties at all (Hurley, Swann, Allen, Ferguson, et al., 2020; O'Connor et al., 2014; Reardon et al., 2017; Wei et al., 2015).

Cultural Representation

MHL research has also been limited by an overrepresentation of Western and White voices in findings relative to other cultural and ethnic groups (Furnham & Hamid, 2014; Jorm, 2012; Reardon et al., 2017). A key limitation to our research (Davidson et al., 2022) regarding MHL skills in a community sample of parents was that, despite receiving recruitment support from diverse community organizations (e.g., different cultural and Indigenous community centres), ethnic and educational backgrounds of the sample were relatively homogenous (i.e., primarily White, and highly educated), limiting generalizability of the results to other sociocultural backgrounds. Other research has identified similar problems with sample homogeneity in this literature area (Hurley, Swann, Allen, Ferguson, et al., 2020; Kutcher et al., 2016; Mendenhall & Frauenholtz, 2015). Jorm (2019) has acknowledged this limitation in the field and suggested that generalizability across sociocultural contexts is likely unattainable for MHL research, due to cultural differences in symptoms and approaches to mental health. However, very little research has explored new avenues for understanding MHL within the diverse sociocultural contexts that exist in Western countries (Na et al., 2016).

Theory Expansion and Reconceptualization

The outlined problems with definition, measurement, and cultural representation in MHL research have raised questions regarding its applicability to mental health research and public mental health outcomes (Kutcher et al., 2016; Spiker & Hammer, 2019). As such, it has been argued that MHL is currently an "approximation of theory" because it highlights sub-constructs that should be measured under its umbrella but presents no clear framework regarding the direction and strength of the relationships between these factors (Spiker & Hammer, 2019, p. 240). Taking all of these findings and discussions in the literature into account, I share the perspective that, at present, MHL may best be conceptualized as a developing theory which captures generally helpful knowledge, beliefs, and behaviours for mental health promotion and prevention. However, I argue that concentrating some MHL research towards inclusion of more diverse sociocultural contexts is a particularly important change that is needed to contribute to more precise, consistent, and impactful findings in the literature over time. The remainder of this review and introduction to Study 1 thus considers MHL theory within the context of cultural representation and its relevance to the newcomer context.

Cross-Cultural Applications

Several researchers have suggested that MHL findings in international, cross-cultural, and newcomer contexts have revolved around a Western cultural worldview as the foundation for the concept (Atilola, 2015; Brooks et al., 2022; Mendenhall & Frauenholtz, 2015; Na et al., 2016). Thus, it has been suggested that MHL is poorly understood across different cultural groups and non-Western countries (Furnham & Hamid, 2014; Hurley, Swann, Allen, Ferguson, et al., 2020; Tay et al., 2018). A summary of international and cross-cultural MHL findings, some of their inherent assumptions and limitations, and unique considerations for the newcomer context, will highlight gaps in this literature area that will be addressed in Study 1.

International and Cross-Cultural Evaluations

Internationally, research on MHL has been conducted in several countries, such as Vietnam, Iran, Uganda, and Pakistan (Dang et al., 2020; Jafari et al., 2021; Miller et al., 2021; Munawar et al., 2020). These studies have found public knowledge, beliefs, and behaviours in these countries to be commonly associated with low MHL skills from a conventional perspective. For example, studies conducted with parents in Ethiopia, Indonesia, and Salvadore have shown common findings such as supernatural or religious explanations of etiology, low identification of symptoms of mental health problems, pervasive stigma, and prioritization of spiritual and faith-based healing or self-reliance over professional treatment (Abera et al., 2015; Brooks et al., 2022; Johnco et al., 2019). Within Western countries, some research has found newcomer and ethnic minority groups to show lower scores on measures of MHL skills (Jacobs et al., 2008; Mendenhall & Frauenholtz, 2015; Yeh et al., 2004, 2005).

However, some research has also demonstrated limitations to this evaluative approach to MHL across different cultures. For instance, in a recent qualitative study, Dixon De Silva and colleagues (2020) examined knowledge and beliefs regarding child anxiety and depression in a sample of Latinx parents. Parents had difficulty recognizing specific mental health problems and reported stigma towards these problems and mental health services, but most were still open to accessing services and desired more information about how to help their children. Another study of East Asian immigrant parents in the U.S. found that 26.3% of parents were able to recognize symptoms of bulimia depicted in a case vignette, while 73.7% were able to recognize depression (Wang et al., 2019). The majority rated both informal help-seeking through close friends (78.9%), as well as seeking professional help through school counsellors and psychologists (68.4-73.7%) and psychiatrists (68.4%), as helpful strategies. Thus, in these studies, traditionally

"low" MHL skills (e.g., preference for informal sources of help, stigma) co-existed with other MHL-consistent beliefs (e.g., desire for more information, openness to professional help).

Assumptions in Research

Considering these limitations, it is important to reflect on assumptions that can be inherent in this evaluative MHL research and potential steps that could be taken to enhance understanding of this concept in different cultural contexts. There has been increasing recognition of the influence of cultural concepts and values in presentations of mental health and help-seeking needs (Bhugra et al., 2021). However, MHL has remained grounded in Western conceptualizations of mental health. For instance, MHL literature has often assumed that interpretations of mental health problems and treatment are less valid when they diverge from evidence-based findings or Western biomedical models for mental health (Atilola, 2015; Furnham & Swami, 2018). Certainly, many central features of mental health presentations (e.g., worry in anxiety, low mood in depression) and treatment concepts (e.g., emotional support, validation) derived from evidence-based research are likely to have applications across cultural backgrounds. However, common experiences regarding mental health problems in different cultural groups should also be considered (Furnham & Swami, 2018). For instance, somatization of mental health problems has been shown to vary by cultural group (Sheikh & Furnham, 2012). Furthermore, case vignettes, the most common strategy for evaluating recognition of symptoms and help-seeking strategies in MHL research, tend to depict more Western presentations of mental health problems, limiting their validity in other cultural contexts (Atilola, 2015). Research in sub-Saharan Africa has also found that recognition of mental health problems in case vignettes can be much stronger when, in addition to standard diagnostic labels, indigenous labels for symptoms qualify as being correct (Atilola, 2015).

Additionally, an underlying assumption of instruments used to measure MHL is that stronger scores should be linked to increased knowledge and use of mental health services (Atilola, 2015). Yet, scores on these measures are unlikely to account for preferences for culturally consistent help-seeking options (Altweck et al., 2015). For example, one study found that newcomers from East Asian countries can view mental health services as less relevant to their concerns due to an emphasis on symptom relief rather than what they may perceive as a more holistic approach that integrates social, emotional, and spiritual well-being (Kwong et al., 2012). Other research has highlighted that these sorts of beliefs can actually strengthen perceptions of professional treatment as an important complement to community support. One study found that greater self-reported interpersonal harmony (i.e., sense of family support, social cooperation, unity) was associated with more openness to both informal sources of help and psychological services (Kuo et al., 2006). Similarly, Altweck and colleagues (2015) compared MHL skills across national samples in India and European Americans in the U.S. The primary difference in their findings was that the Indian sample valued informal help-seeking strategies, while the European American sample did not. Informal help-seeking was also associated with professional help-seeking, leading the authors to conclude that valuing of both informal and professional help-seeking was a key distinguishing factor for collectivist values in MHL.

The outlined assumptions in MHL research thus neglect to account for different cultural presentations of mental health (Kirmayer, 2001) as well as the multi-dimensional nature of MHL as it is currently described in the literature (Atilola, 2015). Closer consideration of how sociocultural context influences conceptualizations of mental health is necessary to better understand and help parents strengthen their MHL skills (Atilola, 2015; Furnham & Hamid, 2014; Miller et al., 2021). These sociocultural differences could alter what may be considered

effective MHL skills, such as identifying distinct symptoms and behaviours in one's cultural context, or accessing of relevant information and help. As a result of this underrecognized gap in the literature, it is also possible that valuable MHL skills have been underestimated, or "hidden" in past findings among non-dominant cultural groups (Atilola, 2015).

Newcomer Context

Newcomers lie at the intersection of the discussed limitations to applying MHL theory to different sociocultural contexts. Because newcomers can experience multiple settlement-related stressors (e.g., acculturation, smaller social and family support circles), as well as experiences that can have a significant impact on mental health (e.g., trauma, discrimination), they are a vulnerable population that could benefit from further efforts to promote MHL (Montgomery & Terrion, 2016). In one Canadian study, a sample of recently-immigrated youth from South Asian countries were interviewed about perceived barriers to accessing mental health services (Islam et al., 2017). They believed that their parents played an important role in addressing youth mental health concerns in their communities and endorsed developing psychoeducational programs for parents as a key strategy for promoting mental health among young immigrants.

Notably, multiple factors in the lives of many newcomer families are likely to complicate the basis on which their MHL skills can be understood and acclimated to improve mental health outcomes in their children. For instance, systemic barriers and psychosocial inequalities can be critical determinants of seeking external supports (Johnco et al., 2019; Na et al., 2016), rather than primary knowledge or informational gaps (Kirmayer, 2015). Financial strain, discrimination, and stigma can inhibit accessibility of mental health services for newcomers (Salami et al., 2019; Tulli et al., 2020), in addition to limited availability of culturally and linguistically sensitive services (Na et al., 2016). However, the traditional approach to MHL

purports that disinterest in these services indicates lower MHL, rather than a reflection that they are not accessible or culturally adaptive, and thus perceived as unhelpful or unsafe. Newcomers also can face unique challenges relating to acculturative stress, changes in employment status, and reduction of social supports and status compared to their life prior to migration (Chung, 2010; Sin et al., 2011), which are factors that are not accounted for in the MHL framework.

Concerns about stigma and family welfare are also notable among newcomers and other marginalized communities, leading to disadvantages in access to mental health information and services. For instance, parents may fear being blamed if they or their children are struggling with their mental health, or that concerns will be dismissed or misunderstood by clinicians. This reluctance towards help-seeking can understandably be amplified in parents who have had prior negative experiences with social and/or health services (Fong, 2019). One study involving Latinx parents and caregivers in the U.S. found that many participants reported they were unlikely to access services, due to fears of being stigmatized and potentially harmful results for their children (Umpierre et al., 2015). A common concern was that accessing professional help for their child could be viewed as a reflection of poor parenting on their part, potentially leading to their child being removed from their care by child protective services. However, the researchers found that parents in the study welcomed printed and video-based psychoeducational materials and perceived the information as important for parents in their communities.

In summary, common practices for understanding MHL skills (e.g., measuring knowledge and recognition of mental health problems) may not be an appropriate match for newcomers to Western countries, whose contexts have shaped different interpretations of mental health, as well as related nomenclature and treatment solutions (Na et al., 2016). These skills may have great value in the lives of newcomer families, but the core objectives of the MHL field

can be achieved more effectively by moving towards a framework which incorporates the social and cultural contexts that shape perceptions of mental health and associated treatment. Na and colleagues (2016) argue that researchers, clinicians, and policy makers have at times pathologized non-Western views and treatments for mental health, rather than prioritizing more information and service options for newcomer communities that promote informed personal decision-making. They also argue that communication of mental health information is most persuasive when it is congruent with one's own values and conceptual language (e.g., alternative expressions, labels), which can differ from Western approaches. Thus, shifting away from the evaluative approach to MHL in this way is conducive to a more contextualized understanding of how sociocultural values and experiences may be embedded in relevant skills (Kirmayer, 2015).

Present Study

This literature review summarized the potential benefits of strengthening public MHL skills, particularly among parents of pre-school and school-aged children, as an approach to mental health promotion and prevention. However, this review detailed several issues involving definition, measurement, and particularly application of the MHL concept across different cultural groups. It is an important undertaking for researchers in this field to consider how MHL theory can be expanded to include conceptions of mental health and treatment based on sociocultural context (Furnham & Swami, 2018; Spiker & Hammer, 2019). Examples include the influence of unique cultural differences (e.g., different symptom presentations, terms describing illness, help-seeking practices) and systemic and structural barriers (e.g., discrimination, access to resources) on MHL skills. Research which examines the traditional conceptual framework of MHL (Jorm, 2012; Jorm et al., 1997) and potential avenues for its adaption toward different clinical (i.e., parenting and child mental health) and sociocultural contexts, is needed in the MHL

literature to strengthen the equitability, accuracy, and impact of findings (Atilola, 2015; Furnham & Hamid, 2014; Spiker & Hammer, 2019). Broadening our cultural, developmental, and experiential understanding of MHL will also be conducive to more effective and tailored psychoeducational interventions which affect wider social issues such as stigma and low accessing of available resources (Brooks et al., 2022).

In addition, the applicability of the MHL framework for newcomers specifically has scarcely been explored (Na et al., 2016). The newcomer context is also highly relevant for understanding differences in presentations of MHL skills across cultural groups (Kutcher et al., 2016). Study 1 focused on addressing the outlined gaps in our understanding of MHL across different sociocultural contexts and newcomers specifically. This study explored how the traditional Western framework of MHL (i.e., ability to recognize specific problems, knowledge of how to seek mental health information, knowledge of risk factors and causes, knowledge of professional and self-help options, attitudes promoting recognition and help-seeking, knowledge of how to prevent problems, recognition of when a problem is developing, and skills to support others with a problem; Jorm, 2012; Jorm et al., 1997) aligns with newcomer parents' unique perceptions, lived experiences, and information needs surrounding child mental health.

Objectives

Through individual qualitative interviews with parents of children ages 2-12 who were newcomers to Manitoba, Canada, the objectives of Study 1 were to: 1) Explore the relevance of the Western MHL framework for this population by examining the interrelation of their sociocultural contexts and mental health perceptions and experiences; and 2) Understand key barriers that newcomer parents in central Canada face towards accessing relevant and desired information and supports for promoting mental health in their children.

Method

Qualitative Framework

The constructivist paradigm guiding this dissertation (i.e., the view that meaning and reality are considerably subjective and influenced by experiences in one's social context) enhances the objectives of Study 1. Exploring the MHL framework's alignment with the newcomer context requires equal valuing of participants' subjective interpretations of key mental health-related knowledge, beliefs, and behaviours. Furthermore, an improved understanding of barriers to mental health information and help among newcomer parents requires understanding of the social contexts that contribute to these barriers.

Following this constructivist lens and these objectives, I adopted Charmaz's (2014) constructivist grounded theory (CGT) method for collection and analysis of the qualitative data. Grounded theory approaches follow systematic guidelines for understanding and developing theory regarding participant experiences that is 'grounded' in their descriptions (Glaser & Strauss, 1967). A grounded theory approach was selected as an inductive method (i.e., generating new theory from important mental health-related topics to participants; Mills et al., 2006). However, unlike traditional, objectivist grounded theory, which emphasizes that theoretical explanations of studied phenomena are intended to be an objective account of participants' experiences (i.e., disconnected from the researcher's influence), CGT emphasizes that interpretation of the studied context is socially constructed between the participants and researchers, and is centered around the discovery of meaning rather than discerning a singular truth or reality (Charmaz, 2014). This method thus aligns well with this research's consideration of more culturally responsive approaches to the conventional framework of MHL, and the aim to bridge Western psychology and newcomer perspectives. In the present study, this consideration

of participants' multiple valid realities and construction of meaning enabled rich descriptions of their beliefs and experiences regarding child mental health. The product of the CGT method is an integrative theoretical model, described in the findings and discussion, which depicts relationships among themes and subthemes identified in the data.

Procedure

Ethical Considerations

This study received ethical approval from the University of Manitoba Fort Garry Campus Psychology/Sociology Research Ethics Board (HE2022-0081). All participants provided written informed consent (see Appendix D for the consent form) prior to participation. They were also reminded at the start of the interview that they could withdraw from the study during or after the interview if they experienced discomfort associated with their participation. To protect confidentiality, potential identifying information has been removed from quotes and descriptions of individual participants, and participants are identified by a number in the findings.

Agency Consultation

A critical aspect of applying a constructivist lens to this research involved consultation with experts on the newcomer context, including on potential barriers for recruitment, participant sample characteristics, framing of interview questions, and study limitations. Consultation included discussions with leadership as well as research and mental health committees from the Manitoba Association of Newcomer Serving Organizations (MANSO) – an umbrella organization which provides support to the settlement and immigration sectors in Manitoba – and the Coalition of Manitoba Cultural Communities for Families (CMCCF) – a non-profit organization comprised of a diverse and collaborative network of individuals with an aim of amplifying the voices of Manitoba cultural communities.

This process initially involved introductory presentations and discussions of the research proposal to staff and committee members (including community representatives) of these agencies, which facilitated relationship-building and feedback. The agencies provided valuable contextual information for designing and conducting this research, such as recommendations to account for participants' immigration category, as well as strategies to mitigate potential guardedness in participants due to discomfort with discussing mental health. MANSO also provided support through circulation of a research advertisement, as well as involvement from their research coordinator, who volunteered as a co-interviewer and contributed to data analysis.

Participant Sample

N = 10 parents of children ages 2-12 who were newcomers to Manitoba, Canada were recruited to participate in this research. 'Newcomer' was defined in this research as an individual who had obtained immigrant or refugee status in the past 1-15 years. The term newcomer has commonly been used in academic and gray literature to capture individuals arriving in a new country in the past five years (e.g., Shakya et al., 2010; Sim et al., 2023), with some research utilizing a broader range (e.g., 6-10 years) or not focusing on a specific time period (e.g., (Beiser et al., 2015; Caxaj & Berman, 2010; Crooks et al., 2011; Hirani et al., 2024; Selimos & George, 2018). Consultation with MANSO and CMCCF suggested that an expanded time frame was recommended to reduce the likelihood of recruiting participants in a vulnerable position, such as those recently experiencing acute war-related trauma (i.e., minimum of one year of living in Canada), as well as to increase recruitment prospects for eligible participants in light of study limitations (e.g., interviews being conducted in English). The required 2-12 age range for participants' children was included due to many commonly-occurring mental health and behavioural problems emerging during this period of development (Kessler et al., 2007), and is

consistent with many parent-focused psychoeducational programs (Peyton et al., 2019). Further, maximum risk reduction for children with mental health difficulties is likely to occur as a result of accessing prevention-based services at a younger age, even prior to school entry (Kieling et al., 2011; Lewis et al., 2014). Thus, inclusion criteria were parents of children ages 2-12, who had lived in Canada between 1-15 years. Exclusion criteria were parents who did not have any children ages 2-12, and/or had lived in Canada for less than one year or more than 15 years. No specific level of English proficiency was requested or evaluated. If participants met inclusion criteria and were willing to have a discussion in English regarding their perceptions around child mental health and differences observed around this subject in Canada, they were eligible to participate.

Recruitment

Recruitment was primarily implemented through distribution of a research advertisement (Appendix A) that was circulated through MANSO's network of immigration, settlement, and community agencies in Manitoba, as well as through their electronic newsletter. Prospective participants expressed their interest in the research via email and were provided a link to the informed consent form (Appendix D) and demographic and background questionnaire (Appendix G) hosted on Qualtrics. Most participants reported that they had learned about the research through the MANSO newsletter or word of mouth (e.g., community members). Participants received a $25 Amazon or Visa gift card as an honorarium for participating in the study.

Demographic and Background Questionnaire

After providing informed consent, participants completed a brief online questionnaire collecting demographic and background information (Appendix G) via Qualtrics. The mean completion time for the questionnaire was approximately three minutes. The questionnaire asked

participants about basic personal information including their age, gender identity, education, occupation status, marital status, ethnic and cultural identity, immigration status, immigration category, number of years lived in Canada, home country, and the number and age(s) of their children. This information was collected to describe the sample and contextualize qualitative data (e.g., cultural and immigration backgrounds which informed their perspectives).

Qualitative Interviews

After completing the background questionnaire, participants completed an individual semi-structured qualitative interview via Zoom videoconferencing software. In line with feedback from MANSO and CMCCF, interview questions were re-designed to improve participant comfort and openness by reducing emphasis on a Western framing of this subject (i.e., symptom-based focus on mental health problems) and primarily concentrate on indicators of positive child mental health and wellbeing. The interview protocol included a small selection of questions about participants' perceptions regarding the following concepts: definitions of mental health and wellbeing; indicators of and barriers to child mental health and wellbeing in their community; approaches to addressing signs of lower mental health and wellbeing in their children; availability of information on child mental health and treatment and perceived barriers; and differences in conceptualization and help-seeking for child mental health and wellbeing in Canada. These questions were designed to explore participants' sociocultural contexts in relation to the core components of the MHL framework developed by Jorm and colleagues (1997), highlight potential barriers to accessing information and treatment, and generate discussion on immigration and settlement factors which can influence mental health and MHL skills.

The initial interview protocol (i.e., prior to the first participant interview) is located in Appendix I, while the final interview protocol, which was modified throughout data collection to

account for gaps in earlier participant interviews, is located in Appendix J. Changes to the interview protocol included the addition of open-ended questions at the beginning and end of interviews (i.e., “What does wellbeing or mental health mean to you?” and “Were there any other questions that you were expecting, but we didn’t discuss?”) to allow for more agency in the direction of the interview. Other changes involved the inclusion of questions to obtain more feedback about where participants would seek information and help, as well as discussion of perceived stigma in their communities. This addition was necessary because initial interviews yielded less information about these topics. Parents who had not previously accessed information or help for their child’s mental health appeared to be less likely to address these subjects. However, more consistently asking hypothetical follow-up prompts (i.e., where would they look for help if needed) aided with obtaining more information. This also appeared to provide more flexibility to participants if they were less comfortable with speaking about their own family or if they were unsure of how to answer the question. For example, we observed that some participants focused more on their perspectives or personal experiences as an adult, requiring more follow-up questions regarding what they had noticed in children or from their perspective as a parent. Further, participants appeared to expand on their lived experiences as newcomers to Canada more easily. Thus, more intentional follow-up with these questions helped to clarify links between these lived experiences and their perspectives on mental health.

The constructivist view adopted for this research influenced framing and communication of these interview protocol questions. While the interview protocol included semi-structured questions to help guide discussion around the research objectives, open-ended framing of questions, flexible facilitation, and use of follow-up prompts helped encourage participants to speak freely and contribute their unique individual perspective regarding child mental health. In

addition, I conducted each participant interview alongside a co-interviewer with a background in social work as well as prior lived experience as a refugee in Canada. The co-interviewer briefly shared her experiences with participants as an introduction and during follow-up prompts for the interview protocol questions to promote participant comfort and engagement. This process also contributed to the co-constructed environment, whereby participants were able to elaborate on desired conversation points outside the structure of the interview protocol. Interviews were audio-recorded and transcribed (verbatim) using Trint audio transcription software. Interviews ranged from 39 to 90 minutes-long, with an average of approximately 64 minutes.

Data Analysis

I analyzed the qualitative interview data alongside a research assistant and the co-interviewer, where we independently coded interview data and met after every one to two interviews to reach consensus on emerging themes. A key aspect of CGT is the constant comparative method, where the researcher integrates emerging themes into further data collection, considers similarities and differences in participant experiences, and revises the interview protocol to account for unanswered questions (Patton, 2002). Thus, to evaluate relationships between emerging themes and adapt the interview protocol in response to new questions that arose during data collection, our analysis occurred alongside data collection.

Coding

Analysis of interview data included three common phases of coding in CGT. The initial coding phase involved a line-by-line coding strategy for each line of text in the interview transcripts. The purpose of this phase was to introduce codes that remain close to the data, allowing for preliminary conceptualization of consistent concepts and potential themes across interviews (Charmaz, 2014). The focused coding phase involved gradually organizing and

synthesizing data into thematic categories, themes, and subthemes, as well as early identification of potential relationships within and across themes (Charmaz, 2014; Mills et al., 2006). The theoretical coding phase involved refining dimensions of codes, including interpretation of relationships between thematic categories, themes, and subthemes, as well as reviewing and revising them to provide a more cohesive structure and narrative (Charmaz, 2014). This phase also informed construction of the finalized theoretical model, described in the findings and discussion, which outlines meaningful themes and addresses the research objectives.

Other important processes to keep with the CGT method involved placing high value on participants' perspectives and phrasing during coding, by viewing the researchers' primary roles as organizers and identifiers of patterns in these themes. This included searching for participants' emphasis on key mental health topics in the data (e.g., the central nature of settlement experiences on mental health). This also included capturing of "in vivo" codes, which are direct quotes from participants that are unique, evocative, or particularly demonstrative of a theme (Charmaz, 2014), contributing to the richness of the data. This approach thus facilitated attentiveness to the intended meaning in participants' words and integration of these words as key elements (titles of themes and subthemes) of the final theoretical model.

Field Notes and Memos

While the multiple phases of coding brought form and meaning to the qualitative interview data, documentation of field notes, memo-writing, and diagramming are also core processes in CGT research, because they aid with conceptualizing, planning, and documenting of theoretical directions taken throughout analysis (Charmaz, 2014). Field notes (i.e., immediate post-interview notes) captured observations regarding participant behaviours (e.g., content that was more evidently emotional), their responsiveness to the interview questions (e.g., those that

did not yield as much information), and interpersonal dynamics (e.g., initial reticence with some participants). Memo-writing (i.e., reflections on progress and next steps) promoted immersion in the data and the emerging coding framework, preparation of new and revised questions for subsequent interviews, and development of insights about the relationships between codes and themes (Mills et al., 2006). Key reflections from field notes and memos are included in the below section as well as in the findings and discussion. Diagramming was also employed as an adjunct tool to memos for developing an evolving visual representation of relationships between thematic categories, themes, and subthemes, which gradually helped to form the integrative theoretical model. Each of these processes were also important for monitoring the co-constructive aspect of CGT by ensuring that codes and themes remained close to participants' comments and documenting and understanding the researchers' organization of the raw data.

Study Quality and Rigour

Determining the quality of qualitative research can be complicated (Tracy, 2010), and the power and impact of qualitative research are a function of processes which demonstrate rigour. Rigorous qualitative research is characterized by a high degree of richness in the descriptions that emerge from the data, including the contexts that are explored, the sources of data, and depth and breadth of theoretical constructs (Weick, 2007). It is in this way that qualitative research can approximate the concept of face validity that is used in quantitative research (i.e., whether a study's method appears to, at face value, measure what it proports to measure; Golafshani, 2003). Rigorous analysis requires thorough explanation of the processes through which data are collected, transformed, and organized into the reported findings (Tracy, 2010).

Key criteria regarding research quality and rigour for the CGT method outlined by Charmaz (2014), including credibility, originality, resonance, and usefulness, were considered

for this study. Credibility was addressed by seeking close familiarity with the setting and topic (e.g., agency consultation about the topic prior to data collection, in-depth and limited structuring of interviews to ensure discussion of both mental health and sociocultural experiences), clarifying links between data and conclusions drawn, and ensuring that the gravity of conclusions is supported by the data (i.e., avoiding overgeneralization of findings). Originality was addressed by focusing on a topic and methodological approach that could generate new insights regarding the research subject and build upon prior theoretical concepts; prior research has not critically explored the relevance of the MHL framework to the newcomer context, and very limited research has explored variations to this framework in cross-cultural contexts. Resonance was addressed by drawing connections between individual participant experiences and the newcomer context more broadly, constructing the theoretical model to be grounded in participants' shared perspectives and experiences, and developing a non-technical summary of the findings designed to be publicly available (discussed in Chapter 4). Finally, usefulness was addressed by providing direction on how findings can inform future MHL research that is more responsive to sociocultural context and multiple knowledge mobilization processes (discussed in Chapter 4). These aspects of rigour are also discussed further in the findings and implications.

Another critical aspect of ensuring rigour was persistent attentiveness to reflexivity, which is also consistent with the constructivist paradigm and CGT. As stated previously, this dissertation bridges Western psychology training and a newcomer participatory perspective to better understand MHL in this population. I believe that Western psychology has historically had a restrictive conception of how mental health and help-seeking realistically function in different sociocultural contexts, and that a door must be left open to understanding MHL differently in these contexts. However, given my cultural background and training, I also acknowledge that I

have a predisposition towards an approach to mental health that is centered around recognizing and labelling a problem, followed by seeking psychological intervention. Documentation in field notes and memos was beneficial for reflecting on these influences of researcher identity on interviews and theory development. Notably, there was potential for participants to feel less comfortable with discussing mental health, particularly with an interviewer with my status and identity (i.e., Canadian, White, male researcher and mental health professional). These potential barriers to participant comfort and openness appeared to be initially present for some interviews but substantially mitigated by my co-interviewer's contributions. For instance, a few participants began interviews by providing shorter or less detailed responses but appeared to speak more openly after she had briefly reflected on their cultural similarities or related her own prior experiences as a newcomer. In addition, this dynamic was valuable during coding and theory development, where her contributions helped to identify and elevate participants' experiences during immigration and settlement as a more central thematic category.

Several processes inherent to CGT also strengthened the general rigour of this study through close documentation of the research process, including simultaneous data collection and analysis, documentation of field notes, and memo-writing. In addition, I maintained a research log of completed analytical steps, methodological changes (e.g., to the interview protocol), and decision-making throughout the research process. Further, qualitative research is generally considered to be more rigorous through triangulation (i.e., when multiple researchers, methods, or forms of data converge on a similar conclusion; Denzin, 1978). The independent coding and interpretation of interview transcripts by three individuals (myself, the research assistant, the co-interviewer) during each of the three coding phases thus further strengthened the rigour of this study. We met regularly to discuss emergent codes and themes (including similarities and

differences in our results), needs for revisions to interview questions, and the potential influences of our backgrounds and experiences on our interpretations. This process aided in reducing assumptions regarding participants' descriptions of their experiences, and reduced the potential consequences of subjective interpretation and improved the credibility of finalized themes.

Throughout data collection and analysis, I also routinely discussed interview progress with the co-interviewer, the research assistant, and Dr. Reynolds during these coding meetings, as well as with the co-interviewer before and after each interview. These discussions aided in discerning the point of theoretical sufficiency (Vasileiou et al., 2018), where additional data did not appear to lead to new qualitative themes. Theoretical sampling was also part of this consideration to ensure that the sample included a degree of representativeness and richness in terms of participants' backgrounds and experiences. This included a variety of cultural backgrounds, immigration categories, mental health experiences (e.g., different levels of familiarity with discussing mental health or help-seeking), and lived experiences in the settlement process (e.g., both positive and negative). We determined that interviews 8-10 helped to support and refine previously identified themes, but that new themes were not emerging. Thus, after the 10 participant interviews were conducted, it was determined that themes became generally consistent and addressed the research objectives.

Findings

Sample Characteristics

Each of the n = 10 participants provided information on the demographic and background questionnaire. The mean age of participants was 36.3. All participants identified as female when asked about gender identity and were mothers. The sample was relatively well-educated, with nine participants having attained some form of post-secondary education. In terms of occupation

status, eight participants worked full-time or part-time, while the remaining two indicated they were a stay-at-home parent. Most participants were married (n = 7) or in a common-law relationship (n = 2). In terms of ethnic identity, half of the sample identified as Latin American, while the rest identified as African, Arabic, Black, and Chinese. Similarly, most participants reported they had immigrated from South American and African countries; their original countries included Bolivia, China, Columbia, Dominican Republic, Ecuador, Egypt, Nigeria, and Uganda. In terms of immigration status at the time of data collection, participants had lived in Canada for an average of 5.4 years, and most (n = 7) indicated that they were a permanent resident. Participants reported they had entered Canada under a variety of immigration categories, including as international students (n = 3), provincial nominees (n = 3), refugees (n = 2), and through sponsorship (n = 2). All participants had between 1-3 children (M = 1.9) with three reporting their perspective that at least one of their children had previously experienced a mental health problem (ADHD, trauma, anxiety), and one reporting that their child had previously accessed mental health services (therapy).

Given the diversity of this study's sample, it is important to note that the themes captured through interviews do not provide information about the commonality of perceptions and experiences that are associated with specific sociocultural backgrounds. This point was additionally emphasized by several participants during qualitative interviews. For instance, at the end of her interview, one participant emphasized the diversity of newcomers' experiences and how factors such as cultural identity and immigration category can influence conceptualizations of mental health: "All immigrants come with different backgrounds and cultures, but also the children. It's not the same. A refugee that is coming sometimes with trauma... Because what they

have been watching... War, poverty, hunger" (P4). She additionally noted the range of different experiences that newcomers can have with adapting to life in Canada:

> Even the knowledge that people have... There are more professionals who are coming as a student than other... Maybe when they're coming as refugees. So, it's a good variable to check on your results, because not all immigrants have the same struggles. (P4)

Qualitative Themes

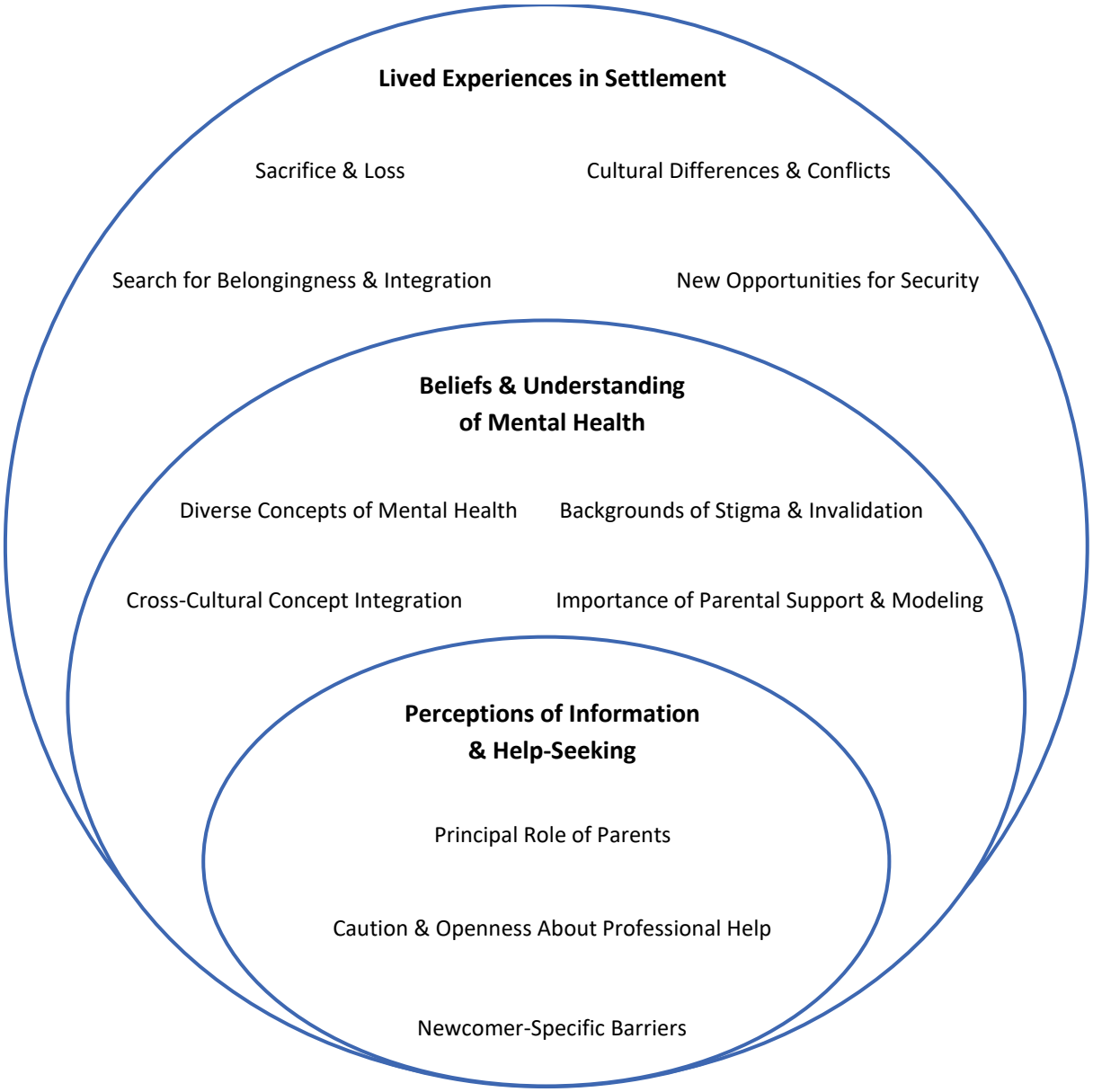
Taking these considerations into account, the findings have been interpreted with a view that they highlight common conceptualizations of mental health among 10 families who are newcomers to central Canada. The theoretical model developed through this analysis captured common themes in this sample, but the model naturally does not cover all possible factors to consider in conceptualizations of mental health among newcomer parents, and the identified commonalities are expected to shift at least to some degree based on the diversity of cultures, immigration categories, and individual experiences that comprise the concept of "newcomers".

Figure 1 provides a visual representation of the theoretical model of participants' conceptualizations of mental health. Their described experiences, beliefs, and observations about mental health were categorized into three thematic areas with their own themes and subthemes: 1) Lived experiences of participants' families within the context of settlement and life as a newcomer; 2) Beliefs and understanding of mental health personally and those that they have observed within their culture more broadly; and 3) Perceptions around seeking information and help for mental health. These thematic categories and their corresponding themes are conceptualized as distinct but nested processes, which is depicted in the model. Participants were asked several questions from the interview protocol regarding their conceptualizations of child mental health (i.e., key signs of wellbeing, observations about cross-cultural differences in

mental health, important responses to challenges, where to look for information and help). It became clear that their beliefs and knowledge on these subjects were embedded within their lived experiences in settlement, due to different mental health-related concerns and needs that are inherently tied to the settlement context. Further, their current perceptions about seeking mental health-related information and help were tied to their beliefs and understanding of mental health that had been influenced by their settlement experiences and time spent in different cultural contexts (i.e., past beliefs and experiences, changes in their beliefs and access to resources across different cultural contexts). A closer look at the findings will provide more information about the interrelated themes and subthemes within these thematic areas.

Figure 1

Model of Newcomer Parents' Conceptualizations of Mental Health



Lived Experiences in Settlement

Participants described major life changes that their families have experienced during and after their transition to life in Canada. These experiences comprised the first thematic category and included themes of: 1) Sacrifice and/or loss resulting from leaving their country; 2) Cultural

differences and conflicts within Canadian society; 3) New opportunities for security and safety in Canada; and 4) Searching for a sense of belongingness and integration in Canada. These themes were critical to understanding participants' current beliefs and understanding about mental health and perspectives on processes for seeking information and/or help, as they described those factors as being heavily influenced by their experiences as newcomers in Canada. Themes within this category were related in how they captured positive and negative experiences during settlement that had impacted the wellbeing of participants' families and the forms of support or resources that could be relevant to these experiences.

Sacrifice and Loss. Although participants were currently at different stages of settlement and integration, it became clear that each of them had endured some form of sacrifice or loss as a consequence of their immigration to Canada. Two subthemes emerged as different aspects of this sense of sacrifice and loss: 1) Migratory grief and the emotional impact of moving away from their previous home; and 2) Stressors associated with the immigration and settlement process itself and adjusting to drastic changes in lifestyle.

"Still in Their Heart": Migratory Grief. Participants frequently described the emotional toll that moving to another country can have on families, due to a sense of mourning about being separated from one's home, separation from family and friends, as well as confusion in children about these major life changes. This emotional impact was described as occurring early in the immigration and settlement process and often continuing for years. One participant discussed the topic of migratory grief, describing her understanding and personal experience with the concept:

> It's a term to describe the psychological and physical symptoms for people that immigrate. And I had almost all of that. Well, sometimes it's not like a diagnosis where

> you have 1 to 3 of the criteria or anything. It's more like the way you feel when you think about your country back home. And your culture. (P6)

She provided examples of cues which triggered this grief when she first moved to Canada: “Every time I was listening to Venezuelan music, I'd start crying” (P6). She also elaborated on the complications that can be associated with this grief:

> One of the learnings in the migration grief... It's that you miss the safety that you feel in your country. Even though I'm Venezuelan, if I go there right now, I won't feel the safety I could feel, even though it's low. I would feel less safety because I don't know the streets anymore. For example, if you go to Kildonan, you know… Okay, this street has a hole. That these houses have whatever... But I don't know that here and I don't know that either in Venezuela anymore. So, it's like you miss a ghost. You miss something that doesn't exist anymore. The Venezuela I remember is not... It's not there. And you don't even know if it's better or if it is worse. (P6)

Another participant communicated what she has noticed about this sense of grief in her children: “Because they are immigrants, they still have something in their heart that's not 100% here from Canada” (P5). She described an emotional pull towards their previous country that her children were still experiencing after several years in Canada:

> I'm always telling them there is no paradise on Earth. So, living here with the stress that we have here in Canada... “And, you know what, kids? If we go back home, it's not going to be paradise as well.” But the feeling of home... Still in their heart as a whole. “Let's go home. Let's be safe at home.” (P5)

One participant expressed her son’s experience of immigrating twice, and her perspective that people underestimate the emotional impact that immigration can have on children:

> When we immigrated to Bolivia, he was close to three years old… He started beginning in the school in Bolivia. He started to speak in Bolivia. All in Bolivia. He liked Bolivia. Your life is in Bolivia. "All is Bolivia", he'd say. "My friends, my family, and my all." I think this affects... Immigration affects all… Children too... But sometimes people think it's only for adults. (P7)

She later emphasized how her son's separation from other family members has impacted him: "We are alone, and we don't have any family in this country. And it all affects my child. Yes. Language, other country, no family" (P7). This experience of family separation was a critical aspect of migratory grief reported by several participants. Some participants and their children were previously separated during immigration, or their child had been separated from their other parent when they had moved to Canada. The following participant described her complicated situation of her children being separated from their parents at different times during their transition to Canada: "My daughter… She was a bit confused because we were all living together, and then all of a sudden, she has to come here with Mommy, and Daddy has to stay there with her brother" (P3). She then shared her experiences of reconnecting with her son after being separated from him during formative years of his life:

> I feel like my son was more affected than the rest of us, because he was young... By the time he was able to... He knew I was his mother, but it was like a virtual conversation, you know? We only talked on video for like the next five years. The first five years of his life. So, it was a difficult moment for me, and I believe even if he was a child… I still think it was also not easy for him. (P3)

"It's Hard as an Immigrant Parent": Immigration and Settlement Stressors. In addition to this quality of becoming disconnected from their lives in their previous countries,

participants also described multiple responsibilities and concerns which had created stress for their families as they began to adjust to life in Canada. These stressors pertained to receiving approval for permanent residency and/or a reduced sense of social status or standard of living. One participant described parent-specific challenges in this respect:

> Sometimes with this type of day by day that we have now that is fast, and you have to work 8 hours or more, and they have to be in day care... So, it's hard to understand their feelings and their emotional needs. And more when you're an immigrant. You have a hard time understanding the system in the new country. In the new culture. So, it's hard to... Well, when you know the emotional needs [laughs]... It's hard for you to leave your child with somebody new. It's like, "Okay, what is the teacher going to do with my kid?" Right? So, it's hard. It's hard as an immigrant parent. (P6)

One of the earliest comments during data collection summarized the gravity and stress associated with the immigration process and obtaining approval for permanent residency: "If tomorrow Canada just says you cannot stay because you didn't pass this thing, I don't know where to go. And that can be a high level of stress" (P1). A related concern that this participant and others highlighted was a fear of their parenting practices being reported to Child and Family Services (CFS), resulting in their children being taken away from their custody or them not being approved for permanent residency. She also described vigilance regarding other systems and institutions (e.g., police) providing information to CFS:

> I try to find laws that support from my end. Because as an immigrant you don't want to mess with the police. You don't want to mess with any entity, because we think... I don't know if it's true that everything is connected, and they will figure it out, or they will find

> out and they will say no to your application. So, you try not to. That makes more stress and... That situation... That happens to a lot of immigrants. (P1)

Another participant described the emotional toll of this sense of vigilance: “You put my general wellbeing in a bad shape because I can't focus at work. I can't focus on things I'm doing because someone is threatening me with taking my kids away from me” (P8). For some participants, another significant stressor upon moving to Canada was a reduced sense of social status or standard of living for their family. They expressed surprise and frustration regarding their credentials (e.g., degree, work experience) being disregarded when moving to Canada, as well as the related impact on the wellbeing of their family:

> I had to re-study, and they totally ignored what... Like, I had the fellowship, I had the diplomas, I had everything from insurance. But I'm working now… Totally different studies… I lost my studies. I lost all what I've been working hard to achieve back home, here in Canada. (P5)

Due in part to these losses, this participant emphasized her family’s regret in their decision to immigrate to Canada and how it has impacted their wellbeing: “We thought it was going to be paradise. Different than our home country. And it turned out to be even more stressful than our country. So, our dreams didn't come true” (P5). Another participant shared a similar experience, describing her need to discontinue her former career and work in any job she could find to provide for her family:

> I have to work hard. My husband works hard too. Because if you don't have a good salary in this country, it's very hard. Because it's very expensive. When you compare with Latin America, it's very expensive… We had our profession in our country we lived in... When I moved to Canada, I needed to work in any job. Because it's to survive. (P7)

One participant provided her perspective after having lived in Canada for longer and witnessing the struggles of several families: “There are instances of parents that have to do 2 to 3 jobs just to keep up with a particular lifestyle for their kids, or for themselves” (P8). She also described her thoughts regarding how this can impact the mental health of children:

> There is no family bond, no time for showing love and affection to the kids. It affects you as a parent. It affects the kids. So, this is a major thing that can also affect your mental health and that of children as well. (P8)

Cultural Differences and Conflicts. In addition to these experiences of sacrifice and loss, participants also identified challenges for their families regarding a sense of pressure from common cultural values and practices in Canadian society. All participants described differences they have noticed in Canadian culture in terms of raising children, and several mentioned conflicts they have experienced regarding their values as a parent and member of their culture. Two subthemes emerged in relation to these cultural differences and conflicts: 1) Discomfort associated with Canada’s relative availability of resources and privileges; and 2) A felt sense of needing to preserve or defend one’s cultural values in Canada.

Culture of “Abundance”. Several participants mentioned that Canada is a society with many resources and privileges, leading to some perceived problems with how children are raised, and concerns regarding how deeper integration with Canadian culture may impact the moral values and wellbeing of their children. One participant characterized this as a lifestyle of abundance: “I feel like the kids have so much abundance here that sometimes they don't think about things as much, like wasting food” (P2). She then detailed her perspective regarding the importance of finding gratitude for the resources her family now has access to in Canada:

> So, that's one value that I am trying to teach the kids more. To be really grateful for food and for the things... The house and the space that we have for health and all these things. But I think sometimes because Canada is a great country and we have so many things and opportunities, that sometimes kids can be forgetful, you know? (P2)

Another participant provided a similar perspective, comparing life in Canada to stressors she experienced in her previous country:

> It's like things that you don't worry about here. Food, water, electricity... You need to solve everything while you're working. You're raising a child. Everything. So, I think I can see that difference, not just in my daughter, but in other kids here. It's everything there already. Food is there. (P6)

Some participants also shared their perception that relatively fewer hardships in Canada can have negative implications for mental health and capacity for coping with stress:

> Whenever there's a hydro outage or something, my kids will be like, “What's happening with the electricity? My internet is not working. My toys are not working.” Where I come from, you don't even have... You don't have electricity for like... You might not have it for like a whole week. So... [laughs]. You find other ways of playing and having fun. You're not dependent on electricity. Their life is all so fully packaged. (P8)

She later outlined why she believes strife and austerity in Nigeria can be valuable:

> That's the way Africa is with things. Just like gold, before you get gold out, it's a very dirty rock... You have to keep going at it. Polishing it... Gold needs all these things before it comes out as beautiful as it is. So, the same way, I think parenting should be... There are times for pampering. There are times for being hard on the kids. There are times for being friends. There are times for just letting them be. But you can't just let them be all

> the time. Then they become spoiled rotten. And that's why they can't handle anything that comes their way… You have to be able to find solutions out for yourself. (P8)

Another participant communicated a similar message, framing this sociocultural difference in terms of the level of need for the development of problem-solving skills:

> When you have hard times as a parent or as a kid… You are having more skills for problem solving, because you have to solve problems every day in your country. So, I think those are the differences that I can see. I think with older kids it's related to problem solving. It's not that developed here as it will be... as it is in those countries. (P6)

"It's Like Taking a Part of Who We Are": Preservation of Cultural Values. Another subtheme of culture-related differences and conflicts was a felt need to preserve or defend their cultural values since moving to Canada. One participant emphasized a need to be proactive and assertive with her children about respecting their cultural roots so that they are not forgotten:

> They were not born in Africa. It's really my daughter, because she knows a lot, and she loves my country. So, I try to infuse the African culture in them. I don't want them to have everything here. No. I try to infuse what we do back home. I will train. I will greet our parents. It's just like... courtesy. Everything is different from this place. The way is just different. (P9)

Another participant provided her perspective about these concerns as a mother of a child who had just begun elementary school: "I feel like sometimes when they go out into the world, there are so many things out there that affect what the parents are trying to do for the kids, for their wellbeing" (P2). She later described her concern about her child entering the school system and becoming confused by differing cultural values:

> That would be a concern to me. That I'm trying to teach the kids at home something, and I feel like if the school is competing with me to teach my kid other things. And then the kids would be confused to know who to listen to, who to trust, you know? (P2)

Other participants conveyed a sense that Canada disfavours some of their cultural values and practices. They described feeling a pressure to conform to cultural norms and different parenting styles in a manner that may negatively impact the wellbeing of them or their children:

> Our culture is really... Kinesthetic? Like, they touch a lot. We hug a lot. We kiss a lot. Like, we are Latins. We are comfortable being together. We hug each other when… It's part of our culture. So, when we arrived here, he was just hugging all the girls, all the boys, and the teachers, mothers. Everyone was like, “Stay away. Don't come here.” And he's having troubles with it. (P1)

This participant also emphasized the associated discomfort for their family: “It's uncomfortable, because it's like taking a part of who we are” (P1). She described the pressure that her family was currently experiencing to adapt their communication style:

> We're in doing our best to adapt and to just... We need to stay. So, we try as hard as we can. And that comes with not kissing someone when we say, “Hi.” Just say, “Hi.”, like, apart. And it's really uncomfortable just for us to do that. (P1)

Several participants described other conflicts associated with cultural norms about discipline and communication with children: “If you're doing anything here, it's determined you're trying to maltreat your child. But growing up, we're not taught that way. Scolding your kids doesn't mean you're maltreating them, and that's what formed us” (P9). Another participant described her perceived differences in communication style between her culture and Canada:

> "Please be quiet! You're being told this, like, four times!" It's normal… You come here as a Latina and you say that... Everyone tells you that if you shout at your kid in the street, you might be accused of violence. So, it's like, I cannot touch my kid. I cannot say anything. And that goes against our culture too. And we are not being aggressive with the kids. We are just raised differently. (P1)

Some participants also reported that corporal punishment was a common form of discipline in their culture, resulting in either themselves or others in their community experiencing conflict about their parenting practices (e.g., with other parents, CFS). For instance, one participant described observations from her own community on this subject, as well as her own experience when she first arrived in Canada and decided to adapt her beliefs and approach to parenting:

> It was very new to me when someone said, "If you spank a child, then it means... It's like trouble for you." I'm like… "Why? You know, spanking is part of living." Because of where I come from, right? But then in Canada, you have to unlearn what you knew, and relearn to say, "Oh, maybe I shouldn't spank. Maybe I should talk to them about it. Maybe we should have a conversation about it." And that's new for so many immigrants." (P8)

Search for Belongingness and Integration. These difficulties with understanding and adapting to cultural differences were closely linked with another theme which captured participants' descriptions of an uphill battle for their families towards a sense of belongingness and integration in Canadian society. Several participants mentioned that their children had experienced a difficult process of trying to adapt to and fit in after moving to Canada. Two subthemes were identified as key hurdles to belongingness and integration: 1) Emotional

challenges associated with language barriers, including the impact on the child's self-concept; and 2) Discrimination and internalized oppression due to cultural or ethnic factors.

"I Don't Want to Speak English": Emotional Impact of Language Barriers. Some participants emphasized the stress that their children have experienced associated with learning English and language barriers. This participant mentioned her son's dissatisfaction with consistently needing to practice English: "I see he has the need to chat with friends in our own language, because he has got to do his English the whole day. It's also hard for him. So, he just wants to get relaxed" (P10). Another participant described the difficulty that children can experience with learning a new language in a new country, as well as complicating factors of her children needing to learn three languages and practice each in different environments:

> I insist on speaking our native language at home because I don't want them to lose it. And, at the same time, they're spending more than half the day outside speaking English, and they are studying in French immersion. So, we have three languages at home. So, it was a barrier at the beginning, because they weren't hearing English at home. (P5)

One participant emphasized confusion that her son has faced with learning two languages at a young age, as well as resulting challenges she has experienced in communicating with him:

> He doesn't speak really good Spanish as his native language, and now he's picking up the English. So, he's trying with both to communicate, but he's not good at it. So, all his emotions are the ones that communicate for him... If he's angry, he starts just hitting things or throwing things. Like kids. And if he's so happy, he starts dancing or just moving around. So, he tries to say like, I don't know… "I fight with my friend." He pulled me." And things like that. But at the end I cannot be sure what is his problem and what should I do with it. I don't have enough information about it. (P1)

Another participant described her son's frustrations with his difficulty learning English, as well as the sense of isolation this difficulty has caused for him: "I say, 'What happened, baby? What happened?' Because when I only speak English… 'No, I don't want to speak English.' 'But [child's name], they speak English in this country.' 'No, I don't like. No'" (P7). She later reflected on her concerns and potential need for her son to access psychotherapy for this reason:

> Learning a language is difficult… And he feels frustration. He feels bad. He feels he doesn't like the school. Don't want to go to the school. I'm not sure if he needs therapy for mental health, because I don't want him to feel frustration. Because this is a problem for a long time. (P7)

"Is It Because I'm Black?": Discrimination and Internalized Oppression. Another key barrier to belongingness and integration reported by participants was a sentiment of feeling like an outsider in Canada. They characterized this as sometimes being a direct result of discrimination, differences in physical characteristics (e.g., skin colour) or differences in culture or behaviour. One participant noted that her children do not feel a sense of belonging in Canada because they were not born here. She reflected on her daughter's preoccupation with her skin colour and how it may affect others' impressions of her: "My daughter, for example, has dark skin. So, even when they say funny jokes about it between friends… But whenever she is in a community, even when she is having fun with it... 'Is it because I'm black?'" (P5). Another participant described a similar experience for her own daughter:

> Yeah, my daughter at times will tell me, "Oh, mom, I'm the only brown skin girl in my class." And I'll be like, "It's totally fine. That's the colour of your skin." [laughs] Like, she'll literally be brown, and be the only one." And she was like, "Oh, this person doesn't want to talk to me." I always tell her, "Everybody can't be your friend. Be a friend to

> yourself, then you attract people to yourself." So, I just try to boost her self-esteem, because those are things that bring kids down. When people tell them, "Oh, I don't want to talk to you. Get away. I don't want to do this. I don't want to play." it hurts them. (P9)

Another participant described self-consciousness that her son developed about his hair after transitioning to school in Canada:

> He would say things like, "Oh, I don't like my hair. I wish my hair was straight." You know, stuff like that... And then I would ask him, "Why don't you like your hair? Your hair's just beautiful." "Oh, it doesn't look like…" You see, one of his friends at school was comparing his hair to theirs. And that's when I started noticing that. Because he never, at his previous school, questioned how he looked and stuff like that. So, I realized that it was something that some of the kids from his school were telling him about his hair and his skin, and he started hating himself [tearing up]. (P3)

This participant later described an escalation of bullying and discrimination that her son had experienced, as well as conflict she with his school during her efforts to advocate for him:

> They talk about bullying and how it's promoted in schools. How they're anti-bullying. But it's all a lie. It's all a lie. They don't care if children are being bullied at school. I know that from my own experience with my children. They didn't do anything. (P3)

Several other participants mentioned that their families have experienced prejudice and discrimination in Canada, leading to them feeling less belongingness and safety. For instance, a participant described repeatedly being reported to CFS for negligence of her child:

> I had this case of the woman next door saying my kid was screaming and crying at 3 AM and they called them saying I did something to the kid or something... And actually, everything that they say... It's considered true until they say the opposite... They need to

> come, even if they know it was maybe not true, but need to verify. So, after they verify, they went through my LinkedIn. Just to check who am I. And that makes everything against immigrants. (P1)

She also reported feeling harassed by her neighbour: “I feel harassed from her. Because she's actually giving just false accusations about me. And constantly” (P1). Another participant noted how prejudicial beliefs among parents can influence how children who are newcomers are treated in school: “They feel that immigrants shouldn't immigrate to Canada. And there are some people that feel this way and they convey the message to their kids, and accordingly at school as well” (P5). She later remarked that messaging of Canada as non-discriminatory multicultural society can be misleading to newcomers and impact their sense of belongingness:

> This is not the regular thing, but some people make our life hell, because they are not accepting the ‘other’ as they are, I would say. Or they are not allowing others to feel belonging to the community… There is definitely some discrimination. 100%. Although we all speak on... No discrimination, no colour, no race, no blah, blah. We all know that, and we've been told that when we came to Canada, but this is still a big thing here. (P5)

New Opportunities for Security. The final theme regarding lived experiences in settlement encircled the benefits that several participants described as a result of transitioning their families’ lives to Canada. Thus far, the themes in this category have outlined negative consequences for the wellbeing of their families. Notably, several participants, including some of those who reported negative consequences in other themes, described moving to Canada as having positive implications for the wellbeing and security of their family. Two related subthemes emerged: 1) Perceived benefits to the security of their relationship with their children; and 2) A sense of autonomy and safety compared to life in their previous country.

"You Need to Understand What They Need": Parent-Child Relationship. Some participants described adaptations to their parenting style after moving to Canada which they felt were helpful for improving their relationships with their children. One participant indicated that she was able to develop better communication strategies with her children in Canada:

> I was raised by an African mom. So, of course, I was raising my children as an African mom. But then it wasn't really giving me the resources that I needed. So, I had to change the way I, you know, parent my children and how I communicate with them. (P3)

She attributed these changes to her work with a family therapist: "The resources that they offered really helped... Mostly me because I was able to learn how to communicate with children" (P3). Another participant indicated that balancing the parenting style she has observed in Canada with her own style has been most beneficial for the wellbeing of her children, in part due to a parenting workshop she attended shortly after she arrived in Canada:

> It's a little bit the other way around in our part of the world, where your parents is your boss. They give you order, and you have to obey. For here, it's more like being their friends while you still maintain that parent status. So, they love you, they respect you, but they're not doing it out of being scared, or out of being coward or just being obedient. They are doing it from a place of love. That's one outcome to learn, and I adopted in my parenting style. And it goes a long way in helping them develop their mental health. (P8)

This participant later described a process of balancing her cultural values around parenting with strategies she learned in Canada:

> The only problem is if you if you are stuck in your old ways, right? That's where there's a problem. But if you're willing to learn new things... Open your arms to new ways of educating and training yourself... And you're also reading and watching things to help

> you learn your environment better, and how to better communicate with your kids... I think, yes, you're on the right path. Don't just be stuck in the old path, to say, “Oh, I'm African, and this is how we do it, and that's it.” If you are not stuck in that, then I think everybody is good. With time, you know? Four, five, six, seven, eight years. We all become Canadian. (P8)

Another participant described some challenges she has encountered in her culture regarding awareness of children’s emotional needs:

> They're not interested in development. In the developmental path of children. Because what are going to do as an accountant with that [laughs]? That person just needs to know about numbers. But it's very important. If you have a child that is growing up in your home, you need to understand what they need. (P6)

She also described her efforts to increase this awareness among parents in her community: “When I'm talking about awareness, it's for them to understand what are the emotional needs of children, because they don't know. And I know if they know about those emotional needs, they will have a better approach to parent them” (P6).

“They Had More Freedom”: Autonomy and Safety. The other key benefit that several participants described after moving to Canada was improvements in their daily sense of safety and freedom. For example, the participant described above indicated that her family will experience less stress in Canada, no longer being in the middle of a “humanitarian crisis” (P6):

> I feel more safe here. So, I think if she feels that I feel safe, she will be developing better. But if I'm there in Venezuela, like, waiting to have water, waiting for electricity, or something… I think she will be having more anxiety. (P6)

Other participants reported similar improvements in their lives, including diminished fears about the safety of their children when they are outside:

> They had more freedom, because in my country, it was not that safe for children to go out of the house and play in the front of the house, or go to a park. So, for them, that was awesome… Going outside and walking and having his mom recording him with a phone outside going to this. We can go to one park. Next, we can go to a splash pad. And doing so many things that we could do back home, but not like that, because of safety. (P4)

Another participant reported similar experiences, emphasizing her ability to allow her son to be more independent due to improved safety:

> I feel more safe to be here. In a park, in nature, or when we did cycling. Those kinds of activities. I feel more safe. Then he got more chances to be... Yeah. Talk to people. And I don't have to worry about him. (P10).

Some participants also described a sense of security in Canada relating to stability of resources such as food, health care, free education, more government supports, etc.:

> I know the government will not... Let me die, as we say back home. Like, we say, the government will let you die there, whatever you are. Here it won't happen. I know my kid will have his studies. He will have food. He will have everything. And I just need to be worry about migration [laughs]. It's a huge thing, but it's not that much. It's not having a life in your hands that you need to be worried about daily. (P1)

This participant also communicated the improvements she has observed in her son's wellbeing since accessing more consistent education in Canada: "We couldn't afford to go to school back then, so he wouldn't have that opportunity. Since day one, he got kindergarten. He was completely another kid. He was happy" (P1). Participants also described expectations for

long-term benefits for their mental health and wellbeing of their families. For instance, one participant conveyed her feeling of having an improved capacity for forming long-term goals since moving to Canada, compared to the two other countries in which she had previously lived:

> Well, right now it's getting better, but when I was living there, you can have a project for one day, because the next day everything was going to change... So, you couldn't have savings, safety in your house, in the street, or anything. So, that's the thing I can feel here in Canada. I feel more safe and that I can have a project for the long-term. I can think about my future. (P6)

Beliefs and Understanding of Mental Health

Participants' experiences during settlement were important to understand because of the unique impact that these experiences had on their families' wellbeing, as well as on their current views about mental health. Having lived in different parts of the world, they were able to reflect on their current beliefs and understanding of mental health, drawing comparisons with their past perceptions as well as patterns they have observed in their culture. When asked to discuss their understanding and beliefs regarding mental health, participants appeared to focus on a handful of key topics that were categorized into four themes: 1) Diverse concepts of mental health, including varied personal definitions and the concept's ambiguous nature in their cultural context; 2) Backgrounds of observed stigma and invalidation of mental health difficulties in their culture; 3) Integration of mental health concepts they had learned in Canada with their previous understanding; and 4) The importance of parents' role in supporting child mental health and modeling healthy behaviours. These different themes that were central to participants' beliefs and understanding of mental health additionally appeared to influence their families' coping during settlement, as well as their current perceptions of seeking information and help.

Diverse Concepts of Mental Health. An overarching theme across participant interviews was that they presented with diverse concepts of mental health based on a combination of their experiences as newcomers, circumstances in their home country, and personal or family-based mental health experiences. Two subthemes emerged to represent this diversity of mental health concepts: 1) A variety of ways in which participants currently defined or perceived as key indicators of mental health; and 2) An ambiguous or lack of a central concept for mental health in participants' culture of origin.

Varied Definitions and Signs. When asked to define mental health and wellbeing, participants shared a variety of ideas and beliefs, demonstrating the complexity and multi-faceted nature of these concepts. Some participants were more responsive to a general question regarding what mental health meant to them, while others provided more detail when asked about specific markers of mental health. Some commonalities in their descriptions included having healthy relationships, emotional stability, the ability to manage daily activities and stressors, and children having a secure attachment to their parents. Participants often emphasized one or two specific signs of positive mental health (i.e., differing emphases on states of mind or behaviour), such as healthy relationships: "Having a good relationship with other children, with their teachers at home, the parents and siblings. That would be a good sign" (P4). Another participant emphasized a combination of healthy relationships and resilience through daily challenges:

> I think mental health will be the most relaxing stage of your mind where you are actually doing daily tasks like going to school, going to work, and then enjoying your daily house relations with your husband, your family. Maybe him with his friends in a way that you actually... You're always going to have problems. You're always going to have things you have to figure it out. But you have the strength and the positive view of doing it. (P1)

Some participants emphasized mental stability as a key indicator of child mental health:

> It's... More like stability kind of thing... If he's stable, he would properly think of everything on the right way. He would have the right way to see what's wrong and what's right, because he's mentally stable. (P5)

Other participants primarily focused on the security of the parent-child relationship as a sign of positive mental health: “I feel that everything is going good when she's coming to me to communicate what she needs... Maybe in a way that is usual for her, or maybe something new, because with toddlers, everything is new every day [laughs]” (P6). The following participant provided a similar emphasis regarding a secure attachment to parents:

> They feel secure enough to be able to face certain things and also... If they feel something weird, they... That's when they come to me, and they need me at that moment. To ask me questions, or if they feel unsafe from something and they come to me and... I feel like, to me, that's wellbeing for a little kid. To feel like that. Not being scared to be out there, but when they feel like it's unsafe, they come to mommy and daddy to protect them. (P2)

Similarly, one participant emphasized withdrawal from parents as a key sign of reduced mental health or wellbeing:

> They could be withdrawn. They could just... They won’t talk to you. Stay on their own. Those are signs. Because one of the... Because my kids are very upbeat. They're always around me. Want to talk… So, once I see that those things are in place, I know there's something going on. Most times, it's the case. If they have issues they don't want to talk about, they withdraw from the parents. And that's a big sign for me. (P9)

“There Wasn’t a Term”: Conceptual Ambiguity. A closely related subtheme to these varied descriptions about mental health was a consistent sentiment about there generally being a

lack of a central concept of "mental" health in participants' culture or home country. They often expressed that mental health was not a common focus or topic of discussion in their home country, including for reasons such as preoccupation with daily stressors, survival, and providing for one's family: "I don't think our parents thought a lot about wellbeing as much... Mental health… They're so busy with trying to provide, you know? That doesn't really happen too much" (P2). Another participant emphasized that mental health is rarely considered in her culture in part because people are not raised to consider it as a concept to discuss:

> Back home, I remember growing up, there was no issue of you... You withdraw from your parents and all that. I don't think... Mental health doesn't come to anybody's mind… We're not raised that way… I never heard all that stuff growing up. (P9)

Relatedly, participants consistently mentioned that there was no equivalent term for "mental health" in their language and culture: "No [laughs]. There wasn't a term. As I said, I never heard of that until I came to Canada… Like, it is more recent, because while I lived with my parents, I never heard that word" (P2). This participant also noted that indirect language was often used to describe similar concepts: "It's just something that we didn't hear about. It was words like... She felt trapped. She felt ignored" (P2). She later connected this less direct terminology with barriers to parents' attentiveness to child mental health in her home country:

> "So, the terms that they would use… That they could have been there more. That they could have been more kind to her. Like, show more compassion towards what she was feeling, even if it was something that they felt was stupid or something immature... Because they are dealing with trying to provide, you know? Surviving and all these things. And they don't have the time to worry about a child's problem. (P2)

Another participant provided her own example of alternative terms she encountered in her home country: “The fragile heart. We say you have a heart, like, made of glass. So, that's the key thing. ‘No, you're too sensitive.’ It's like glass. Easy to be broken” (P10). Some participants also communicated that challenges with emotions and behaviours are conceptually distinct from or not associated with “mental health”: “When people have a mood swing, a little bit of depression here, a little bit of that there, it's not considered ‘mental health’ per se” (P8). The following participant described an absence of a concept of mental health and that discourse relating to it would be concentrated around mental illness or mental disorders: “Well, in Venezuela and Colombia... And I will take the risk to say in Latin America... It is not normal to talk about mental health without thinking on mental illness or disorder” (P6).

“You Don’t Have Your Senses Anymore”: Backgrounds of Stigma and Invalidation. Due in part to these varied and ambiguous concepts of mental health, participants described observations of pervasive stigma towards mental health difficulties in their culture or home country. For instance, one participant discussed how individuals with mental health problems may be perceived as having something wrong with their mind or to be uncurable. She described her personal experiences while growing up as well as her broader observations:

> There's this stigma in the African community about it. So, my mom was like, “I know what's better for my family, and thanks for the offer, but no thanks.” Because it's considered... It's like you're crazy or something like that. They don't think it's something that can be cured. They think once you do that, then you're doomed... Back home, they associate it with witchcraft and whatever. It's not really like a mental illness. (P3)

The following participant reported the common use of the term “crazy” in her home country, including how it is associated with use of mental health services:

> When you're experiencing mental health issues, they call you crazy. If you go to a psychologist... “No, I'm not going to the psychologist because I am not crazy.” And not crazy, like, “Oh, [Interviewer], you're crazy.” No, it's not like that. It's like, “Oh my goodness, you're crazy.” It's not mental health. (P4)

Another participant emphasized the finality of being labelled with a mental health problem: “Wellbeing and mental health are two different things back home. So, when someone tells you [laughs] you have a mental problem, you are already... Like, you've gone ga ga already. Like, you're not... You don't have your senses anymore” (P8). Due to this stigma associated with admission or disclosure of mental health challenges, participants described the necessity of concealing these challenges in their cultural contexts: “Because we feel... If you talk about that experience, there's something wrong with your mind, and then people try to hide that” (P10). Participants additionally described more passive forms of stigma where mental health concerns are invalidated or disregarded. For example, one participant described her personal experiences with anxiety and panic, as well as sentiments she had encountered from others:

> First, in Dominican Republic, I didn’t know. And second, even if I did know back there, people don’t see it like that... “What? Why do you have anxiety? You have food. You have company. You have 15 people working with you. You can leave any time you want. You have money in your pocket. Why are you feeling like that? Like, be grateful.” People tell you to be grateful for everything you have. But they don’t understand. (P4)

The following participant provided her perspective regarding how mental health difficulties experienced by children can be invalidated: “Most times, they won't take them seriously. They think they're just joking or... Your parents will be like, ‘What are you saying?’

They would think you're joking" (P9). Another participant provided similar comments, emphasizing how a child's struggles with mental health may not be believed:

> Well, mental health around children is not something that's really talked about at all back home… Before they even think about it as mental illness, first they actually have to believe what you're saying. So... which is almost never, most of the time, you know? Especially when you're a child. (P3)

Despite pervasive stigma, several participants believed that mental health awareness has gradually been improving in their communities, such as through hearing media stories:

> It was discussed more now because some news happened. Kids committed suicide, or they jumped from a high building. Then, there are many articles starting to discuss why those children now... They live better, they have better environments, better education opportunities… And now they became more easily to commit suicide. I noticed there are more topics discussed like that during the past five years or six years. (P10)

Similarly, the following participant described how social media has contributed to improvements in mental health awareness:

> When I was growing up, there was nothing like the social media. Facebook, Instagram. But now there's awareness that... You know what? You go through stuff. This mental health is real. So, now the awareness is coming up, and people are now aware. Then you now refer to some people that died and you'd be like, "Oh my God. Maybe that was what killed this person. Maybe that was what this person was going through." But nobody knew because they couldn't speak up and there was no help. Proper help. (P9)

"I Did Not Know About Mental Health": Cross-Cultural Concept Integration. In addition to these general societal changes in mental health awareness, another theme captured

participant comments about mental health being more of an explicit or natural concept in Canada compared to their home countries, and how this enabled them to learn new information and integrate it into their understanding of wellbeing more broadly. For example, this participant reported that she was first exposed to the concept of mental health in Canada:

> When I was growing up, wellbeing and mental health wasn't really a thing… It's something that I hear more about here in Canada... I feel like I'm just learning now, because I grew up with not knowing or not caring about it. (P2)

The following participant also mentioned that she felt more educated about mental health after moving to Canada: “Well, of course I'm able to call it mental health because I'm in Canada and, you know, I'm more educated about what it is” (P3). She later described how contact with a Canadian social worker facilitated her understanding and eventually receiving support for her mental health: “The lady who was working with my family… She was from Canada, so she was more informed about mental health. So, she was able to identify it, I guess” (P3). Similarly, other participants indicated that naturally hearing more about mental health (e.g., through conversation or word-of-mouth) and increased availability of mental health resources had influenced their perceptions regarding mental health and/or led to positive changes in their lives. One participant described her experiences with panic and the benefits she attained due to being able to label and identify with the concept, after her university instructor noticed that she appeared anxious:

> And then she, after talking to me for some time, told me, “Oh, you're having panic attacks.” And I was like... “What?” When I went home, I started looking for that, and that's the way it came up. Panic attacks. Then I started looking for that about anxiety, other symptoms, and those things… I never heard that term. And if I didn’t talk to her, and she didn’t know, I would be having panic attacks all the time, and not knowing. (P4)

Later, she stated: “I did not know about mental health… I didn't know what a panic attack was. What is that? And then I started searching, because... The concept that I had from mental health was different” (P4). Notably, some participants expressed that some aspects of Canadian society can be excessively attentive to mental health: “It's extremely important. And we don't look after mental health in Nigeria like we should, but I think it's a little bit excessive here” (P8). She elaborated that daily stressors and hardships in Nigeria contribute to a perspective of her and others that mental health concerns in Canada can sometimes be relatively trivial: “You wouldn't even have anybody to complain to, because the person you're probably complaining to is going through worse, and they are not feeling down… Mental health is not heavy in Nigeria like it is here” (P8). Another participant shared her similar perspective:

> Because when you come here… kids are going through this. Like, what's going on? Like, something is wrong some way [laughs]. Because growing up we never had that. And you see people going through worse things than you see here, and you still hear of mental health here. (P9)

Conversely, this participant also described her belief that Canada’s relatively greater availability of mental health resources allows for better understanding of mental health and developmental challenges in children, such as through earlier diagnosis:

> It's better here because you have all the resources. It's a known fact. Because a lot of people go through issues, and it's already narrowed down. They have been diagnosed. In Africa, they don't really... It's not like you get properly diagnosed and all of that. (P9)

Other participants mentioned the benefits of relatively more mental health resources in Canada: “In Venezuela, for example, if you are sick, and you cannot find the medicine… Or maybe you have schizophrenia, and you need those pills, and there's no pills in Venezuela. So,

it's almost like there's no human rights" (P6). Another participant noted more options for psychotherapy in Canada:

> Compared to Canada, of course, there's a big difference. There's child therapies where a child can go to a specialist, which is a very huge difference compared to back home. Yeah. So, it's a good thing that we have those things in Canada. (P3)

Importance of Parental Support and Modeling. The final theme regarding participants' beliefs and understanding of mental health related to the parent's role in mental health promotion for their children. Specifically, they described the parent's ability to model a basis of strength and support as being central to child mental health and wellbeing. This theme was described in the context of personal experiences or observations they hade made regarding mental health stigma or invalidation (e.g., from their own parents), as well as changes in how they have come to understand and perceive mental health in Canada. Two subthemes represented closely related aspects of this parental role of support and modeling: 1) The importance of parents demonstrating emotionally healthy styles of thinking and behaviour for their children; and 2) The importance of establishing secure and supportive relationships with their children.

Parents Are "the Rock": Emotional Awareness and Resilience. A common message across participants was the parent's key role in modeling emotionally healthy styles of thinking and behaviour for their children. One participant emphasized modeling a sense of stability within the family system: "I think that affects the wellbeing of kids, because if the mom and dad are the ones that show the kids instability… The mom and dad are like the rock, right? For the kids" (P2). Another participant had mentioned how she will try to model a willingness to overcome her difficulties and learn new things by taking her son to activities such as volunteering:

> I always try to bring him and show him. “You see? It's also hard for me. You are first time. I'm also the first time. After I talked to the person, you saw the information I got, and that’s something I learned?” Allows him to see how I improved and how I overcome my difficulties. (P10)

She also described the benefits of improving awareness of her emotions and helping her son to identify his own:

> Sometimes I just came to him, to say, “Do you... Did something happen to you? Did you notice…?” I helped him to define his emotions, at that moment. I even learned some terminology to describe that. Upset or angry, or complaining, or something. I tried to learn those terminology to describe the emotion. In earlier times, no one taught me that. Even after that, I noticed I can also... I identify myself with those terms. I think it's really helpful to let me and let my son understand what emotion we have now. (P10)

Similarly, another participant highlighted the link between her own emotions and her daughter’s, and the importance of maintaining awareness of this dynamic: “I can see that sometimes her wellbeing is more related to how I'm feeling. So, if I'm feeling like I'm tired or like I have no patience, she's going to start asking me for more connection or attention” (P6).

“You Have to Make Your Kids Your Friends”: Supportive and Secure Relationships. Participants also believed that parents serve an important role of supporting and listening to their children, both to provide direct support, as well as to model a secure interpersonal style. One participant emphasized a need for parents to be aware of how their emotional responses and receptiveness to children’s concerns can influence their coping abilities:

> It's the reaction of the adult that caused that behavior sometimes. If you are experiencing some anxiety, and you see someone that you could lean on, you will cope easier than

> when... “Hey, why are you feeling like that? Why are you doing that?” When you feel that bad for any reason, you're expecting someone else to feel like you feel, and understand you. (P4)

The following participant provided an example of her strategy of trying to model healthy and secure relationships:

> I tell my kids, “Even when I'm upset with you, don't be scared to speak your mind. Just find a good time.” And then I am always open to them when I'm wrong. I don't wait for them to tell me I'm wrong. I agree that I'm wrong. And I tell them why I'm wrong and I apologize. This I'm trying to model, so when they are wrong as well, they don't have to wait for me to say, “Oh, you're wrong. Go wait for me to get upset.” (P8)

Relatedly, participants identified the importance of demonstrating to their children that they can have an open channel of listening and support, as described by the same participant: “I just make it like an open relationship whereby we are free to talk to each other. We are not scared to lay our weaknesses before each other, whether as an adult or as a child” (P8). Another participant emphasized the importance of proactively establishing a strong and supportive relationship, because children can withdraw and become less likely to disclose their challenges:

> So, I think when you see your kid that's a happy child that, all of a sudden, is withdrawn... We need to do something. Then that child is going through something. Most times, kids don't want to say anything, so we need to get them to talk. We're trying to engage them. Just... You have to make your kids your friends. Let them talk to you about anything. Because that's the only way they can open up to you.” (P9)

Perceptions of Information and Help-Seeking

In addition to describing their beliefs and understanding regarding mental health, participants were asked to describe actions they would consider taking (or have previously taken) if they noticed their child was facing difficulties with their mental health, as well as anticipated challenges with accessing necessary information or supports. Their responses were organized into three themes under a thematic category regarding their perceptions of seeking information and help: 1) The principal role of parents in addressing challenges with child mental health prior to considering more formal help-seeking; 2) General openness mixed with caution towards accessing professional help for their children and/or themselves; and 3) Barriers specific to the newcomer context which limit options for seeking information and help. These themes appeared to be influenced by participants' beliefs and understanding of mental health (e.g., more openness towards seeking professional help since learning more about mental health concepts in Canada) and their experiences in settlement (e.g., requiring additional support for migratory grief). These themes also appeared to play a role in their experiences during settlement (e.g., more difficulties during settlement due to information and help-seeking barriers) and beliefs and understanding of mental health (e.g., changes through previous accessing of information and treatment).

Principal Role of Parents. In terms of considering available options when responding to child mental health difficulties, a common sentiment among participants was that parents should first strive to resolve these difficulties as a family prior to considering more formal help-seeking: "I think it's important for the child to hear from you first, because, again, you are that chain of command… They should go through the parents first" (P8). Two subthemes emerged in these descriptions: 1) A key part of their role as parents is to notice unusual changes in their children's behaviour and gather necessary information prior to further decision-making; and 2) Emphasis on advocating for their children (e.g., seeking support, standing up for them).

"I Never Underestimate": Assess & Gather Information. Participants consistently mentioned that a critical part of their role as parents in determining their children's needs for help is to watch for signs of emotional difficulties or unusual behaviours: "I would observe them… Like, what's the source of that sadness? If it's something from the outside that is causing it, or if it's something on the inside, that is just them feeling like that" (P2). They additionally described a process of gathering information from multiple sources (e.g., teachers) to identify potential causes and any need to advocate for them:

> First, I would ask the teachers how they're doing. I would ask if they have noticed any changes. I would see, evaluate, the environment in the house. If something happens. If there is some problem with my husband, with me. I would talk to my children, but usually I would go to the teachers and ask. And based on what they say, I would keep looking for help at school. (P4)

Another participant underlined how she remains vigilant about behavioural changes:

> I never underestimate anything my kids tell me about school. So, sometimes he says a word... A strange word in the middle of a sentence. I never underestimate it and I ask for details. So, in case that is something that he feels is a small thing that's not affecting him... In my point of view as an adult, and as my point of view, this is a lot. (P5)

"I'm Done Being Polite": Advocate and Defend. The other subtheme was derived from participants' emphasis on their role in advocating for their children, such as defending them to the school during conflicts with other children:

> I encourage my kids to tell me exactly what's going on at school. I stand for them. So, if there is anything that I can do, I just go to school... Blah, blah, blah… Whatever it takes. I give them support at home to tell me what's going on. Because sometimes with kids,

> when they get bullied, they just want to hide it. They don't want to say it. So, I push on... If they can't support themselves at school, their parents can. So, we can do something for you. We can be your support. We are not weak… Like, there is nothing wrong with us to hide… We can stand for you. We can speak loudly. There is nothing to fear. (P5)

This participant described a similar resoluteness about resolving difficulties for her children and standing up for them:

> I know when there is something that is off, and then once I'm able to establish what the issue is, I try to talk to them about it. We try to resolve it. I'll give them ideas as to resolving it. But if it's something like what I mentioned with the teacher, or something, I like my kids knowing that I'm able to stand up for them any day, any time. (P8)

Another participant shared her experience of defending her child in relation to bullying he was experiencing at school:

> I was tired of complaining and calling the school all the time. So, I just sent them an email and said, "My son is not going back to your school until you guarantee that he's safe, and he feels good to be in class, and he's happy. He doesn't look forward to going to school anymore because of this boy." The school... They didn't like my approach. They even wanted me to apologize to them for how I was talking. I'm like, "This is my child. I'm done being polite at this point, because my child is being hurt." (P3)

"I'm Not Going to Risk My Kids": Caution and Openness About Professional Help. Participants were also asked about their perspectives on accessing mental health services if they believed that their child required further support (i.e., in addition to parents, family, and/or community). Broadly, they all expressed openness to this option, with varying levels of comfort and interest. For instance, some participants reported that seeking professional help for their

children would be a last resort. The following participant expressed her concern that accessing a psychologist could lead to a prescription and reliance on medication:

> I don't know if I would go to a psychologist, to be honest, right away, or... Because I think what they would do is give me a pill and say, “Oh, he might be depressed.” and antidepressants, or... I don't know if the first thing I would do is go to a psychologist, to be honest. I would try to be there as a mom and try to see what's going on. And later on, maybe I would think of a psychologist. (P2)

Another participant expressed a concern about how seeking professional help would affect the privacy of her children:

> Well, I haven't reached this point, but my belief, as a mom, is that privacy is number one. But if it's an urgent medical need, or we need to consult someone, definitely I will. But I feel that exposing my kids to... Like, if it was so hard for them to tell me, how would it be if they told anybody else? However, I haven't been exposed... God forbid... I haven't been exposed so far to something that can alarm me as a mom and I need help. But definitely I would ask for help if I feel I can't make it. I'm not going to risk my kids.” (P5)

Despite these concerns, all participants stated they were open to accessing mental health services in the future for their children or themselves if needed. One participant provided her perspective that it is ideal for the parent to first seek information about the problem as well as options for help, but that ultimately professional help should be considered if needed:

> If it's something that is going to help… Maybe something that is beyond you that you don't even have a clue about. First, you want to read about it and get as much information as possible. And secondly, you want to see what help is available around your community

– around the province – that can help you. And then you want to reach out to them first. Let them explain it to you. And then we can bring the child in. (P8)

The following participant described some of her personal experiences with psychotherapy and her current perspectives on seeking help:

Well, I would say I'm a work in progress, you know? So, every day I work on myself. But I can certainly admit that the experience that I had in my... Before I had my children… Kind of affected the way I'm raising my children now. Because I still have those traumas that I went through back home. And suddenly I did not get the help that I needed. So, when I got here, I did get... I went through counselling, and I even saw a therapist for a couple months. (P3)

She later responded to a question regarding seeking professional help for her children if it were needed:

Yeah, absolutely. Because it's something that I actually want... Even if it's just not for a long time. But I think it would help, because I believe they've been through some experiences where it would help. Because as a mother, sometimes you hit a roadblock where you feel like you need outside help… I'm doing everything on my own. So, sometimes it's overwhelming and you just feel like, "I need help." So, I will definitely be open to seeing a psychologist or something like that in the future. (P3)

The following participant also shared her personal experiences with accessing psychotherapy and how they have shaped her openness to accessing help for her daughter: "I will be more than happy to do that… If I have a problem, I have to go to therapy. It's more, like, to understand more of my perspective, my desires... Who am I? All of that" (P6). She continued by describing circumstances where she would prioritize accessing professional help:

> I think if I see a change in her development or if something's happening in the daycare… Or if something is more often than usual. If she's having more tantrums, or something changed and she's just very different. If she doesn't want to be with anybody. Or if she's more attached in a way that she starts crying, like screaming like crazy, or something. I would think, like, "Okay, let's do this. Let's find somebody." (P6)

Another participant expressed that seeking help for children is important to provide reassurance to the family:

> Yeah, it's very important. If a child is going through issues, you need to seek help. Just like marriages go through issues, you go to the counsellor. That's the only way you can save someone. So, if you seek help, they can find a solution. Just to give the person reassurance that, "Oh, you're going to be fine. Everything is going to be..." (P9)

She later mentioned the importance of not assuming too much about the wellbeing of one's children: "Seeking help can give you rest of mind. That assurance that, 'Oh, this guy is okay.' Not you assuming and he's not okay. So, it's really okay for you to just seek help when you need it" (P9). One participant reported that she had previously accessed help for her child, but emphasized that her beliefs regarding help-seeking are uncommon in her culture:

> Totally normal, because I am an educator. I understand that this is important… Even I had my own school back in Dominican Republic, and I was the first one to refer my own son. So, for me, it was normal. However, parents struggle lots to do it. I did it because of my background, but this is not a normal mom [laughs]. (P4)

"I Would Be Very Lost": Newcomer-Specific Barriers. Despite this consistent openness to seeking professional help across participants, they described several factors pertaining to their contexts as newcomers to Canada which limited their access to information

and help resources. One participant presented as open to accessing services for her child but was currently feeling uncertain about how to find additional information and consider her options. She expressed a difference she had noticed in her child's wellbeing since moving to Canada compared to her own coping and adjustment process: "Sometimes I feel bad, I feel depressed, or... But it's different. Now, I need help with how to talk to my child" (P7). She then mentioned her current perspective that she will require external support: "It's difficult for me to manage the situation for my child, because I probably... I want to know the better tools, but I'm not sure if it's better… I think that... No. This area is for a professional" (P7). She continued by describing some of her confusion about where to access support for her child:

> I think in the school they don't have… If he has any problem. If he needs a psychologist, if you need a special condition... No, they don't have any support. Because I talked with the teacher, and said I think [child's name] needs a professional to observe in the school, because... It seems very important. It's no problem for me, because I understand if he has a problem… Probably he doesn't psychoanalyze the problem, because he's a child. I understand. But the teacher said, "No, they don't have any resources for that." (P7)

She described the immigration centre has her central resource for information, but indicated that it has been more helpful for understanding legal guidelines and other administrative processes: "I know the immigration centre, but… I'm not sure if they have any support for a different person, no? Only for laws, for rules… Different rules, or banking, or documents" (P7). After the interview, local resource options were discussed with her. Other participants also described the limited availability of information on mental health resources for newcomers, as well as confusion they have observed in their community:

> They won't look for that information unless they have a problem with their children… I'm just trying to remember when the parents talked to me about... One of the ladies is worried because her son might have autism… There are no psychologists in Venezuela... So, sometimes it's hard because you don't know where to find that information. You don't know where to go. So, for me, because I have my in-laws here, they helped me, but if I didn't have them, I would be very lost. (P6)

This participant also highlighted the barriers that many newcomers experience in terms of availability of information and resources in their first language:

> I recommended that parenting group to one of my friends… But her English is not well yet… So, sometimes it's hard because there are a lot of resources, but they don't know how to access them, or they don't have the language. (P6)

She also explained why availability of resources in one's first language is important not only for accessibility but also effectiveness:

> Sometimes, it's harder to go to a therapist that doesn't speak your language, because you have to speak in another language, and it's so different... But sometimes when I have to explain myself or an emotional subject in English, I use more my logical brain. So, it's like blocking my emotion one... To not be able to express all of that... I haven't gone to therapy in another language. Just Spanish. So, for me, it's easier to go with somebody that understands my culture. (P6)

Participants also communicated a reliance on searching for information online. However, they described challenges with this modality, such as finding health information when it is generally only available in English, as described by the same participant: "I don't even know – wouldn't know – how to look for it in Google, because you have to do it in English. So, I can do

it in Spanish, but in English you have to use different words, different meanings" (P6). Another participant expressed her frustration about trying to access legal guidelines and health information: "Because I don't find anything... Like, even Googling things about Canada is really hard. Finding information online is really hard" (P1). She additionally highlighted the anxiety her family has experienced with having limited knowledge of health resources in Canada:

> You don't have anything, anyone to call. And it's so hard to take care of your kid by yourself without anyone in an emergency. And even if something happened, I don't know anyone to call and say, "Where should I take him? Where should I go?" (P1)

Discussion

The objectives of Study 1 were to: 1) Explore the relevance of the Western MHL framework for this population by examining the interrelation of their sociocultural contexts and mental health perceptions and experiences; and 2) Understand key barriers that newcomer parents in central Canada face towards accessing relevant and desired information and supports for promoting mental health in their children. These objectives were pursued through individual qualitative interviews with parents of children ages 2-12 who were newcomers to Manitoba, Canada. A summary of the qualitative themes and some of their links with past literature will first enhance discussion of the implications of this study as they pertain to the objectives.

Summary of Qualitative Themes

Themes identified in this study were organized into four thematic categories which are connected as interrelated processes in the theoretical model (Figure 1), where themes represented in each category appeared to influence and be influenced by themes represented in other categories. The thematic categories are: 1) Lived experiences of participants' families within the context of settlement and living as a newcomer in Canada; 2) Personal beliefs and understanding

of mental health and those that they have observed within their culture; and 3) Perceptions around seeking information and help for mental health.

Lived Experiences in Settlement

While the initial interview protocol revolved primarily around direct questions about child mental health (i.e., signs of wellbeing, responses to challenges, where to look for information and help), it immediately became clear during interviews that sociocultural experiences and cultural values were ingrained in participants' accounts surrounding these MHL-related skills, and constituted an important, distinct group of themes. Brooks and colleagues (2022) similarly found that unique cultural values and experiences were salient in qualitative interviews focused on exploring MHL among Indonesian youth and their parents and were necessary to include as additional context for the themes that emerged. In the present study, four themes emerged through participants' accounts in this area, which had direct relevance to their beliefs and understanding of mental health (e.g., settlement factors influencing their family's wellbeing, culturally influenced understanding of mental health), and their thoughts about seeking information and help (e.g., which resources could be accessible or useful): 1) Sacrifice and loss; 2) Cultural differences and conflicts; 3) Search for belongingness and integration; and 4) New opportunities for security.

Sacrifice and Loss. The concepts of sacrifice and loss identified in the findings pertained to participants' experiences both during and after migration. Two subthemes were identified as distinct but joint contributors to this sense of sacrifice and loss, including migratory grief and the inherent stress of the immigration and settlement process.

"Still in Their Heart": Migratory Grief. Migratory grief is a term that encompasses interpersonal, material, and abstract losses associated with immigration and has been shown to have a significant relationship with psychological distress (Renner et al., 2024). This term was

identified explicitly by one participant as a key component to her personal mental health journey since immigrating to Canada. The term also effectively captured other participants' experiences with their families, such as feelings of confusion, loss, and sadness experienced by their children after uprooting their lives from their previous country and being separated from family.

"It's Hard as an Immigrant Parent": Immigration and Settlement Stressors. Stressors described by participants included the busyness of transitioning to life in a new country (e.g., documentation for immigration, understanding new systems), changes in career and social status, pressures associated with approval for permanent residency, and vigilance about CFS and other institutions that may obstruct their approval. These common stressors have been well-documented in past research with newcomer families (Cha et al., 2019; Crooks et al., 2011; Salami et al., 2019; Thomson et al., 2015; Tulli et al., 2020). They were evident both in participants' comments about experiences with moving to Canada and their reflections about mental health (e.g., impact of these stressors on parent wellbeing and capacity for attending to their children).

Cultural Differences and Conflicts. Another challenge for participants' families that appeared to arise early while adjusting to life in Canada related to cultural differences and conflicts. Parents' descriptions in this area comprised two closely related subthemes, including general discomfort and uncertainty associated with some values in Canadian society and its influence on children, as well as a more specific pressure to preserve or defend their cultural values and customs.

Culture of "Abundance". The broader discomfort and uncertainty were captured by one participant who described Canada as having a culture of "abundance" of resources (i.e., food, electricity). Other participants shared related concerns including lack of gratitude and respect for these resources, overly permissive parenting in Canadian society, and potential implications for these observations around development of problem-solving skills and resilience in children. In

addition to general acculturative stress (i.e., discomfort regarding differences in the social environment) some of these concerns also bear resemblance to the concept of differential acculturation, where newcomer parents and their children adapt to the new culture in different ways, which can lead to differences between parent and child regarding cultural values (Costigan & Dokis, 2006; Khaleque et al., 2015; Telzer, 2011; Yoon et al., 2013).

"It's Like Taking a Part of Who We Are": Preservation of Cultural Values. Participants' preservation and defense of cultural values included concerns about uncontrollable influences from Canadian society on their children (e.g., other children, teachers), ensuring that their children continue to have close ties with their original culture's values and practices, and more direct conflicts (e.g., with CFS). These concerns relate again to the concept of migratory grief as well as acculturative stress, both of which are commonly associated with efforts to reduce a sense of loss of cultural values and practices, and experiencing a pressure to assimilate rather than integrate with the host country (Burgos et al., 2019; Lewig et al., 2010; Matthiesen, 2019; Renner et al., 2024).

Search for Belongingness and Integration. These difficulties involving cultural differences appeared to be closely related to another theme surrounding challenges that participants' families had faced with developing a sense of belongingness and integration in Canadian society. This included two subthemes involving the emotional impact of language barriers, as well as experiences of discrimination and internalized oppression.

"I Don't Want to Speak English": Emotional Impact of Language Barriers. The first subtheme captured the emotional impact that language barriers had on participants' children. Language barriers are a very common source of stress among newcomers that can encompass nearly all aspects of life. They can also contribute to several problems relevant to this research, such as breakdowns in parent-child communications (and other notable people such as teachers)

and difficulty navigating educational and health systems in the host culture (Khaleque et al., 2015; Salami et al., 2019; Selimos & George, 2018; Telzer, 2011; Tulli et al., 2020; Yoon et al., 2013).

"Is It Because I'm Black?": Discrimination and Internalized Oppression. The other reported challenge with belongingness and integration was participants' family's experiences with discrimination and internalized oppression. Internalized oppression has been defined in multiple forms in academic literature with largely overlapping concepts. From a psychological and cognitive-behavioural therapy perspective, it has previously been defined as "a set of self-defeating cognitions, attitudes, and behaviours that were developed as one consistently experiences an oppressive environment" and has been linked to difficulties associated with self-esteem, depression, and anxiety (David, 2013, p. 14). Participants emphasized their children's experiences of feeling like an outsider in Canada due to bullying and self-stigmatization based on ethnic features, which were described as negatively impacting their self-image. Such experiences and impacts on mental health have often been documented in past research with newcomer youth, with a concern being that they can also contribute to a sense of alienation and isolation by families (Beiser et al., 2015; Caxaj & Berman, 2010; Guruge & Butt, 2015; Selimos & George, 2018; Tulli et al., 2020).

New Opportunities for Security. The final theme pertaining to lived experiences in settlement contrasted the more negative consequences of moving to Canada described in the other themes. This theme of new opportunities for security in Canada was described by several participants as a key benefit of moving to Canada, including some who also reported difficult experiences in other themes. Specifically, these new opportunities for security were characterized by sub-themes of increased opportunities for security in the parent-child relationship, as well as a broader sense of autonomy and safety, compared to life in several participants' original countries.

"You Need to Understand What They Need": Parent-Child Relationship. Participants who reported changes in their relationship with their children attributed these changes to communication strategies learned through parenting workshops or psychotherapy in Canada. Past research has demonstrated that educational strategies which avoid "deficit assumptions" and instead help newcomers to integrate cultural values with educational content, allow for the individual to avoid marginalization and experiencing meaningful change where needed (Matthiesen, 2019), which may have contributed to these perceived positive changes.

"They Had More Freedom": Autonomy and Safety. The other aspect of security reported by participants was a sense of autonomy in Canada resulting from improved physical safety (e.g., for their children to play outside) and availability of resources (e.g., government supports, access to more consistent public education). Importantly, a few participants' experiences did contrast this theme: "We thought it was going to be paradise. Different than our home country. And it turned out to be even more stressful than our country. So, our dreams didn't come true" (P5). This is important to consider as a part of conceptualizing the findings as representing some potentially common, but non-universal experiences for newcomer parents. For instance, it is common for newcomers to experience difficulties that are not conducive to autonomy and safety, such as food insecurity and housing instability (Girard & Sercia, 2013; Walsh et al., 2016).

Beliefs and Understanding of Mental Health

Experiences during settlement had clearly impacted participants' families' wellbeing, as well as their current views regarding important mental health topics. Participants were asked about how they would define mental health, as well as to reflect on differences they had noticed between Canada and their original country. They provided insightful perspectives on how they have noticed mental health is perceived and discussed in these different parts of the world. Their beliefs and

understanding of mental health also appeared to impact processing of their lived experiences (e.g., link between depression or anxiety with life changes as newcomers, identification with migratory grief) and current perceptions of seeking information and help (e.g., skills that could be worked on, applicability of different supports). Four themes emerged to represent their perspectives: 1) Diverse concepts of mental health; 2) Backgrounds of stigma and invalidation; 3) Cross-cultural concept integration; and 4) Importance of parental support and modeling.

Diverse Concepts of Mental Health. The theme of diverse concepts of mental health resulted from participants sharing a wide range of definitions and key signs of mental health (representing one subtheme), as well as a common notion of "mental health" having an ambiguous, unclear, or lack of identity in their original country or culture (representing another subtheme). This theme is reflected by efforts in recent years to incorporate cultural formulations (e.g., personal, cultural, social meanings) in psychological evaluation (Lewis-Fernández et al., 2014).

Varied Definitions and Signs. The wide range of definitions and key signs of mental health appeared to reflect participants' diverse backgrounds (e.g., potential influences of culture, career, personal or family experiences) and demonstrated the multifaceted nature of the concept. Past research with newcomer parents in the U.S. has also shown variety regarding terms and concepts used to describe children's emotional problems (Umpierre et al., 2015).

"There Wasn't a Term": Conceptual Ambiguity. Conversely, the subtheme of conceptual ambiguity for mental health captured consistent messaging from participants that mental health was not discussed and/or did not have standard language or associated terminology in their original country. Similarly, past interview-based research with Latinx immigrant parents in the U.S. found that they described their children's problems in terms of observed symptoms or behaviours, rather than psychological constructs (Dixon De Silva et al., 2020).

"You Don't Have Your Senses Anymore": Backgrounds of Stigma and Invalidation. These varied and ambiguous concepts of mental health also were described by participants in the context of pervasive mental health stigma they had observed in their home country or culture. They described more passive forms of stigma and invalidation that they had witnessed or experienced towards people with mental health difficulties (e.g., not believing that mental illness is real), as well as more direct forms of stigma (e.g., that they are "crazy" or have lost their senses). Stigma towards mental health problems is very common, including those experienced by children (Pescosolido et al., 2007, 2008), and has also been identified as a common occurrence in past MHL research with newcomer populations (Dixon De Silva et al., 2020; Montgomery & Terrion, 2016; Salami et al., 2019; Tulli et al., 2020; Umpierre et al., 2015; Wang et al., 2019). In the present study, participants did not demonstrate many signs of stigma towards mental health problems, but rather highlighted stigma as a prominent barrier towards more open discussions of mental health and/or help-seeking in their communities. Notably, some participants did perceive there to be recent improvements in mental health stigma in their home country and globally.

"I Did Not Know About Mental Health": Cross-Cultural Concept Integration. In addition to these references to changes in mental health awareness, another theme related to participants' observations that mental health was a more explicit or natural concept in Canada compared to their original country, and that they had been impacted by this difference. This difference was attributed to more widespread resources, discussions, and word-of-mouth about mental health in Canada, which had positively influenced some participants' perceptions and their desire to learn more. Some participants also expressed that mental health discourse in Canada can be excessive because of relatively fewer hardships. Notably, they simultaneously valued this cultural difference and described a balance between cultural approaches as ideal. This theme aligns

with past research indicating that mental health concepts can resonate with newcomers who are unfamiliar or uncomfortable with discussing the subject, but that attentiveness to culture-specific terms, idioms, and non-verbal communications is more likely to have a meaningful impact compared to Western mental health concepts (Crooks et al., 2011; Sim et al., 2023).

Importance of Parental Support and Modeling. The final theme in this category was described in the context of participants' experiences or observations regarding mental health stigma, as well as changes in how they have come to understand mental health in Canada. This theme captured descriptions about how a parent's ability to provide support and model strength as is central to their children's mental health. Two subthemes were identified, which pertained to comments about the need for parents to demonstrate emotionally healthy styles of thinking and behaviour for their children, as well as to establish secure and supportive relationships with their children. Both subthemes resemble a construct in parenting literature known as family cohesion, which has been defined as the "degree of togetherness or closeness or emotional bonding that family members have toward one another" (Vandeleur et al., 2009, p. 1205). This has been shown to be a protective factor towards mental health problems for immigrant youth and associated with developing resilience (Mulvaney-Day et al., 2007; Zhang & Ta, 2009).

Parents Are "the Rock": Emotional Awareness and Resilience. Participants conveyed the importance of the parent's ability to demonstrate emotionally healthy thinking and behaviour as a determinant of child mental health. Examples included modeling a sense of stability in the family unit (e.g., a harmonized front between parents), demonstrating persistence through discomfort (e.g., willingness to try and learn new things), and emotional awareness for oneself and one's children. These ideas and examples were communicated as strategies for acting as a pillar of mental health for their children, or a "rock", as was described by one participant.

"You Have to Make Your Kids Your Friends": Supportive and Secure Relationships. A related aspect of this theme was that participants described the importance of parents modeling and providing secure and supportive relationships with their children, such as listening, compassionate responses, and allowing vulnerability. Other Canadian research has also found newcomer mothers to emphasize open, two-way communication as critical for promoting mental health through family-centric listening and problem-solving (Montgomery & Terrion, 2016).

Perceptions of Information and Help-Seeking

A final key area of questioning concerned what actions participants would consider taking (or had previously taken) if they noticed their child was experiencing mental health difficulties, as well as potential challenges with accessing external sources of information or support. Three themes arose in relation to their responses, which appeared to interact with their experiences with settlement (e.g., requiring additional support for migratory grief and adaptation to acculturative processes, influence of information and help-seeking barriers on settlement difficulties) and their current beliefs and understanding of mental health (e.g., perceived roles of parents as both models and advocates for mental health, more openness towards services since learning more about mental health in Canada, accessing of information or support which influences identification with mental health concepts). These themes included: 1) Principal role of parents; 2) Caution and openness to professional help; and 3) Newcomer-specific barriers.

Principal Role of Parents. A key theme was an emphasis that parents should first strive to manage child mental health difficulties as a family. It is a common finding in past research for parents to prioritize initially addressing mental health concerns within the family or community, particularly for members of collectivist cultures (Alegría et al., 2017; Khandelwal et al., 2004; Mood et al., 2017; Salami et al., 2019; Sanchez & Gaw, 2007). This idea was reflected in two

subthemes in the present study, which included monitoring for signs of unusual behaviours or emotional difficulties in their children and seeking out information, as well as advocating and defending their children when they appear to be experiencing threats to their wellbeing.

"I Never Underestimate": Assess and Gather Information. Participants underlined that a key process for their role as parents is remaining vigilant for unusual behaviours in their children, as well as compiling information from multiple sources (e.g., children, teachers, other parents) to identify sources of problems (e.g., bullying, isolation) and be able to advocate for them. This quality of monitoring and evaluating problems by collecting information has been tied to an authoritative parenting style in past literature, which has been shown to have a positive impact on internalizing and externalizing difficulties for children (Mood et al., 2017) across different cultural and ethnic backgrounds (Steinberg, 2001).

"I'm Done Being Polite": Advocate and Defend. Participants also described advocating for and defending their children (e.g., in the context of school) as another central process to their role as a parent prior to seeking external supports. Other research has found immigrant mothers to identify helping their children build confidence and overcome adversity and stereotypes, and advocacy around these issues at school, as central to their role as parents (Guo, 2012). In addition, a recent qualitative study described these qualities as key to immigrant mothers' sense of fulfillment by serving as "the Good Advocate Mother", which appeared to empower them as they sought optimal care, treatment, and services for their children (Kibria & Becerra, 2021).

"I'm Not Going to Risk My Kids": Caution and Openness About Professional Help. Participants were also asked whether they would consider accessing mental health services if they believed that their child required support that was external to their family or community. The theme of caution and openness to professional help was derived from participants'

unanimous openness to accessing professional help for their children in the future if it were ever needed, although this openness was communicated with varying levels of comfort and interest. Several participants presented as enthusiastically open to accessing professional help in the future, while one mentioned she had previously accessed help for her child but described pervasive stigma towards help-seeking in her culture. It is likely that some participants' personal positive experiences with psychotherapy influenced their openness to future accessing of services for their children. Notably, some participants mentioned that accessing professional help would be a last resort despite their openness (e.g., because of the importance of parents addressing the problem first, because of privacy concerns). In addition to more direct stigma or disinterest towards help-seeking, a common finding in past research is that newcomers can be skeptical about seeking mental health services, or have not considered this to be an option due to these services not being common in their sociocultural context (Cha et al., 2019; Dombou et al., 2023; Straiton et al., 2018). Similar to the present study's findings, a qualitative study of Latinx parents found that most parents were open to both formal and informal help-seeking strategies despite endorsing stigma about mental health problems and treatment, and had inquired about collaborative community and professional care options (Dixon De Silva et al., 2020).

"I Would Be Very Lost": Newcomer-Specific Barriers. Although participants communicated openness to seeking professional help, a common theme was an emphasis on important barriers to accessing mental health information and help resources for themselves and/or observing this among others in their community. For example, one participant considered the immigration centre to be her central resource for information in Canada, but found their support to be confined to immigration and legal information. Other participants elaborated on similar confusion they have observed in their communities, as well as their perception that there

is limited available information on mental health resources for newcomers. In particular, a few participants noted a lack of availability of information and help resources in one's first language. Relatedly, participants identified limited availability of online information about local resources in languages other than English as an important barrier, reliance on online information is common. Past research has found the same barriers to information and service access for newcomer families (Tulli et al., 2020). Many other key barriers for newcomers have been identified in past research, such as perceived lack of cultural competence or sensitivity among providers, or preference for community-driven resources that may not be available (Sim et al., 2023; Wang et al., 2019). Participants did not explicitly describe such barriers, potentially due to study factors which may have biased certain sample characteristics (e.g., stronger English skills, relative comfort with discussing mental health).

Implications

Understanding the diversity of newcomers is critical to understanding the implications of the findings, particularly given the diversity of several characteristics in the sample (e.g., amount of time lived in Canada, different cultures, originating countries, and immigration contexts). This important consideration was highlighted prior to data collection during consultation with agencies (MANSO, CMCCF), as well as by several participants during interviews. Multiple participants in this study still expressed hope that their knowledge and personal experiences could be shared through this research to contribute to an understanding of the unique impact that the newcomer context can have on the mental health of families, as well as their interactions with Canadian health and social systems (e.g., differing beliefs and understanding about mental health, awareness and accessibility of resources). The implications of their perspectives in relation to the study objectives and directions for future research are discussed below.

Comparison with Mental Health Literacy Framework

One objective of this research was to explore the relevance of the Western framework of MHL within the context of newcomer families by examining how their sociocultural contexts may relate to their mental health perceptions and experiences. This framework has included several components: (a) ability to recognize specific mental health problems, (b) knowledge of how to seek information on mental health, (c) knowledge of risk factors and causes, (d) knowledge of available professional and self-help options, (e) attitudes that promote recognition and appropriate help-seeking, (f) knowledge of how to prevent mental health problems, (g) recognition of when a mental health problem is developing, and (h) mental health first aid skills to support others with a mental health problem (Jorm, 2012; Jorm et al., 1997). It has also been suggested that there is a need to include knowledge of how to achieve and maintain positive mental health (i.e., positive MHL) as an additional component or alternative approach to MHL (Bjørnsen et al., 2017; Carvalho et al., 2022; Cresswell-Smith et al., 2023; Kutcher et al., 2016).

Important limitations surrounding the definition, measurement, and cross-cultural applicability of this MHL framework have been identified within the past decade (Kutcher et al., 2016; Na et al., 2016; Spiker & Hammer, 2019). As previously mentioned, this dissertation seeks to both acknowledge these limitations and work towards a more holistic understanding of MHL that could be applied to more diverse sociocultural contexts. Thus, rather than directly evaluate these MHL components, the aim in this study was to adopt a more exploratory approach to understanding how this sample's sociocultural contexts could influence the relevance or nature of the qualities that are needed for these skills. It was nonetheless evident that this study's participants seemed to possess strong relevant skills.

Several aspects of this study's findings suggest challenges with applying the MHL

components that involve knowledge of specific mental health problems, risk factors and causes, how to prevent problems, and signs of developing problems, to the newcomer context. Perhaps most notably, experiences during immigration and settlement appear to greatly complicate the basis on which we can understand these MHL skills among newcomers and apply existing psychoeducational and treatment methods. For example, the discussed aspects of sacrifice and loss (e.g., migratory grief, family separation, changes in career and social status) and cultural differences and conflicts (e.g., acculturative stress) demonstrate unique presentations of mental health that can occur among newcomer families, as well as barriers to information and services that could help. Themes around cultural differences and conflicts, as well as a search for belongingness and integration in Canada, also highlight antecedents and systemic challenges which can be implicated in otherwise common mental health problems for children, such as anxiety. Further, the diverse concepts of mental health described by participants (e.g., the ambiguous and culturally driven nature of how it is discussed and understood) and influence of the settlement context (i.e., integration of different cultural views on mental health) are additional complicating factors in one's understanding of risk factors and signs of mental health problems.

The MHL components of attitudes that promote recognition and help-seeking, as well as supportive mental health first aid skills, appeared to have clearer overlap with participants' perspectives about strategies for promoting child mental health. Namely, they emphasized the importance of parents to adopt an active approach (e.g., helping to identify emotions, supportive listening), and discerning the source of mental health problems (e.g., at school, isolation) and trying to resolve them for their children prior to considering mental health services. Notably, they also described observations from their cultures about there generally being low familiarity and/or diverse concepts around mental health (e.g., variety of terms or no central terminology),

as well as prominent stigma. This suggests the importance of integrating these ideas in how MHL skills are discussed with newcomers who reach out for information and services (e.g., use of culturally congruent terms, helping with identification of psychological concepts which do resonate). Further, because newcomers to the Western world will commonly have a background of personal experiences with or exposure to stigmatizing messaging around mental health, the concept of positive MHL (i.e., emphasis on positive mental health and wellbeing) may be more relevant or have more resonance as an approach to working with newcomer populations.

Finally, in terms of the MHL components pertaining to knowledge about how to seek information and available professional and self-help options, the findings show that these components of MHL would be more relevant in a landscape with more available and accessible resources for newcomer populations. The findings suggested clear openness and interest among participants for there to be a closer link between their communities and accessible mental health information and services. This investment was evident in their past personal or family experiences (e.g., services accessed or desired to be accessed), as well as observations they described within their communities (e.g., perceived psychoeducational needs for other parents). They generally held positive perceptions about seeking external information and support regarding child mental health despite some hesitation from a few participants (e.g., only as a last resort, concerns about a treatment focus on medication, privacy). However, participants clearly identified a key gap in terms of access to information which can help newcomers learn more about mental health and seek external support (e.g., available in first language, contextualized around immigration and settlement). In addition, factors such as a perceived need to preserve cultural values and avoid discrimination are likely to contribute to less value being placed on Canadian mental health resources directed towards the general population.

Taken together, the findings from this sample of parents who were newcomers to central Canada provide insight regarding potential similarities and differences in how MHL can be conceptualized in this context. Some aspects of MHL could potentially be considered as remaining relevant and to have fewer differences in how they may present in some cultural contexts (e.g., mental health first aid skills such as providing emotional support). However, the findings also show several meaningful sociocultural differences in how mental health itself can be understood (e.g., due to lack of common language used to describe it in some countries), distinct presentations, risk factors, and causes of mental health challenges (e.g., migratory grief, acculturative stress, discrimination), and different related information and support needs. Thus, these findings show that some skills which are typically classified as key indicators of MHL must be considered from a more holistic perspective in this context, such as recognition of different kinds of symptoms, risk factors, and causes.

Barriers to Information and Support

Another objective of this research was to understand key barriers faced by newcomer parents in terms of accessing information and supports for promoting mental health in their children. The implications discussed above also demonstrate distinct barriers that newcomer parents can face to strengthen MHL skills through information and external supports. For instance, the findings provide useful information regarding the notion of newcomers receiving more natural exposure to mental health information in Canada (e.g., through word-of-mouth, in educational system), which may be an unfamiliar, uncomfortable, or new concept. Given this finding, as well as participants' descriptions about stigma and invalidation towards mental health difficulties, stigma is also an important consideration that may have unique culturally associated beliefs. This may require a more gradual approach to psychoeducation and intervention to

develop a sense of comfort or safety with mental health-related topics. Further, language barriers and discrimination can prevent newcomers from accessing help or naturally redirect them towards sources of help which feel more culturally appropriate (where available).

In addition, factors such as family separation, stress of the immigration process, and diminished career and social status present clear barriers to available time and energy to seek out new information, particularly if it is unfamiliar or uncomfortable. Loss of familial support in particular can be tied to feelings of disempowerment for newcomers to Canada, which can be helped through psychoeducational initiatives focused on reducing mental health stigma and improving confidence about accessing new community supports or service providers (Tulli et al., 2020). Participants in this study also identified an important gap regarding information that helps with understanding of mental health problems for newcomer parents and facilitation of further help-seeking where needed. Reducing this gap through increased availability and accessibility of such information (e.g., easily found, available in first language) is conducive to greater empowerment in their roles as parents and strengthened MHL (Montgomery & Terrion, 2016).

While this study focused on gathering information about these barriers from participants, it is also worthwhile to highlight some useful avenues for navigating these barriers. Despite the resource gaps and barriers described by participants, they conveyed interest in obtaining more information and help for child mental health when needed. Their accounts of their families' lived experiences also demonstrated the range of complicated life changes that newcomers may experience as part of immigration and settlement. Positive life changes that were described, in the form of new opportunities for feelings of security, captured some transformative experiences that newcomer families can have in the Western world (sometimes with external supports such as counsellors and parenting programs), which can be helpful avenues for outreach initiatives to

help with integration of new skills and reinforcement of existing ones.

Overall, these findings provide further support to the strong influence of structural barriers and psychosocial inequalities as key determinants of seeking external supports (Johnco et al., 2019; Na et al., 2016), which extends beyond individual-level knowledge or information gaps (Kirmayer, 2015). They also highlight the value of increased community-level psychoeducation and outreach initiatives for different newcomer communities, because these more holistic care approaches will be better positioned for navigating more specific sociocultural differences in how mental health can be experienced and understood (Brooks et al., 2022). Through partnership with the immigration and settlement sector, mental health professionals can serve a proactive role in psychoeducational initiatives in a manner that is more consistent with culturally tailored concepts, language, and challenges to be addressed.

Future Directions

The theoretical model of conceptualizations of mental health in this sample can provide a foundation for future research that focuses on extending our understanding of MHL among newcomers broadly, as well as for specific groups and communities. For instance, additional nuances or contrasts to the themes that were identified in this study could likely be clarified with a more concentrated examination of specific cultural backgrounds, immigration categories, socioeconomic status, or region of settlement. The findings can additionally inform research focused on development of psychoeducational resources and programs to support parents who are newcomers. As with our understanding of MHL skills in this population, this research shows that the unique sociocultural contexts of newcomers are likely to limit the suitability of existing resources. The clear embedding of these sociocultural experiences and values in how mental health and MHL can be understood is important to consider for guiding the tone and scope of

future psychoeducational resources and programs (Brooks et al., 2022). Examples of these features include use of culturally relevant terms and expressions, inclusion of topics at the forefront of the settlement context (e.g., immigration-related sacrifices and losses), and/or an approach for individuals whose cultural background may not have a centralized concept for mental health, to make information more approachable.

Limitations

The limitations of this study primarily pertain to the study's context, researcher influence, and composition of the participant sample. First, because this study was conducted in English, recruitment generally yielded participants with strong English skills. By extension, their experiences may not fully represent those of newcomers facing even more extensive language barriers than what was described in the findings. The meanings derived from participants' descriptions may also have differed if the interviews were conducted in their first language. In addition, this study's focus on child mental health likely drew in participants who were relatively more comfortable or experienced with discussing this subject. Given this study's subject and English format, newcomers with other experiences (e.g., less integration with Canadian society and/or familiarity with mental health resources) may have provided additional perspectives which would build on captured themes. In addition to this language-related limitation, recruitment was more likely to include individuals with a higher level of comfort with the subjects of mental health and parenting. Thus, concerns about participating in this research led by an institutional representative (e.g., concerns about CFS, limits of confidentiality) may have reduced recruitment interest and/or disclosure of certain information by those who participated. Notably, this study's participants did also describe their observations regarding other members of

their communities (e.g., stigma around mental health, concerns and challenges associated with accessing help and information), which helped mitigate these limitations to some degree.

Relatedly, because I adopted a constructivist lens for this study, I acknowledge that my identity and past experiences inevitably influenced the construction and interpretation of the findings. This is expected because this dissertation is intended to unify Western psychology training with a newcomer participatory perspective, but it is also worth noting that this process potentially limited the scope of the findings to some degree. Potential examples may include level of interest from prospective participants, types of information shared by participants, and my understanding and communication of the findings. For example, a researcher with more relevant personal or professional experiences associated with the immigration and settlement sectors (e.g., ability to speak participant's first language, similar cultural or ethnic background) may have obtained different information or interpretations from the interviews. However, several mitigating factors involved with this study (i.e., agency consultation, inclusion of co-interviewer, independent coding of transcripts) likely helped to reduce some of this influence.

As highlighted previously, the findings of this study were obtained through interviews with a diverse sample of parents (e.g., different cultures, original countries, immigration categories, number of years lived in Canada) who were newcomers to Canada. A notable exception was that all participants identified as female and were mothers. This outcome was not surprising or unusual, as past research has commonly shown that mothers of newcomer families are more likely than fathers to engage in parent-child dialogue regarding mental health (Montgomery & Terrion, 2016), and it is not uncommon for women and mothers to be more represented in MHL-related research (Davidson et al., 2022; Hurley, Swann, Allen, Ferguson, et al., 2020; Mendenhall & Frauenholtz, 2015), as well as in child development, child mental

health, and parenting research (Gonzalez et al., 2023; Panter-Brick et al., 2014; Parent et al., 2017; Schulz et al., 2023; Tully et al., 2017). Generalizability of the findings to newcomer fathers thus may be limited and similar research which includes fathers would help to identify similarities and differences.

Lastly, there are some limitations to the composition of this study's sample. The diversity of other aspects of participant backgrounds represents both a feature of this study (i.e., identifying some common experiences and perceptions among a sample of newcomers in central Canada), as well as a limitation in terms of understanding potential differences based on their contexts. For instance, comparing specific cultural communities or immigration categories may yield differences in the explored themes (e.g., terminology used to describe mental health, perceptions of help-seeking), and would be necessary to draw more specific conclusions based on such factors. Further, data collection concluded with a relatively small sample size (n = 10); this was determined to be a point of theoretical sufficiency, but also may have been naturally larger if there were fewer recruitment difficulties (sporadic contact from new participants, some who did not reply after consenting). This is a limitation to the generalizability of the findings and prompts a need for additional research to build upon this study's theoretical model with a broader sample of newcomer parents and form more definitive conclusions.

Conclusion

Through qualitative individual interviews with parents of children ages 2-12 who were newcomers to Manitoba, Canada, this study: 1) Examined the relevance of the Western MHL framework through the lens of participants' sociocultural contexts and their mental health perceptions and experiences; and 2) Explored their perceptions about key barriers towards information and support for child mental health. One key implication of this study is that several

aspects of the conventional framework of MHL appears to have limited applicability to the newcomer context, due to unique sociocultural experiences (e.g., lack of common language used to describe mental health, difficulties such as migratory grief and acculturative stress) which complicate both experiences of mental health as well as the MHL skills that are needed to understand and respond to these experiences. Another key implication is that there are several distinct barriers for this population (e.g., language, stigma and discrimination, stressors of the immigration process, lack of resources relevant to one's culture or the settlement context), which can limit newcomer parents' access to information and supports that may help with strengthening their MHL skills and promoting mental health in their children.

This study adds to the literature that is necessary to continue building on MHL theory to include conceptualizations of mental health based on sociocultural context (Atilola, 2015; Furnham & Hamid, 2014; Furnham & Swami, 2018; Spiker & Hammer, 2019), as well as the fit of the Western MHL framework for newcomers specifically, which has not been adequately explored in the literature (Kutcher et al., 2016; Montgomery & Terrion, 2016; Na et al., 2016). Valuable directions for future research include additional efforts with a similar approach to the present study to understand and adapt the concept of MHL to specific sociocultural contexts. For example, further research which improves our understanding of MHL skills in newcomers from specific cultural groups and immigration pathways is needed to better understand group-specific skills, information needs, and barriers to support. This is also necessary to build towards more effective and culturally adaptive psychoeducational strategies for newcomer populations in the future, which is the focus of Study 2.

Chapter 3: Study 2

Introduction

Despite increased availability of evidence-based interventions, global estimates indicate increased prevalence of child and adolescent mental health difficulties in recent years (Racine et al., 2021; Tully et al., 2019). Numerous barriers limit the accessibility of clinical services and even basic psychoeducational resources. Some major barriers include socioeconomic status, high costs, long waitlists, geographic location, transportation, limited available information about resources, negative beliefs about their value, stigma around accessing them, and believing a problem is not severe enough to access help (Andrade et al., 2014; Carbonell et al., 2020).

Newcomer families can face many of these barriers, but often with added complications such as language barriers (Tulli et al., 2020), as well as culturally driven aspects of more general barriers such as stigma (e.g., concealing to prevent shame for the family; Misra et al., 2021). Several factors surrounding immigration and settlement can also limit means for accessing resources, including but not limited to instability of basic needs (e.g., shelter, food), more limited support and information networks, changes in employment, and reduced socioeconomic status (Chung, 2010; Guruge & Butt, 2015; Islam et al., 2017; Khan et al., 2018; Sin et al., 2011; Tulli et al., 2020). Further, low familiarity with health and social systems in the host country is a common barrier towards understanding how to access resources, or trusting these systems due to concerns of discrimination or mistreatment within them (Burgos et al., 2019; Ellis et al., 2011; Marshall et al., 2016). There can also be barriers at the cultural level, such as different approaches to learning, seeking help, and discussing mental health (Kirmayer & Jarvis, 2019; Na et al., 2016). Beyond all of these barriers, there are simply few psychosocial interventions available in the Canadian context that are designed for newcomer families (Hirani et al., 2024).

Study 1 highlighted several of these barriers in its findings, including low familiarity with mental health concepts (or having different, culturally-informed concepts), stigma, discrimination, language, settlement stressors, and availability of information. The second study in this dissertation is concentrated towards enhancing our understanding of psychoeducational approaches that could be implemented to help mitigate some of these barriers for newcomer families. Specifically, Study 2 adopts a participatory focus group approach towards understanding avenues for strengthening MHL-related skills within the sociocultural contexts of newcomer families. These focus groups were comprised of settlement sector professionals and newcomer parents, who discussed psychoeducational program development needs in this context and provided feedback on the need for, and feasibility of, a hypothetical program outlined in a program logic model. The remainder of this literature review provides further rationale for this approach by summarizing research findings regarding the potential benefits of psychoeducational programs concentrated towards strengthening parent MHL skills, current limitations in the field, and the potential fit of these programs within the sociocultural contexts of newcomer families.

Parent Psychoeducation

Considering the many barriers that parents can face for accessing mental health information and care, there is value in proactive psychoeducational strategies that can promote positive mental health, reduce the risk of problems, and/or encourage help-seeking. Multiple psychological theories have guided different psychoeducational efforts that aim to instill knowledge, beliefs, attitudes, and behaviours in line with this notion. For instance, the theory of planned behavior (Ajzen, 1985) posits that personal attitudes about a behaviour, perceived difficulty of performing it, and beliefs about how others perceive it, all influence intention and subsequent action (e.g., accessing mental health services). Further, key stigma theory concepts

suggest that more mental health knowledge is conducive to less negative attitudes that drive behaviours such as discrimination and avoiding help-seeking (Thornicroft, 2006). In the context of parenting, it has been argued that knowledge and attitudes contribute to early recognition and help-seeking for child mental health problems, which is important to reduce their long-term impact (Castagnini et al., 2016; Copeland et al., 2015; Johnson et al., 2023), and that parents are naturally positioned to engage in these behaviors as caregivers for their children (Bonanno et al., 2021; Johnco et al., 2019; Tambling et al., 2023; Tully et al., 2019).

Given the outlined barriers to information and care, and the potential benefits of proactive psychoeducational strategies, there is a need to innovate on relevant resources. One potential approach is to strengthen MHL skills in parents to promote child wellbeing and identify mental health challenges that may require additional support. This is particularly relevant for newcomer families because of additional pre- and post-migration stressors that children in these families commonly experience (e.g., acculturative stress, exposure to war, discrimination) during a critical period of development (Islam et al., 2017). In general, reviews of programs focused on MHL skills training have demonstrated significant post-intervention outcomes such as increased knowledge about mental health problems, more favourable help-seeking attitudes, new skills for helping others who are struggling with their mental health, and reduced stigma (Bond et al., 2015; Brijnath et al., 2016; Jorm et al., 2010; Jorm & Kitchener, 2011). For example, a recent systematic review and meta-analysis was conducted on Mental Health First Aid, which is a training program that provides information on how to support others experiencing a mental health problem or crisis (Morgan et al., 2018). The researchers found small to moderate improvements across 18 randomized control trials (RCT) in terms of program recipients' knowledge and ability to recognize mental health problems, stigma, and confidence and intention

to engage in helping behaviours at six-month follow-up. However, there are some important methodological and cultural limitations to this approach which will be discussed.

Parenting Programs

To capitalize on parents' influence on their children's development, several programs have arisen in the past few decades to help facilitate parenting behaviours that will reduce children's risk for emotional and behavioural challenges (Sahle et al., 2020; Sandler et al., 2011; Yap et al., 2016). These strategies are rooted in attachment, social learning, and developmental theories, with rationale that strengthening positive parent-child interactions promotes a more nurturing family environment that facilitates emotional, social, and adaptive skills development in children (Doyle et al., 2023; Sanders, 2023). Significant research evidence supports the notion that modifying parenting strategies in this way can lead to significant long-term improvements in children's behaviors and emotional wellbeing, as well as parents' own wellbeing, knowledge, and confidence in their skills (Jeong et al., 2021; Sanders et al., 2024; Solomon et al., 2017; Spencer et al., 2020). For example, Circle of Security is a group and individual-based program that combines psychoeducational and therapeutic techniques to help parents provide emotional support to their children and form more secure attachment bonds (Cassidy et al., 2017). This program been shown to improve supportive maternal responses to child distress and reduce disorganized and insecure attachment in children (Cassidy et al., 2017; Sahle et al., 2020).

Similarly, the Triple P-Positive Parenting Program focuses on promotion of family wellbeing to reduce the risk of social, emotional, and behavioral problems, as well as maltreatment, for children and adolescents (Sanders, 2012). Systematic reviews and meta-analyses of this program have found short and long-term benefits including improved social, emotional and behavioral outcomes for children, increased positive parenting practices, and

greater parental satisfaction and efficacy (Sanders et al., 2014). Some programs such as Triple P are stratified into different levels of intervention depending on level of risk or intensity of problems to be addressed (i.e., offered to parents of children with an existing problem, or have known risk factors, or regardless of risk level; Sanders, 2023; Yap et al., 2016). This is similar to stepped care models of health, which argue for the efficiency of different stages of intervention intensity, allowing earlier stages to be minimally restrictive in terms of eligibility and resources required for delivery (Bower & Gilbody, 2005). Thus, programs offered at lower levels of risk and intensity can have potentially smaller effects, but are likely to have a more widespread public health impact because they can reach a larger portion of the target audience (Yap et al., 2016). This broader application can also reduce stigma associated with accessing a program (e.g., fear of being a bad parent, family identification with mental illness; Yap et al., 2015).

Parent Mental Health Literacy Programs

Parenting programs and MHL programs have the potential for similar outcomes (e.g., improving wellbeing, providing support). Parent MHL programs are more concentrated towards strengthening parents' knowledge and confidence around navigating mental health problems and treatment for their children, and have received limited research attention (Hurley et al., 2021). Key targets for these programs may include providing information about symptoms of child mental health problems, how to differentiate mental health problems from developmentally normal and/or transient challenges, etiology, risk factors, and how to access resources that could be helpful (Tully et al., 2019). For example, a two-week online program sought to strengthen parents' knowledge and confidence about managing child mental health via interactive modules which provided information about anxiety, depression, and help-seeking options (Deitz et al., 2009). Compared to waitlist control, the intervention group demonstrated increased knowledge

of depression and anxiety, as well as a greater sense of self-efficacy in helping their child manage them. This effect was observed regardless of whether they knew or suspected their child was experiencing a mental health difficulty. These forms of programs can be conceptualized as aiming towards an indirect transfer of beneficial outcomes from the parent(s) to their children over time (Anderson & Pierce, 2012; Hurley et al., 2021). Of the limited programs developed for parents, most have been concentrated towards parents of adolescents, despite parents playing a much larger role in initiating treatment for children. As a result, several researchers have recently called for a renewed literature focus on MHL skills and programs for adults supporting school-aged children, due to differences in epidemiology, treatment strategies, and help-seeking pathways for this age group (Hart et al., 2023; Johnson et al., 2023; Tully et al., 2019).

Examples of MHL programs focused on parents of adolescents can also highlight potential benefits of these types of programs. For instance, trials of Youth Mental Health First Aid, designed for adults with significant work or care roles for adolescents (including but not limited to parents), showed significant improvements in participants' knowledge, attitudes, and helping behaviours at up to a six-month follow-up (Kelly et al., 2011). There is also some evidence suggesting that brief, low-intensity MHL programs can be valuable for increasing access to key mental health knowledge, with lower time and cost-related demands. For instance, a two-hour seminar-based intervention with small discussion groups was evaluated for parents of adolescents with perceived emotional and behavioural problems (Gilbo et al., 2015). Qualitative analyses of parents' experiences showed that they felt more knowledgeable about and prepared to assist their child with their mental health, as well as a felt sense of support and connection with other group members. Another example involves an RCT with 221 parents and primary caregivers of adolescents in New Zealand, which evaluated the impact of a program delivered

via SMS text messaging on MHL skills and parenting sense of competence (Chu et al., 2019). Parents received one daily psychoeducational text message over the course of four weeks. Compared to the control group, participants in the treatment group reported higher a higher sense of parental competence, greater knowledge of help seeking options, reduced parental distress, and improved parent-adolescent communication at one and three-month follow-ups.

Similarly, a recent series of evaluations was conducted on a one-hour parent MHL workshop delivered through community sports clubs (Hurley et al., 2018, 2021; Hurley, Swann, Allen, & Vella, 2020). In their first evaluation, workshop participants showed more significant improvements in knowledge of anxiety, depression, and help-seeking options, as well as greater confidence in how to assist an adolescent struggling with their mental health, compared to a waitlist control group – effects which persisted at a one-month follow-up (Hurley et al., 2018). A follow-up qualitative evaluation revealed key themes of increased awareness and knowledge of mental health problems and help-seeking options, as well as an improved sense of confidence and preparedness to assist a child with their mental health (Hurley, Swann, Allen, & Vella, 2020). Parents also reported that the intervention stimulated discussions with their children and other parents about mental health, as well as that they continued to use the information and resources provided to them, and that they recalled the workshop content when noticing changes in their child's behavior. This series of findings demonstrates several benefits that can be attained from further expansion of parent-focused MHL programs, including improvements in knowledge and recognition of key symptoms, familiarity with help-seeking and treatment options, as well as self-efficacy and skills for supporting the mental health of their children.

Despite the potential benefits of MHL programs, the utility of findings from this line of research has often been confined by challenges with consistent and/or long-term intervention

effects. For example, in a follow-up trial of their program delivered through community sports clubs, Hurley and colleagues (2021) were unable to determine any significant improvements in MHL outcomes (i.e., knowledge of symptoms, attitudes toward mental health and help-seeking) at one-month follow-up compared to waitlist control. However, parents receiving the workshop did report reduced personal psychological distress, feelings of support from other parents in their club, as well as feeling more confident and knowledgeable about how to help a child struggling with their mental health. Similarly, a recent systematic review of nine MHL programs focused on parents of adolescents also determined that mental health knowledge and confidence was significantly improved in several studies, but that changes in stigma, intention to seek help, and actual help-seeking did not occur (Kusaka et al., 2022). As previously described, the MHL field faces several challenges with consistent definition and psychometrically sound measurement of the concept (Hurley, Swann, Allen, Ferguson, et al., 2020; Kutcher et al., 2016; O'Connor et al., 2014; Reardon et al., 2017; Spiker & Hammer, 2019; Tully et al., 2019; Wei et al., 2015), which has likely impacted replicability and expansion of programs developed for parents.

Sociocultural Responsiveness

Another important limitation in the MHL field is that, due to its conceptual roots in the Western biomedical models for health, MHL programs and resources have also been limited in responsiveness to the unique needs and experiences of different cultural groups (Brooks et al., 2022; Dixon De Silva et al., 2020; Hurley, Swann, Allen, Ferguson, et al., 2020; Mendenhall & Frauenholtz, 2015; Na et al., 2016). It has been argued that the validity of a psychoeducational program is in question when it is offered to different cultural groups, unless fit and/or cultural adaptation of the content has been demonstrated for the specific context (Kutcher et al., 2016). Further, even more accessible MHL programs (e.g., minimal time and cost-related barriers) may

be ineffective for influencing culturally-held beliefs and practices surrounding mental health and help-seeking (Hurley, Swann, Allen, Ferguson, et al., 2020). Initiatives for strengthening MHL among newcomers and different cultural groups should therefore be critical of the limitations and assumptions of its roots in the biomedical model by considering aspects of cultural diversity in mental health presentation, beliefs, and help-seeking strategies (Na et al., 2016).

Thus, there is value in exploring approaches to MHL for newcomers, but efforts are also needed to identify how programs can provide meaningful information while being more responsive to this diversity. Psychoeducation should be perceived as an approach for integrating evidence-based knowledge with one's "mental scaffold" of pre-existing beliefs, preferences, and cultural contexts, rather than an authoritative method for instilling expert-based knowledge to the public (Jorm, 2019, p. 60). It is in this way that programs can "transcend marginalization" by facilitating social and/or behavioural change through empowerment (Matthiesen, 2019, p. 109). Thus, a socio-culturally responsive program would provide information to enhance knowledge, confidence, and perceived help-seeking options, rather than pathologizing or aiming to replace one's cultural beliefs and practices (Na et al., 2016).

Newcomer MHL Programs

To date, very little research has examined the benefits of MHL programs offered and adapted to the context of newcomer parents. One study in Sweden sought to evaluate the impact of a five-week group program focused on strengthening MHL skills among Somalian and Arabic-speaking refugee mothers (Ekblad, 2020). The findings showed that participants were unlikely to discuss mental health and/or personal experiences directly. However, participants endorsed feeling empowered by the information in the program, more prepared to help their children cope with stress and anxiety, and desired to learn more related information. The

researchers concluded that MHL programs for parents who are newcomers to the Western world can help bridge the gap between the original and host culture regarding conceptions of mental health and treatment (e.g., understandings of pre- and post-migration stress), which could also translate to more options in care for their children. The limited research on this subject is a noteworthy gap in the literature because information gathering and help-seeking for children's emotional needs among many cultures first begins with family-based discussions, often with mothers (Khandelwal et al., 2004; Sanchez & Gaw, 2007; Vera & Conner, 2007). For instance, a qualitative Canadian study of immigrated South Asian women's health perceptions and behaviours found that they and their families associated motherhood with primary health and caregiving responsibilities, which was also associated with stress for participants (Grewal et al., 2005). These research findings emphasize the importance of parental roles in the communication of mental health-related principles and intervention strategies (Montgomery & Terrion, 2016).

Community-Driven Approaches

In addition to tailoring MHL programs to improve their fit within different sociocultural contexts, there is a need for proactive initiatives that can more consistently reach newcomer families to strengthen protective factors, mitigate risk factors, increase early identification and intervention, and reduce pressure on mental health services (Sim et al., 2023). It is likely that the perceived relevance and stigma associated with accessing these programs can be improved for programs that are designed to be lower intensity and widely available within communities (i.e., regardless of mental health status). For instance, hosting programs in trusted spaces such as cultural community organizations, and facilitating programs by trained "near-peers" (e.g., non-clinicians, clinicians living in the community), are promising strategies for reducing stigma associated with program participation (Rusch et al., 2020, p. 339). These community-based

strategies are likely to be more efficient for newcomer families, particularly in settings where specialized mental health services are under-resourced or overloaded (Brooks et al., 2022). Further, cultural community groups and organizations are already major welcoming links for newcomers, often acting as key sources of a sense of belonging and support, as well as buffering against immigration-related losses, isolation, and discrimination (Kirmayer et al., 2011).

In a recent Canadian study, Sim and colleagues (2023) conducted a qualitative framework analysis of perspectives from professionals in the health, education, settlement, and social service sectors regarding needs for reimagining mental health support for newcomer families. Participants in their study emphasized how more low-intensity resources for mental health promotion and prevention within newcomer communities are necessary for normalizing discussions of mental health and help-seeking. They also highlighted a gap along the continuum of mental health supports (i.e., between basic psychoeducation and psychotherapy) for newcomer families. They discussed how this gap limits early identification of mental health difficulties, resulting in families rarely accessing services prior to intensive or crisis-level challenges. They also discussed challenges with how psychosocial supports for newcomer families are defined (e.g., boundaries between psychoeducation, psychotherapy) and the roles and capacity of different professionals for providing this support (e.g., professional liability, areas of competence and comfort). However, it was also discussed how professionals across sectors are already drawn into providing this support regardless of these factors. One key recommendation from this multidisciplinary sample was a streamlined process of integrating mental health promotion and prevention activities across the different sectors that interact with newcomer families and communities, as well as development of programs which can be integrated in this manner.

Community Collaboration and Empowerment

Improved sociocultural responsiveness for MHL programs also must entail collaboration with target communities to ensure that programs are relevant and foster a sense of autonomy regarding help-seeking. Kosyluk and colleagues (2022) suggest that, due to children's reliance on their parents to access external supports, there is an important overlap between MHL and family empowerment (i.e., a family's overall sense of knowledge, competence, and self-efficacy in seeking necessary care). Their research investigated the relationship between MHL and family empowerment to predict parents' willingness to seek mental health care for their children. Their findings suggested that both MHL and sense of empowerment acted as facilitators to care-seeking and had the potential to mitigate the impact of stigma on help-seeking. Other researchers have emphasized the importance of this sense of empowerment for newcomer communities in particular, where it is ideal for programs to transcend pure psychoeducational approaches by engaging attendees as active participants in learning and discussion (Dixon De Silva et al., 2020; Ekblad, 2020; Misra et al., 2021; Rusch et al., 2020; Umpierre et al., 2015).

Participatory and community-based research methods are likely another important aspect of empowerment for child mental health promotion and prevention efforts. Collaborating with consumers of mental health resources during their development is critical for improving resource accessibility and relevance (O'Brien et al., 2021), as educational health programs can otherwise be overly-generalized and misaligned with user experiences (Neuhauser, 2017). However, MHL programs have rarely been designed with input from potential users, which is important to improve their fit in different sociocultural contexts (Umpierre et al., 2015). A scoping review of digital psychoeducational programs for parents of children ages 2-12 did not identify any that were designed collaboratively with parents (Peyton et al., 2019), suggesting a need for future research to move towards participatory development methods. By implementing these methods,

the mental health and settlement sectors could collaborate with each other and newcomer communities to understand the fit of MHL programs in these contexts and empower learning.

For newcomer families in particular, it is important to consult on their specific information needs to enable development of resources which are sensitive to transgenerational stressors such as war-related trauma or other safety concerns (Ekblad, 2020; Leask et al., 2019). An important aspect of this collaboration is likely to require flexibility toward deviations from Western models for mental health and MHL, and typical psychoeducational approaches (Atilola, 2015; Furnham & Swami, 2018; Na et al., 2016). In Sim and colleagues' (2023) study, Canadian professionals in the health, education, settlement, and social service sectors communicated a need for a shift towards methods which empower newcomer families' voices in the development of mental health resources. Conversely, they also noted the time and resource-intensive nature of approaches such as co-designing programs with newcomers, and how most organizations do not have the capacity to design and deliver programs at this level. This suggests a need for additional contributions to the literature that outline MHL program development needs for newcomer families, which can serve as a process for empowering their voices and a step towards development of resources that are more responsive to their sociocultural contexts.

Present Study

Overall, the discussed research highlights the potential value of socio-culturally responsive resources focused on promoting MHL skills among parents of pre-school and school-aged children. Unfortunately, there are few established, accessible, and research-informed knowledge resources focused on strengthening MHL skills among parents (Hart et al., 2023; Peyton et al., 2019, 2022; Tully et al., 2019), particularly for those from newcomer populations (Ekblad, 2020; Na et al., 2016). To help address this need, the present study evaluated MHL

program development needs for parents of children ages 2-12 who are newcomers to Canada. Specifically, this study constituted a feedback and discussion process regarding a hypothetical MHL program that could be offered widely to parents within a newcomer community (i.e., regardless of mental health status or risk level of their children). This was pursued via participatory focus groups with professionals in the settlement sector and newcomer parents. Participatory focus groups allow for inclusiveness and collaboration across diverse perspectives regarding program design, and can help to ensure that content is accessible, effective, and relevant (Liamputtong, 2015). They are also useful as a preliminary investigative approach to better understanding the target audience for a MHL program and ensuring that its content is tailored appropriately (Kelly et al., 2007). Further, this is a valuable method for helping to shift power dynamics from the researcher toward the participants (Kamberelis & Dimitriadis, 2013), with the aim of promoting increased autonomy and comfort for them when providing feedback.

Program Logic Model

Prior to beginning Study 2, I drafted a program logic model (Appendix M) for a hypothetical MHL program to be evaluated by participants. A program logic model can be defined as a visual method for representing data that "details resources, planned activities, and their outputs and outcomes over time that reflect intended results" (Knowlton & Philips, 2012, p. 5). Accordingly, the logic model employed in the present study was organized by inputs (i.e., resources required to run the program), activities (i.e., specific processes and content that characterize the program), outputs (i.e., processes for ensuring and evaluating program success), and outcomes (i.e., intended impacts of the program). The program logic model was informed by a combination of common group and community-based program considerations (e.g., active participation and discussion activities, measures of participant engagement; Barry et al., 2005;

Blanco-Vieira et al., 2018), prior consultation with MANSO and CMCCF (e.g., needs for discussion of positive mental health factors), and findings from Study 1 (e.g., activities discussing factors in the newcomer context which impact mental health). The model was also reviewed with the dissertation committee and their feedback was incorporated.

Inputs were organized by personnel (administration, community participants, program facilitators), financial (e.g., supplies, wages), resource (e.g., materials, physical space), and time-based requirements to operate the program. Activities included discussion of the concept of mental health (e.g., differing cultural definitions), mental health in children (e.g., signs of both symptoms of mental health problems and positive mental health, impact of newcomer context), strategies for parents (e.g., emotional support, help-seeking), help options (i.e., differences between professionals, benefits of psychotherapy, local resources), and an open discussion period. Outputs included program feedback processes (e.g., session ratings), signs of program engagement (i.e., sign-ups, attendance, active participation), and post-program products (e.g., follow-up materials and mental health resource lists distributed to participants). Outcomes included improved MHL (i.e., knowledge of signs and symptoms around child mental health, help-seeking options), self-efficacy (i.e., confidence and preparedness to support children's mental health), and knowledge transfer (i.e., spreading program information into communities).

Objectives

Study 2 sought to understand the need for and feasibility of developing a MHL program for newcomer parents that focuses on promoting the mental health of their children. Two participant samples were recruited to obtain their different perspectives via participatory focus groups: professionals in the settlement sector (Sample 1) and newcomer parents of children ages 2-12 (Sample 2). Three focus group meetings were held in total due to participant cancellations

and technical difficulties for the parent sample. Through these focus groups, Study 2 addressed the following objectives: 1) Understand how a MHL program about child mental health could be effectively situated within the sociocultural contexts of newcomer parents; and 2) Determine key revisions to the program logic model to enhance the utility of the program.

Method

Qualitative Framework

Data was collected and analyzed according to reflexive thematic analysis (RTA; Braun & Clarke, 2019). Thematic analysis (TA) is a qualitative method for identifying, analyzing, and reporting themes within data by minimally organizing it and describing it in rich detail (Braun & Clarke, 2006). RTA is a more recent term coined by Braun and Clarke (2019) to differentiate from use of TA in research where reflexivity has not been considered in factors influencing study procedures and analysis. RTA is an interpretive method that has wide applicability across qualitative health-related research designs, due to its flexibility towards generating themes that are accessible for different stakeholders involved in a complex research subject (Braun & Clarke, 2021; Campbell et al., 2021). It provides a systematic six-phase framework for capturing meaningful patterns of themes within and across qualitative datasets (Braun & Clarke, 2019).

RTA is a theoretically flexible, but not atheoretical qualitative approach (Braun & Clarke, 2021). Braun and Clarke (2021) emphasize that RTA cannot be conducted in a "theoretical vacuum" (p. 337), and that the researcher is always involved in assumptions made regarding the data, which are guided by their theoretical approach. Thus, I maintained the epistemological lens of constructivism described in previous chapters. This paradigm interprets meaning and reality as largely a product of subjective experience and context, and that qualitative data is thus co-constructed between the participant(s) and researcher, due to the researcher's inevitable role in

influencing the findings (Lincoln & Guba, 2013; Mills et al., 2006). Above all, RTA considers the "centrality of researcher subjectivity and reflexivity" (Braun & Clarke, 2019, p. 590), which includes consideration of the impact of personal beliefs, cultural background, and social status on data interpretation, and is highly consistent with the constructivist view. RTA also places equal value on analysis of both descriptive (i.e., directly indicated by participants) and interpretive (i.e., inferred through their remarks) themes (Braun & Clarke, 2019), and this flexibility is often important for obtaining richer data in qualitative health-related research (Campbell et al., 2021), as well as for focus groups, which can have meaningful explicit and implicit group dynamics.

Procedure

Ethical Considerations

Study 2 received ethical approval from the University of Manitoba Fort Garry Campus Psychology/Sociology Research Ethics Board (HE2023-0165). All participants provided written informed consent (see Appendices E-F for consent forms) prior to participation. During the informed consent process, participants were required to sign an oath of confidentiality as confirmation that they would respect other focus group members' rights to privacy. Participants were informed that they could withdraw their participation during the online questionnaire or before completing the focus group if they experienced discomfort associated with participation. However, they were informed that the focus group data could not be destroyed if they had already begun participating or completed focus group participation, due to audio information and feedback being combined with other group participants. To protect confidentiality, potential identifying information (e.g., names, workplace) provided in quotes or descriptions of participants has been removed, and participants are identified by a number in the findings.

Agency and Expert Consultation

As in Study 1, an important component of applying a constructivist lens involved consultation with experts on the newcomer context. This included discussions with leadership as well as research and mental health committees from MANSO and CMCCF about study methods. This consultation suggested that there would be substantial value in incorporating the perspectives of settlement sector professionals in this study, given their breadth of experiences with observing newcomers' different beliefs, barriers to services, and information and resource needs after moving to Canada. MANSO additionally provided support through circulation of advertisements for this study. In addition, the inclusion of settlement sector professionals as study participants constitutes another aspect of this consultation. A volunteer co-interviewer was not enlisted for focus group meetings due to the briefer nature (i.e., a handful of focus groups) and more structured format of these meetings compared to the individual interviews in Study 1.

Participant Samples

This study involved conducting focus groups with two participant samples. Sample 1 (S1; $n = 5$) was comprised of settlement sector professionals, whose roles involve supporting newcomers to Canada within their communities, assisting them in understanding their rights, and aiding them in accessing programs and services. Inclusion criteria for S1 required that participants were settlement professionals who could speak to their past experiences with newcomer parents, and the challenges these families may have faced with accessing health information and services. Exclusion criteria included those who did not work in this sector or did not yet have experience with these demographics. Sample 2 (S2; $n = 8$) was comprised of parents of children ages 2-12 who were newcomers to Manitoba, Canada. As in Study 1, newcomer was defined in this study as an individual obtaining immigrant or refugee status in the past 1-15 years. This broadened definition was employed to reduce the likelihood of recruiting vulnerable

participants (e.g., recent war-related trauma), as well as to increase flexibility of recruitment to account for study limitations (e.g., interviews being conducted in English). Inclusion criteria for S2 thus required that participants were parents of children ages 2-12 and had lived in Canada between 1-15 years. Exclusion criteria for S2 were parents who did not have any children ages 2-12, and/or had lived in Canada for less than one year or more than 15 years. While one focus group meeting was planned for each sample, hosting an additional third group was necessary for the parent sample to account for participant cancellations and technical difficulties.

Recruitment

Recruitment was facilitated through research advertisements (Appendices B-C) that were circulated through MANSO's network of immigration, settlement, and community agencies in Manitoba, as well as through their electronic newsletter. For S2, participants from Study 1 who expressed interest in further research participation were first contacted and provided the option to participate, prior to additional recruitment. Participants expressed their interest in the research via email and were provided a link to the informed consent form (see Appendix E for settlement professionals and Appendix F for parents) hosted on Qualtrics. All focus group participants received a $30 Amazon gift card as an honorarium for their participation.

Data Collection

Demographic and Background Questionnaire. After providing informed consent, participants completed the demographic and background questionnaire (see Appendix G for parents and Appendix H for settlement professionals) online via Qualtrics, prior to participating in a focus group. The mean completion time for the questionnaire was approximately 2.5 minutes for both the settlement professional and parent samples. For settlement professionals, the questionnaire inquired about their age, gender identity, level of education, occupation title and a

brief description of their role, number of years in their position, and ethnic and cultural identity. For parents, the questionnaire (also used in Study 1) inquired about their age, gender identity, level of education, occupation status, marital status, ethnic and cultural identity, immigration status, immigration category, number of years lived in Canada, home country, and the number and age(s) of their children. Information collected from the demographic and background questionnaire was used to describe the samples and contextualize focus group findings (e.g., cultural backgrounds, original countries, immigration categories of participants).

Focus Groups. After completing the demographic and background questionnaire, participants were scheduled to participate in a focus group, depending on their background and context for participating (i.e., in response to S1 or S2 advertisement). Focus groups were hosted using Zoom videoconferencing. Due to participant cancellations and technical difficulties for the parent focus group, a second focus group was scheduled for this sample to obtain feedback from additional participants (for a total of three focus group meetings). Focus groups were centered on obtaining feedback regarding the program logic model. Excluding introductions and review of informed consent, focus groups ranged from 67 to 86 minutes-long, with an average of approximately 75 minutes. The S1 interview protocol (Appendix K) included semi-structured questions about the perceived feasibility, quality, relevance, and impact of the program outlined in the program logic model. The S2 interview protocol (Appendix L) included semi-structured questions about the perceived meaningfulness, quality, relevance, and benefits of the program outlined in the program logic model, including whether participants would anticipate accessing and benefitting from the program in their own lives. Focus groups were audio-recorded and transcribed verbatim using Trint audio transcription software and copy-edited for accuracy.

Data Analysis

RTA involves six phases of data management, coding, and theme development: 1) Data familiarization; 2) Systematic data coding; 3) Generating initial themes from coded and collated data; 4) Developing and reviewing themes; 5) Refining, defining and naming themes; and 6) Report production (Braun & Clarke, 2021). Data familiarization requires immersion in the data through repeated readings, searching for patterns and meanings, and note taking. Coding involves generating initial codes to organize the data, as well as naming and organizing segments of data into meaningful groups. Generating initial themes involves sorting groups of codes into initial themes, identifying relationships between codes and themes, and diagramming initial themes. Reviewing of initial themes and their relationships helps to identify more coherent patterns, ensure there is enough data to support themes, and combining, removing, or revising themes as needed. Theme naming and defining expounds the underlying story of themes to fit the context of the research objectives and data set, as well as reorganization and remapping of themes to organize their story within this context. Finally, RTA involves a concise written and visual presentation of the data, and discussion of its relevance to the research objectives.

I analyzed focus group data with two research assistants, where we independently coded transcripts and met to discuss our perspectives on themes in the data. We adopted an iterative process to the phases of RTA, where we revisited coding and discussion of themes multiple times. While the six phases of RTA provide a general structure for this approach, they do not require a linear analytic process, and returning to prior phases is often necessary (Braun & Clarke, 2021). Due to the time-sensitive nature of scheduling focus groups and retaining interest of recruited participants, this analysis occurred post-data collection rather than concurrently. This process included meeting multiple times during coding and theme development to discuss similarities and differences between coders' findings, discussing participants' explicit and

implicit meanings in the data, and collaborating on phrasing and organization of themes. The focus group nature of data collection allowed closer identification of participant consensus (e.g., key program logic model changes) because it enabled the research team to distinguish between individual comments and ideas that were shared and built upon between participants.

Study Quality and Rigour

Braun & Clarke (2021) outline 20 key questions for evaluating research quality in TA and RTA, which were considered for this study. While these 20 questions will not be detailed at length, several aspects have been discussed thus far, including justifying selection of RTA as an analytic approach and its consistency with the constructivist paradigm and research objectives, as well as outlining the coding process. In addition, in keeping with their guidelines, efforts were made to maintain consistency with the chosen theoretical paradigm (e.g., maintain a constructivist lens by avoiding objectivist assumptions about the data), to clearly outline the thematic framework (i.e., visual and text-based summaries of themes and subthemes), to extract meaningful themes (rather than topic summaries), to provide support for conclusions drawn (e.g., inclusion of quotes that support themes), to discuss actionable outcomes for the themes, and to avoid both overgeneralizing and undergeneralizing the utility of the findings. These considerations are addressed further in the findings and discussion sections.

Another important consideration in these guidelines and the constructivist paradigm is attentiveness to reflexivity. With this approach, the researcher should “own their perspectives” and positioning in relation to the study context, particularly for subjects where the researcher does not belong to marginalized and/or vulnerable groups whose voices are intended to be represented (Braun & Clarke, 2021, p. 345). It is thus important to explore assumptions made throughout study processes. Participant feedback clearly emphasized additional considerations

that would be necessary for the program outlined in the program logic model to run effectively, which highlighted some assumptions in the design of the model. For instance, the program being available in different languages was considered to likely be a necessary feature but was not stated explicitly given the organizational style of the logic model (i.e., inputs, activities, outputs, outcomes). This reflects my academic and institutionalized perspective on program development, which focused my attention primarily towards this process, and less towards how the program outline could be interpreted from other perspectives. A related assumption was that community-focused elements were inherent in the different program components. This assumption likely reflects my status as a non-immigrant and may have contributed to additional feedback which emphasized this need (e.g., because participants were speaking with a White, Canadian-born researcher). Other less clear or subtler assumptions may have occurred throughout the research process based on other aspects of my identity, experiences, and/or professional background.

The systematic RTA approach, including documenting of field notes (post-focus group) and familiarization notes (during analysis), allowed for more rigorous data analysis. Further strengthening study quality was the process of having myself and research assistants code focus group transcripts and meet to discuss revisions to themes. Notably, the most important aspect of quality in RTA is the researcher's reflexive and thoughtful engagement with analysis, rather than reliable coding coder consensus (Braun & Clarke, 2021). However, this collaborative process can still allow for a richer or more nuanced interpretation of the data (Braun & Clarke, 2019).

Findings

Sample Characteristics

S1 (n = 5) had a mean age of 46.2 and all participants identified as female in terms of gender identity. All participants had a Bachelor's (n = 2) or graduate degree (n = 3). Participants'

occupation titles included Settlement Facilitator (*n* = 3), Project Coordinator (*n* = 1), and Program Coordinator (*n* = 1). Four participants indicated they had been in their current position for one year but referenced significant prior experience in the settlement sector in other roles (i.e., they all recently transitioned to their current position), while one participant did not specify how long she had been in her position. Three participants identified as White, one identified as Arabic, and one identified as Mexican. All participants indicated that they previously immigrated to Canada, from Germany, Kuwait, Mexico, Russia, and Ukraine.

S2 (*n* = 8) had a mean age of 38. In terms of gender identity, one participant identified as male, while the remainder identified as female. Most participants had a bachelor's degree, while one had a graduate degree. In terms of occupation status, four participants worked full-time, three worked part-time, and one indicated they were a stay-at-home parent. In terms of ethnic identity, five participants identified as Latin American, while the remaining three identified as Black or African. Participants had immigrated from several countries, including Colombia, Ecuador, Mexico, Nigeria, and Peru. In terms of immigration status at the time of data collection, participants had lived in Canada for an average of 2.9 years. Six participants indicated that they were a permanent resident, while the remaining two indicated that they were a non-permanent resident and Canadian citizen, respectively. In terms of immigration category, five participants reported that they were international students, two were part of the sponsorship program, and one was part of the provincial nominee program. All participants had between 1-3 children (*M* = 1.9) with only one indicating that at least one of their children had previously experienced a mental health problem (ADHD) and had accessed cognitive behavioural therapy.

As in Study 1, it is important to conceptualize the qualitative themes as capturing common perceptions and experiences among the participant samples, as opposed to an analysis

of these factors at the level of specific demographics (e.g., cultures and countries, immigration categories, length of time in Canada). For instance, the following settlement sector professional noted that there are unique mental health considerations for refugees:

> There are so many categories… You can see that refugees, refugee claimants… They have maybe more challenges when it comes to mental health when they come here. And that's something just to keep in mind as well when you talk to them... Immigration status makes a difference in the mental health of newcomers. (P2)

Thematic Framework

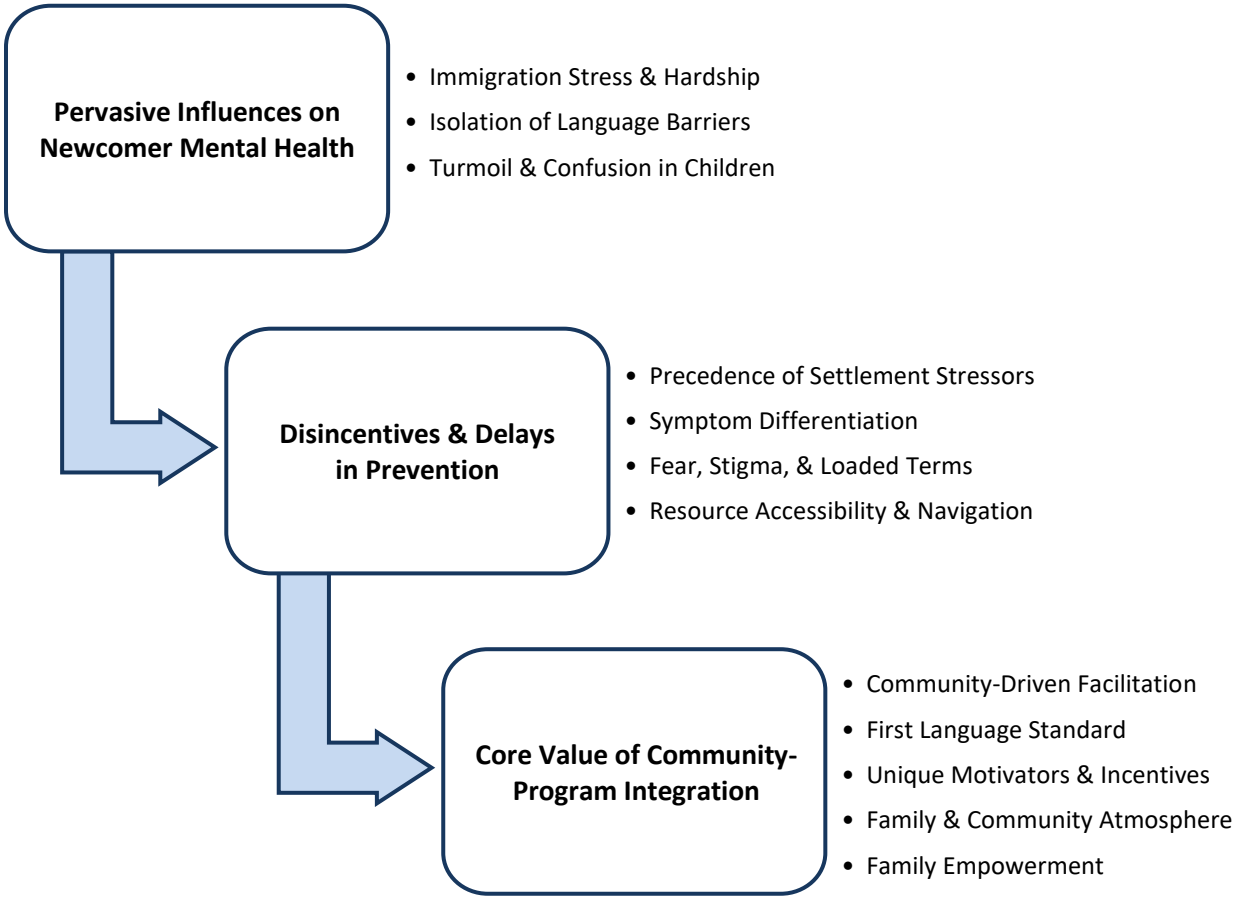
Several important themes pertaining to the life contexts of newcomer families were identified which may contribute to MHL program interest, relevance, and/or attrition. These findings are organized under three main themes with their own sets of subthemes: 1) Pervasive circumstances that influence mental health among newcomer families; 2) Factors that disincentivize families or delay them in taking preventive action; and 3) A necessary core value in program development around the program being closely integrated within a community for it to be accepted. Figure 2 provides a visual representation of this thematic framework.

The thematic framework outlines a conceptual pathway to identified MHL program development needs for newcomer parents. Several pervasive influences on mental health in newcomer families were highlighted during focus groups, and while not an exhaustive list, they represent some common and unique risk factors as families transition to life in a different part of the world, and which should be considered as key topics in a MHL program oriented towards newcomer parents. However, findings suggested that newcomer parents' seeking of information and help for these and other difficulties can often be impeded by distinct systemic and practical barriers, which disincentivize or delay action that could prevent more pronounced difficulties

with mental health. Finally, findings highlighted a need for a core value around the program being closely integrated within a community, as well as fundamental program processes that are aligned with this value. This core value can also help concentrate program content around important factors which may influence mental health in newcomer families, as well as to circumnavigate barriers to seeking information and help and potentially reduce these barriers in the future. These main themes and their respective subthemes will be further detailed below.

Figure 2

Framework of MHL Program Development Needs for Newcomer Parents



Pervasive Influences on Newcomer Mental Health

When discussing potential content for a psychoeducational program and its relevance for newcomer parents, participants provided their perspectives on key challenges that contribute to

the mental health of families and would be important considerations for program topics and discussions. This included subthemes of: 1) The all-encompassing nature of immigration stressors and hardships; 2) Isolation that occurs through language barriers; and 3) A distinct sense of turmoil and confusion in children resulting from immigration.

Immigration Stress and Hardship. The first subtheme captured the wide range of stressors and responsibilities associated with immigration (e.g., family separation, many administrative steps toward permanent residency, culture shock, difficulties adapting) and how this can impact the mental health of newcomer families. One parent outlined how family and community-oriented educational resources can be valuable to newcomers for this reason:

> I'm always grateful that there's these kinds of initiatives and programs, because we have many issues... Daily issues as a newcomer. Try to adapt, try to get a job, try to finish the school, try to handle the kids, and... So, this kind of a space is like we can share with another person, with other people... So, for me, it's great. These kinds of efforts to know how to help the mental health for the kids. (P12)

Another parent provided observations about others in her community, comparing her own experience of having more advantages that allowed her to be more prepared for life in Manitoba:

> I think it [the program] is relevant because I can remember coming in ten years ago and I had to go to Manitoba. It was a very good start for me because I was able to learn so many things about Manitoba. So, for parents who actually are drained coming into the country… They have so many challenges from how to go about the kids, how to blend into the system, the mental health of themselves and the kids... (P8)

One settlement professional mentioned her own family's related experiences in the past: "We had a lot of hardships… because there's no help whatsoever. And even when you speak the

language, it's a different culture, different system. It's not like overseas" (P2). Another settlement professional described what she has observed in recently immigrated mothers: "I started to see a lot of the stress in my clients. Specifically, with women, because they have a lot of things on their shoulders. They're moms, they're students, taking care of home, etc." (P3). She continued:

> The process for immigration is very stressful... Renew the papers. Filling out the forms. Do this… You need to be holding your study permit. You need to have good marks. You need to find a job. You need to do this, and that. You need to find daycare. (P3)

Isolation of Language Barriers. Of the various stressors and hardships associated with immigration, a distinctive one that was emphasized by participants was challenges with isolation, prejudice, and sense of belonging due to less fluency with speaking English. The following settlement professional highlighted the experience of a child she had seen in her work:

> I saw a 7-year-old guy whose parents were settled in an area of Winnipeg that had a low immigrant population level. So, none of his classmates were from immigrant families. They were all born Canadian and they could speak good English. And he was really suffering in this class. In this school, basically. Because teachers probably didn't have much experience with these kids. Because they were never exposed to that. (P5)

She also shared her own children's experiences with bullying due to challenges they have faced with learning to speak English:

> And my kids, even though two out of three were born here... We still speak Russian at home, and they don't know English at the same level as Canadian-born kids who speak English at home. So, they're struggling now. They're struggling in the school. They're getting bullied by other kids because they don't speak good English. And it's so sad. You know? I feel like we need to move to another area again. (P5)

Another aspect of this isolation mentioned by participants was a difficulty with expressing emotions due to language barriers. One parent described communicating in English as being similar to having a different personality: “You have a totally different personality in English than your normal language. You can have a different personality because you're thinking in a different way. When you start thinking in English, you start your own personality in English” (P9). She then described how this can impact children at school:

> In Latin America, we are not used to expressing our feelings. Like the schools, they're saying, “Today you're feeling angry...” They [children] are not too emotional… So, actually, when they come here, it's overwhelming for them to learn English, plus learning how to express those feelings and recognize them. (P9)

Another parent shared a similar comment regarding the compounding difficulties for children with learning to express emotions both in their first language and in English:

> When you're introduced in a new country with new language, it's hard for the kids to try to express their emotion... Well, it depends the age. But when they... My older boy is ten and my daughter is six. They don't even recognize all emotions. And how they feel. So, it's hard to say in Spanish. It's our born language. So, then in English it's more hard. (P12)

He also shared how this has impacted his daughter ability to communicate and advocate for herself at school:

> She doesn't say anything to the teacher about the kid bothering her because she doesn't know how to do it. And if the other boy tells the teacher something against her, she doesn't have the elements or the arguments to try to say, “Hey, I'm not hitting here.” (P12)

Turmoil and Confusion in Children. A related theme to the above participant's comments pertained to an idea of children often having distinct and more considerable challenges with adapting to life in Canada which impact their mental health. This included not fully understanding reasons for immigration, not choosing to immigrate, and being particularly impacted by family separation during immigration. For instance, one settlement professional shared her experience of immigrating to Canada as a child, underscoring how newcomer children frequently experience a sense of upheaval in their lives:

> It changes your whole world, right? It puts it upside down. You feel like you're completely out of control because you weren't asked if you wanted to move to a different country. That wasn't your decision to make. But now you are in this new environment, and you have to deal with it just as much as your parents did. But you felt like they kind of had a leg up on it because they knew it was coming. (P4)

Similarly, the following parent emphasized a sense of confusion that newcomer children can experience in their developmental process about social, cultural, and behavioural norms:

> They see how other kids scream or fight with the instructors, with the teachers... And they are in conflict because they say, "Okay, at home, I know that I have to respect people who are senior, but then in school I see that a kid is fighting with the instructor." Or maybe, "When I'm going to the park, I see how the kid is screaming and raising his voice up in front of the parents." (P13)

One parent summarized how drastic life changes through immigration had impacted her daughter's wellbeing: "When we arrived to Canada, she had many changes in her lifestyle. She left her friends, house, habits, right? She started to show in her emotions as, first, very irritable. A little sad about what she left" (P11). Another settlement professional also reflected on the

sense of turbulence that many children must learn to passively accept and endure, despite not always understanding why their parents have required them to uproot their lives and live under new circumstances that may feel isolating and confusing:

> The little ones... They just go with the flow, you know? “Okay. You need to go to daycare, you must do this.” And unfortunately, for most cases, when they [parents and children] don't come with that same project of working together, they start to separate. And then that is another challenge for the kids. They move from another country. They need to adapt. They need to be flexible. New school. No friends. Everything is new. They need to follow the rules now for the parents. (P3)

Disincentives & Delays in Prevention

The pervasive influences on mental health described in the above theme also generated discussion on potential challenges with hosting a psychoeducational program for newcomer parents that could broach these and other important mental health topics. When reflecting on these challenges, participants described factors for many newcomer families that are likely to disincentivize or cause delays towards accessing mental-health related resources, including resources that are psychoeducational and not focused on treatment. These factors were captured in the following subthemes: 1) The precedence of settlement-related stressors over new commitments; 2) Symptom identification and differentiation from normative stressors; 3) Fear, stigma, and loaded terms associated with mental health; and 4) Low accessibility of existing resources and difficulties with navigating them.

Precedence of Settlement Stressors. Because of the multi-faceted stressors associated with adapting to life in a new country, participants communicated that newcomers fundamentally

tend to have very busy lives, which can be associated with stress or financial limitations, and as a result, lack of time or motivation to seek information or help pertaining to mental health:

> I'm putting myself in the shoes of a newcomer that is barely trying to get what to do. They'll go get a job and have to do 9 to 5. And then those resources are there. What if they are time constrained? So, for instance, if I can only access it, say, during the same work hours when I'm supposed to be out there fending for my kids… Then I'm thinking, at what time would they have it? The available time probably would not be when this program is there for them. (P6)

This parent further described the time constraints of newcomer parents, noting that mental health may need to fall below a list of other priorities:

> Yes, it's important for the family, but then you want to prioritize to see which comes first. Survival or this. You may not want to plan this, because it's not like sickness that is physical that you can really see. You may want to push it to a later time. (P6)

One settlement professional provided similar comments and remarked that this often leads to common informational resources such as brochures not being reviewed:

> And newcomers are so busy, especially in the first probably six months to a year. Often, my clients come with a stack of papers. Immigration papers, some handouts. Their briefcase is overflowing with them. And there is day to day life. You know, there is a laundry, there is cooking, there is cleaning, English classes, and so on. So, often people don't even read those brochures. They just glance at them. (P1)

Symptom Differentiation. In addition to these pressures in the immigration and settlement context, participants also identified uncertainty or low familiarity with symptoms of mental health problems as a key deterrent towards accessing information or resources: “Since

I've been through mental health issues, I know the signs. I know the symptoms. I worked on my healing, so I'm very aware of it. But a lot of parents, they are not aware of that" (P2). More specifically, this was described by other participants as a challenge of distinguishing mental health problems from expected or normative emotional or behavioural difficulties, as mentioned by the following settlement professional: "So, that's what I like about your outcomes, is that you will identify what those key symptoms are so that as soon as it has that switch of, 'Okay. Now, she's not just upset, she's struggling, she's depressed.'" (P4). This participant and others suggested that it can be particularly challenging for families to differentiate common immigration and acculturative stressors from distinct or prolonged mental health problems:

> It is normal for any child when they come to a new country to spend the first weeks, if not months, crying, being upset, having anger outbursts, just being upset... But it doesn't necessarily mean it's a mental health crisis. It just means their world just got turned upside down and they're spinning out of control. But... For me, for example, I had a very hard time with it for about a year, but mental health hadn't really been a part of that. But then after about the year mark, it did turn into a mental health issue. But my parents didn't know the difference. They were like, "Well, she's still upset and she's still angry. It's probably just because we moved and it's just... prolonged." But now it had already turned into a mental health issue, and they didn't even know. (P4)

The following parent's comment provided further support for this important distinction between expected versus more intensive acculturative stress among children:

> It's not that he's not healthy, but he's just adapting through the first [years]. So, it should come with what to expect until they adapt, and then that would be your line to see if he's actually developing his mental health the right way. (P9)

Other participants highlighted a related challenge that parents can experience with distinguishing mental health problems from developmentally normal emotional changes, as mentioned by the following parent: “For example, some parents of my community... They have suspicious diagnoses of autism in their kids, and they are in this denial state, like, ‘Oh, maybe he's not. Maybe he's just being, you know, the age.’” (P7). Another parent shared this perspective and mentioned what she has observed in her community:

> Because so many newcomers... They kind of sweep it under the carpet and they don't really understand mental health in that way. They just think maybe the child is just throwing tantrums, or this child is just being a child, not knowing it could be deeper. (P6)

Fear, Stigma, and Loaded Terms. For newcomers who contemplate seeking external information or help, another deterring factor that participants highlighted was fear (e.g., of CFS or police attention) and stigma (e.g., shame, what it could mean for their child or family if there is a mental health problem), as communicated by one settlement professional:

> There is a lot of stigma attached, and I see a lot of clients who... I recently had a young client who was contemplating committing suicide, and it took me 2 hours to convince him to go to the psychiatric ward at Health Sciences Centre. Because he said, “Oh, they are going to put me in jail, and I will be sitting there in handcuffs.” (P1)

Relatedly, several participants described mental health-related terminology as generating an emotional response associated with fear or stigma. Another settlement professional mentioned how mental health stigma can create a fear of being labelled as “crazy”, based on both her professional and personal experiences in her culture:

> Mental health is a totally different issue because of the taboos in certain cultures. So, for example, in my culture, if you talk about mental health, or if you're going to talk to a

> parent, they're not going to even accept it because they think you're thinking they're crazy, right? That's the conception. That's how we look at things. (P2)

The following parent provided a similar comment about stigma and noted that a program would not be easily embraced in her community if it explicitly focuses on mental health:

> In my community, mental health is not a word [laughs] you just want to throw around. Because, again, [laughs] people wouldn't want to talk about it, especially even if it affects the child. It's not something they would easily – we would easily – embrace. (P6)

Another parent described a similar observation in her community and suggested that a mental health-focused program would need to be framed in a less explicit manner:

> I wanted to mention that sometimes mental health... I don't know, sometimes people get scared with that [laughs]. Mental health... They immediately think on getting sick, or the psychiatrist, or something... Sometimes I talk with people about that – with parents – and they'll start saying, like, "Oh no, everything is fine, everything is working well." But then in private they're telling me more things that... So, I was thinking, like, the name of the program... That tells a lot on how people are going to participate. (P7)

Resource Accessibility and Navigation. For newcomers who do attempt to access mental health-related information or help, participants also communicated several ideas regarding systemic barriers that they will often encounter. Examples included limited availability of relevant resources, delayed or lack of access to provincial health coverage and insurance, and limited finances. For instance, one settlement professional emphasized how language barriers limit pathways to information and help due to limited available options in their first language:

> So, what I've heard from our clients is that they are always looking for a psychologist who can speak their first language, and it's hard to find one sometimes. So, we do refer

> clients to Mount Carmel, to Aurora Family Therapy, but the lack of specialists who speak their language make it uncomfortable because they need a translator. And then having a third person in the room makes it a barrier for them to actually be open. (P5)

Another settlement professional provided Ukrainian refugees as an example of a population that may struggle to access applicable information and help despite their special circumstances and potential need for more urgent support:

> They came under special measures where they do have access to Manitoba Health benefits, but often seeing, say, a psychologist, is out of their reach because they do not have extra insurance. And Manitoba Health cards... The wait time… Probably it's a week, it's months, if not over a year to see a specialist. (P1)

It was emphasized by the following settlement professional how temporary residents are particularly limited in terms of options for health resources and services:

> For temporary residents, there are not a lot of resources, and my thinking is they need a lot. Because they start to search where they can go, and see where they can be a permanent resident, or they need to be Canadian citizen, or put up to a temporary residence… There's not a lot of help. (P3)

In terms of navigating resources that are accessible, participants indicated that a psychoeducational program could be helpful as an introductory pathway for information about local mental health resources: “A lot of parents always ask about those resources and sometimes they don't know where to ask, or even what to ask. So, I think it will be very, very helpful” (P7).

Core Value of Community-Program Integration

Participants’ descriptions of factors impacting the mental health of newcomer families, as well as factors that cause delays in preventive action, were provided in the context of how the

program outlined in the logic model could fit within the gaps of existing resources. The final main theme is centered around unanimous feedback from participants that the program would need to be closely integrated with an individual community to have genuine appeal and impact within that community. This core value around community-program integration was further captured in the following subthemes: 1) A need for the program to be facilitated by community partners or representatives; 2) A standard for all program communications, content, and materials to be available in the community's first language; 3) A need for unique program factors which motivate and incentivize attendance; 4) A family and community atmosphere for the program; and 5) Empowering families to feel more prepared to discuss mental health and seek support.

Community-Driven Facilitation. To promote close engagement with the program, participants consistently emphasized the importance of it being marketed and facilitated in a manner that has close ties with the community it is targeting:

> Educate counsellors and go in their communities and talk about what mental health is. Why is it so important? What to look for? And I think that could be more beneficial for people than someone coming with an academic background and using big English scary words. It could intimidate people because you get lost. (P1)

Suggestions for strengthening community ties included local community association involvement, facilitators having lived experience with the newcomer context and ideally in the program recipients' specific community, and the program being easily found and accessed by community members (e.g., likely to come across it on a social media group). For example, the settlement professional described above continued her point by describing the importance of program facilitators having a clear connection to the community:

> Many people, unfortunately, don't get out much. They are living with many children. They are cooped up in their homes and there is so much to take care of when you have one or five children. So, the model of educating a person within the community who speaks the language... Who is also an immigrant. Who can relate to that experience. Who has lived in their shoes. Who can explain it on their level. So, I love the idea of having a person within the community teaching or helping them identify. (P1)

One parent outlined several reasons regarding why newcomers would be more likely to engage with program content if it is facilitated by someone with similar lived experiences:

> Having a face that is similar to yours, that has your lived experience as per culture, as per the way you talk, the way you think, the way you will reason... That would go a long way to make the programming a success. Because most of the time, when you hear of a program somewhere and it's supposed to help... They think they are helping you, but then they are saying some things and you're thinking, "Uh... nah." Or you're thinking, "This person doesn't even know what they're talking about." Because they are not relating to you from your lived experience. They are talking about it from their own experience, and how they perceive life, or how they perceive things, or how their training demands. (P6)

Similarly, another parent described the value of a program being facilitated at this community level, emphasizing the importance of participants feeling understood:

> I think to be aware of the cultural background. I think that will help a lot. Makes you feel that, "Okay, they're going to understand you." Not necessarily about the history or something about your country, but to kind of make you feel that, "I'm going to understand your culture and the problems you have faced." Like all that background story that you have because of your culture, your country... For example, I have never lived

> through a war, but I have lived through some other social or political situations in my country that, if somebody tells me, “Here, okay, I understand, and that's why I have this program for you.” I will be, “Okay, that person understands me. Or understands my situation, my family.” (P7)

First Language Standard. A closely related but distinct theme was the importance of programs being offered in the first language of recipients for all aspects (e.g., advertising, facilitation, post-program feedback). This was emphasized for the purposes of stronger interest, comfort, and comprehension of program content, as captured by one settlement professional:

> If you are planning to advertise in English, many people, those who are on social media... They follow that social media in their native language because it's easier, right? Especially at the end of the day when you are so stressed out, the last thing you want to do is to read anything in English, right? You just want to read in Russian, Ukrainian, in Spanish. Whatever the case may be. Because it's just easy. It's comfortable. (P1)

Another settlement professional emphasized how learning about and expressing one’s thoughts on mental health can have less resonance in the context of using a foreign language:

> Once they learn some English, they still cannot express their mental health issues in the foreign language. Because when you speak another language, you feel like a different person. But when you want to really cry out, you need to speak your first language… So, accessibility in any language would be ideal. (P5)

The following parent described how her and her children may benefit from certain programs that are offered in English, but that this adds an additional layer of difficulty and can reduce the effectiveness of a program if it is not offered in one’s first language:

> It's important to maybe put persons in a different language… My English is not fluent, and for my children is neither. So, I would like to participate. I would like to help them. I would like to receive help for how manage the stress in them. But maybe if it could be any assistance or any person who speaks a different language, it could help a little. (P11)

Unique Motivators and Incentives. Logistically, participants commented that the logic model did not account for some potentially necessary expenses, resources, and program processes that would be required to truly motivate and incentivize newcomer parents to attend a program. Primary examples included providing some form of assistance with childcare, food, and transportation, due to barriers to attendance (e.g., competing demands, stigma, socioeconomic status). The following settlement professional summarized these considerations:

> A lot of them, if they're immigrants, they came and they don't have jobs. Then you need to find funding for transportation as well. So, it becomes more cumbersome and more expensive, particularly if there isn't enough funding to do such a thing, right? But you have to keep in mind, if you're going to do 3-4 sessions, then you have to get the childcare and snacks, of course, and refreshments, and as well, transportation. (P2)

Participants largely expressed that the style of program described in the logic model would be a valuable resource for parents they have observed in their communities, or throughout their professional experiences, provided that its uniqueness is strengthened through the described incentives. In addition, to justify development of a program with similar content and principles, some participants communicated that it would need to have additional unique qualities that are tailored to newcomer communities to encourage parents to access and benefit from it:

> You need to bring out its uniqueness. What makes it different from the others? And that's what you have to factor in. And I'm sure that's one of the reasons why you're having this

> group as well. So, that uniqueness is what you impute into it, so that it doesn't become like any other mental health resource for kids or for parents. It has to have something unique that only it would offer to newcomers and that would attract newcomers. (P6)

Family and Community Atmosphere. Another critical subtheme was that participants underscored the importance of a psychoeducational program feeling like a space of support, trust, and openness. They emphasized the benefits of an atmosphere where program participants feel like they are attending alongside local community members or like-minded individuals, to facilitate a sense of safety and comfort with learning about and/or discussing mental health:

> Like a Saturday evening when you can schedule a time for "having a good time", right? Like, I know it's going to be family friendly. It's going to be like I'm going to have fun. I'm going to learn. My kids are going to be safe, and I am going to have a good time, right? It's like I'm going to think about something other than working and taking care of the house, while I'm learning. I think that will be a very, very good point. (P7)

Some participants recommended a potluck or some form of food sharing process to instill this atmosphere. As a part of this atmosphere, it was also suggested that use of less direct and non-clinical terminology in program communications (e.g., de-emphasizing the term "mental health") would be beneficial for reducing potential stigma associated with seeking information or help through the program. For example, the above participant suggested that the program could be framed in a manner that allows parents to feel more autonomous when accessing the program:

> The Latino communities will be very, like… Kind of romantic. Like "happy kids" or this type of, "Oh, nobody's asking for help because nobody needs that." [laughs]. So, we'll be like, "Oh, I'm just doing this because I want it. Not because I need it." (P7)

One parent suggested that this atmosphere is important for allowing some parents to develop comfort with the subject of mental health, but that this may require a longer program:

> If they have enough space, they just want to talk. Talk first about how you've been coping or how you got to know about things... You don't want to pour it all out. A few meetings – so, a few hours – would not do that. (P6)

Another parent suggested that a benefit of a more family or community-oriented atmosphere could be that program participants develop connections with each other. She suggested that this may allow them to continue sharing information and support beyond the scope of the program, reducing need for follow-up or ongoing support from program facilitators:

> It helps a lot during the programs to have kind of... Kind of a family club that they can actually be communicating between each other. And if the program goes well, they can give support through each other, so you don't have all the inquiry for everyone and you have to be following up with that. (P9)

Family Empowerment. A closely related subtheme was that participants emphasized how an impactful program would be concentrated towards empowering parents to discuss mental health with their children. They suggested that this empowerment could be achieved through a combination of education (e.g., education about symptoms, resource mapping), normalization (e.g., open discussions, case examples), and reduction of stigma (e.g., discussing positive mental health factors). One settlement professional suggested how this could benefit children: "Empowering them to see the difference between where you need to see a specialist and when it turns from just feeling down to being depressed. That's the key issue. Empowering them to help their child at the same time" (P1). One parent's comment also suggested the value of a program

helping parents to, in turn, empower their children by encouraging them to recognize their strengths (e.g., speaking other languages despite having trouble with English):

> It's important to empower them. To express that, okay, maybe they are struggling with the English language. However, they are good enough that they are able to speak two languages against Canadian kids that are unable to speak Spanish, or Russian, or whatever. Any other language. So, maybe try to empower them. Make them feel, "Okay, it's fine. It's part of the process." (P13)

Similarly, it was suggested that discussing positive mental health factors and adopting less of an illness-focused approach could be empowering for families and reduce stigma:

> I think kind of a new perspective that I think could be good for children is also to show that things like, for example, ADHD... It doesn't necessarily mean it's all bad. Some mental health situations actually have positive sides. People with ADHD, for example, have an incredible ability to focus on one task, where... Kind of change the narrative a little bit. And then for parents, too. Show them it's not all bad. You can pick out the good things and use them in your daily life. So, that's why I really like that you didn't just, say, focus on anxiety and depression. Because it's so much more than that. (P4)

Discussion

The objectives of Study 2 were to: 1) Understand how a hypothetical MHL program about child mental health could effectively fit within the sociocultural contexts of newcomer parents; and 2) Determine revisions to a MHL program logic model to enhance the program's utility. These objectives were pursued through participatory focus groups with settlement sector professionals and newcomer parents to Manitoba, Canada. A discussion of the qualitative themes and their fit with extant literature will help clarify implications in relation to these objectives.

Summary of Findings

The thematic framework developed in this study (Figure 2) is organized into main themes and subthemes that outline MHL program development needs for newcomer parents. The main themes included: 1) Pervasive influences on newcomer mental health; 2) Disincentives and delays in prevention; and 3) A core value of community-program integration.

Pervasive Influences on Newcomer Mental Health

The first main theme encircled participants' emphasis on major contributors to mental health challenges in newcomer families, which would be important to address in a MHL program designed for newcomer parents. Subthemes included: 1) Immigration stress and hardship; 2) Isolation of language barriers; and 3) Turmoil and confusion in children.

Immigration Stress and Hardship. The first subtheme captured an emphasis on how immigration itself can lead to challenges with mental health for families. Implicated factors included separation from family members, difficulty adapting to a different culture and society, confusing and lengthy processes for immigration, and major life changes (e.g., new careers and schools). Other research has shown that this mental strain can become normalized as a natural product of a sense of instability during immigration (Cha et al., 2019). Other factors relevant to this theme that were not discussed by participants in detail (potentially due to not having personal experiences and/or time available in the focus group format) can include experiences of fleeing from war or persecution, living in refugee camps, and labour exploitation, among others (Barnes & Theule, 2023; Ekblad, 2020; Khan et al., 2018; Marshall et al., 2016; Syed, 2015).

Isolation of Language Barriers. A particular immigration and settlement-related stressor described by participants was difficulties associated with navigating language barriers, and how this can lead to isolation, stigma, reduced sense of belonging, and difficulties with

understanding and communicating emotions to others. A great deal of research has identified this link between language barriers with the host country's primary language and reduced wellbeing (e.g., anxiety, isolation, perceived lack of integration; Dryden et al., 2021; Hajak et al., 2021).

Turmoil and Confusion in Children. The final subtheme captured remarks about how immigration contributes to considerable challenges for children, including confusion about the purpose of immigration, anger and sadness about not choosing to immigrate, and being especially affected by family separation. Other research has found that newcomer children frequently experience a sense of upheaval after immigrating, which can complicate several developmental processes due to not experiencing belongingness in the host country, and needing to construct an identity which blends the original and new culture (Caxaj & Berman, 2010; Marshall et al., 2016). Often, they can undergo a migratory grieving process around both the loss of their home country and a portion of their childhood (Volkan, 2018). They may also experience discrimination and social exclusion around their foreign status or English proficiency, which can impact social support and self-esteem (Caxaj & Berman, 2010; Selimos & George, 2018).

Disincentives and Delays in Prevention

The next main theme surrounded potential difficulties that could arise for a MHL program that addresses key mental health topics for newcomer families such as those described in the previous theme. Participants described common factors for newcomer families that are likely to disincentivize or delay accessing of mental health-related resources, which were captured in four subthemes: 1) Precedence of settlement stressors; 2) Symptom differentiation; 3) Fear, stigma, and loaded terms; and 4) Resource accessibility and navigation.

Precedence of Settlement Stressors. Participants' comments indicated a theme surrounding the busyness of newcomer parents' lives (e.g., daily stressors, financial strain,

prioritization of achieving permanent resident status), and how this reduces the likelihood that they will devote time and energy towards seeking out mental health-related information and help. In their recent qualitative study, Sim and colleagues (2023) found that professionals in Canadian health, education, settlement, and social service sectors reported that newcomers' time and "emotional energy" are often expended due to the primacy of material, financial, and other basic needs over mental health needs, thereby limiting recognition and actions taken regarding mental health. Other research has also shown that newcomers may perceive seeking external support as futile because it cannot address these underlying immigration-related stressors (Cha et al., 2019).

Symptom Differentiation. Participants' comments also suggested that uncertainty or limited familiarity with symptoms of mental health problems can deter newcomer parents from more readily or consistently seeking out information and help. They emphasized the challenge of distinguishing distinct and prolonged mental health problems from more common immigration and acculturation stress, as well as developmentally appropriate emotional changes. Irrespective of sociocultural context, MHL research has shown that it is common for parents broadly to experience challenges and low confidence about identifying signs of common mental health problems (Cormier et al., 2020; Davidson et al., 2022; Frauenholtz et al., 2015; Royal Children's Hospital, 2017). Other research with parents has also suggested the complexity of differentiating developmentally normal and transient emotional and behavioural difficulties in children from those that may require intervention (Abera et al., 2015; Cormier et al., 2020; Tully et al., 2019).

Fear, Stigma, and Loaded Terms. Fear, stigma (e.g., being labelled as "crazy" or having a severe illness, concern about CFS police attention), and loaded mental health terminology (i.e., negative connotations associated with "mental health") were also described as prominent factors that deter families from seeking out mental health-related information and

supports. These are well-documented barriers towards discussing mental health and accessing external supports among newcomer populations (Dixon De Silva et al., 2020; Montgomery & Terrion, 2016; Salami et al., 2019; Umpierre et al., 2015; Wang et al., 2019), including for concerns about exacerbating or creating additional grounds for discrimination (Tulli et al., 2020). In Sim and colleagues' (2023) research described above, Canadian professionals noted that they had observed pervasive stigma and fear associated with disclosing mental health concerns among newcomer families, including being viewed as crazy and having an illness that requires clinic or hospital-based care. Other concerns detailed by participants in this study included fears of negative reactions from family or community members, a negative impact on their immigration status, and their children being removed from their care by child protective services.

Resource Accessibility and Navigation. The last subtheme captured comments on how accessing mental health information and help is limited by existing resources' fit or relevance to families' life situations. Examples included delayed or lack of access to provincial health coverage and insurance, limited finances for paid options, lack of first language resources, and confusion about where information or help could be accessed. Research has previously identified similar barriers to accessing external resources among newcomer parents, including economic pressures, not knowing or having access to information about available resources, avoidance of reaching out due to feeling unheard by providers, and language barriers (Tulli et al., 2020).

Core Value of Community-Program Integration

In the other two main themes, participants described pervasive factors which influence mental health among newcomer families, as well as factors that disincentivize or delay steps that could be taken preventively. This contextualized how the style of program outlined in the logic model could fit within the gaps of existing resources. The final main theme pertains to

participants' comments about the need for a MHL program to have a central value of being closely integrated within an individual community to be more likely to draw interest and be successful. This theme comprised five subthemes that identify more specific guiding values for program development: 1) Community-driven facilitation; 2) First language standard; 3) Unique motivators and incentives; 4) Family and community atmosphere; and 5) Family empowerment.

Community-Driven Facilitation. The subtheme of a community-driven facilitation was derived from participants' consistent emphasis on psychoeducational programs needing to have close and readily apparent ties with the newcomer community they are targeting, to promote a sense of safety. A key suggestion for strengthening these ties included facilitators having lived experience with a shared cultural background, as newcomers, and ideally in the specific community. Other suggestions included local community association involvement (i.e., hosting at a familiar and accessible space) and the program being easily found and accessed by community members (e.g., advertised on local social media communities, through community associations). In Sim and colleagues' (2023) focus groups with Canadian professionals across social and health sectors that serve newcomers, participants perceived community-based care approaches (e.g., embedded where they live and access other services to streamline service navigation) to be essential for improving accessibility and quality of mental health supports for newcomer children and families. They also highlighted lack of representation (e.g., lived experience, ethnicity, language spoken), mental health knowledge, and cultural competency as key barriers for effective engagement with newcomer families. community members and providing a light introduction to more intensive services where needed.

First Language Standard. A related aspect of creating a community-driven experience was suggested to be a standard for the program being offered in recipients' first language at all

levels of operation (e.g., advertising, facilitation, materials, post-program feedback) to improve buy-in and impact. Participants reported that a common experience for newcomers is that many programs and resources are only available in English, or at least unavailable in one's first language. Language is a common barrier for newcomers in accessing mental health-related resources and can limit their comprehension (including for those who have learned the dominant language of the host culture) and related effectiveness of the resource (Giammusso et al., 2018). A meta-analysis by of a wide range mental health interventions (i.e., different therapeutic orientations, treatment lengths, both individual and group formats) found that they can be twice as effective when provided in clients' first language (Griner & Smith, 2006).

Unique Motivators and Incentives. The next subtheme captured other logistical feedback around the program outlined in the logic model likely being a valuable resource for parents from different newcomer communities, albeit with additional components that would truly motivate them to attend and be engaged. It was suggested that other factors such as additional cost considerations (e.g., assistance with childcare, food, transportation) would likely be needed to incentivize attendance and stand out as a more unique program feature. These more distinct features would aid with distinguishing the program from other psychoeducational resources that typically are not tailored to individual newcomer communities.

Family and Community Atmosphere. In addition to these considerations for capturing initial program interest and attendance, participants also emphasized the importance of how a psychoeducational program would "feel" for members of a community. They suggested that an atmosphere which evokes a feeling of participating alongside like-minded community members would increase the likelihood that program recipients would experience enough safety, trust, and openness to engage with program content. It was suggested that these outcomes could be

achieved through processes that are educational as well as fun and family friendly, including a potluck or food sharing process, inclusion of children in the program (directly, or a separate, supervised area for children), and a range of activities to promote active engagement. Other research has suggested that parent and family-based MHL programs are likely to be most effective through interactive and multi-faceted content (e.g., including self-directed and cooperative activities, parent-child interaction, and facilitator interaction), rather than a focus on stand-alone educational content (Bagnell & Santor, 2012). Participants also noted that minimizing clinical and academic terms in program communications would be helpful for reducing stigma associated with accessing the program and contributing to the family and community-based atmosphere. This aligns with past research which has suggested that use of culturally consistent concepts, terms, and phrases in psychoeducation and treatment is likely to have more resonance and impact for newcomers (Crooks et al., 2011; Sim et al., 2023).

Family Empowerment. The final subtheme also related to the general feeling and atmosphere of a program, and captured participants' valuing of fostering a sense of empowerment for families. Participants suggested that this empowerment could be attained through a combination of psychoeducation (e.g., about common symptoms, resource discussion and mapping), normalization (e.g., open discussions, case examples), and reducing stigma (e.g., discussing positive mental health factors in addition to key symptoms of child mental health problems) throughout program content. Notably, participatory program development with members or leaders from the target community is likely to be another effective method for increasing empowerment at the community level (Sim et al., 2023). Other research has suggested an important overlap between stronger MHL and family empowerment (Kosyluk et al., 2022)

and this relationship may be particularly important for newcomer communities (Dixon De Silva et al., 2020; Ekblad, 2020; Misra et al., 2021; Rusch et al., 2020; Umpierre et al., 2015).

Implications

The implications of Study 2 are organized by the general significance of the thematic framework for MHL program development with newcomer populations, as well as program development recommendations based on participants' feedback on the program logic model.

Psychoeducation and Newcomer Communities

One objective of this research was to understand how a MHL-focused program about child mental health would fit within the sociocultural contexts of newcomer parents. MHL resources have largely not been tailored to the sociocultural contexts of different cultural groups or newcomers (Brooks et al., 2022; Dixon De Silva et al., 2020; Ekblad, 2020; Hurley, Swann, Allen, Ferguson, et al., 2020; Kirmayer & Jarvis, 2019; Mendenhall & Frauenholtz, 2015; Na et al., 2016). Further, these resources have rarely been designed with inclusive and participatory methods, which is important for diverse populations such as newcomer parents to improve the accessibility and relevance of resources, as well as empower them to promote mental health in their children (O'Brien et al., 2021; Peyton et al., 2019; Umpierre et al., 2015). This study's findings help to address these literature gaps by underlining important considerations for MHL program development with newcomer families, and in diverse cultural contexts more broadly.

The first main theme in this study captured participants' perspectives on pervasive influences on mental health within newcomer families. One subtheme suggested the complicated and interwoven nature of stressors and hardships around the immigration process with mental health among newcomers, as well as the value of psychoeducational resources that can validate and provide information on these connections. Another subtheme suggested the value of program

content that focuses on how language barriers create additional mental health challenges for newcomers, such as with navigation of health and school systems, as well as how children can struggle with adaption and sense of connectiveness to the dominant culture in the host country, creating a sense of isolation or alienation. In addition, another subtheme indicated that immigration and settlement can lead to a distinct sense of turmoil and confusion in children due to uprooting their lives from their previous home, suggesting that MHL programs concentrated towards newcomer parents should highlight these unique stressors and risk factors for children, as well as how parents could help navigate and relate them to their own acculturative experiences. Collectively, this theme and its subthemes do not represent all potential influences on the mental health of newcomer families, but their importance necessitates psychoeducation and discussion about them as core subjects in MHL programs tailored to newcomer communities. Further, the central nature of these factors for many newcomer families would indicate a need for program facilitators to have knowledge and attentiveness to them to be able to elicit discussion and respond to questions about how they may be implicated in mental health.

Another main theme captured difficulties for newcomers that could disincentivize or delay their accessing of a psychoeducational resource on child mental health. Some subthemes reflected more systemic challenges (the precedence of stressors relating to settlement, limited resources that are available in different languages or easy to navigate) that indicate a need for MHL program designed for newcomer communities to try and circumnavigate these more fundamental barriers (e.g., low time commitment, minimal administrative processes for signing up) to increase motivation and interest. Considering the burgeoning population of newcomers in Canada (IRCC, 2024), this also clearly emphasizes a need for clearer and more accessible pathways to information and resources for this population. Other subthemes provided

implications for content and communication strategies for psychoeducational programs. For instance, findings suggested that allocating time to provide psychoeducation around common signs and symptoms which frequently present across different cultural groups, as well as differentiating these symptoms from expected emotional challenges for children as they develop and adapt to life in a new country, is critical. In addition, programs tailored to newcomer communities must mitigate stigma and fear-related barriers for them to be utilized and be effective, including attentiveness to subtleties such as program naming for this purpose. Taken together, this theme and subthemes suggest a fit and untapped potential for MHL programs which have low barriers to entry on both practical (e.g., low financial cost, low time investment for signing up and attending) and emotional (e.g., marketed with culturally relevant terms, emphasis on educational rather than clinical content) levels. One of the primary benefits of programs with these lower barriers to entry would be that newcomer families would be more likely to obtain potentially helpful information and any needed support prior to their children experiencing significant mental health challenges or reaching a point of crisis.

The final main theme captured a consistent sentiment among participants that a psychoeducational program for newcomer parents would need to be designed around a core value of being closely integrated within the individual community it is offered. Several subthemes indicated key avenues for this integration, such as all program features (communications, program content and materials) being available in the community's first language. Further, negative connotations around program access can likely be reduced by speaking to communities' specific terminologies around mental health (e.g., stress, pressure) compared to "mental health" and clinical terms such as depression and anxiety (Sim et al., 2023). This can likely be achieved by training of program facilitators from allied fields (e.g., social

work, nursing) and peer providers or community leaders who live in the same community and have frequent contact with community members (Na et al., 2016). Leveraging of extant resources in newcomer communities in this manner could also reduce strain on the mental health system by assisting with prevention and limiting the need for program facilitation from dedicated mental health providers (Sim et al., 2023). These peer-based approaches in trusted community locations are likely to reduce stigma and foster a sense of empowerment (Rusch et al., 2020). This sense of empowerment was another important focus that was described by participants, as it may enable families to experience more confidence in drawing from a wider range of resources (e.g., community or culture-specific, or those offered in the Western health system). Overall, given that there is a high threshold for newcomer families to seek out mental health-related resources (Sim et al., 2023), these suggested strategies for a MHL program that can draw attention from the target community and encourage attendance are important considerations. If a program is appropriately tailored and integrated into the intended newcomer community, benefits may include increased knowledge about mental health, new coping strategies for families, a sense of support from the community, and reduced stigma among program recipients.

Program Development Recommendations

Another objective of this research was to determine key revisions to the logic model developed prior to data collection (Appendix M) to enhance the utility of the hypothetical MHL program for newcomer parents. Appendix N includes a revised program logic model that integrates feedback from participants. The revised model is conceptualized as a set of recommendations and potential starting point for a MHL program for parents of children ages 2-12 who are newcomers to Canada. These may be used by professionals across sectors to develop or adapt MHL and other psychoeducational programs to this sociocultural context. Perhaps the

most notable revision to the model pertains to the inclusion of guiding values for the program, which are derived from the thematic framework, and are included at the top of the recommendations. These guiding values for community-program integration (community-driven facilitation; first language standard; unique motivators and incentives; family and community atmosphere; family empowerment) are placed above specific program components (i.e., inputs, activities outputs, outcomes) as necessary considerations to increase the likelihood that a MHL program is accepted by the community and is relevant to their specific needs.

In addition, revisions were made to each section of the original program logic model based on participant feedback. These revisions are intended to improve comprehensiveness of the model and general suitability to the contexts of different newcomer communities. Changes to the model's inputs included consideration of other personnel (e.g., peer facilitators), expenses (e.g., potential wage for childcare supervisor), and time investments (e.g., other administrative tasks, program development, and/or research time). Changes to program activities included discussion of mental health challenges specific to newcomers (e.g., language barriers, family separation, culture shock, seeking permanent residency), the impact of immigration on children (e.g., difficulties with integration, isolation, discrimination, language and communication), common stressors for newcomer children and developmentally normal behavioural challenges versus distinct mental health challenges, cultural perspectives on other help or treatment options, and extra emphasis on any local resources that they be more applicable to the community (e.g., those in community members' primary language, or specifically for newcomers). Changes to outputs included multiple options for program feedback for accessibility, ensuring long-term follow-up for feedback and program evaluations, and including testimonials from previous program participants. Finally, changes to outcomes included other potential benefits of a MHL

program tailored to newcomer parents, such as additional possible aspects of MHL (e.g., influences of settlement stressors on children), and empowerment and stigma reduction (e.g., increased comfort with discussing mental health, normalization of mental health challenges).

Overall, the findings suggested a clear need for MHL programs for newcomers to be developed and operate at the level of specific cultures or communities (e.g., using first language, culturally relevant terms). Given that the program development recommendations advocate for this community-centered approach, they are not intended to be utilized strictly and without adaptation. It is recommended that the guiding values are first used to consider community-specific needs before adapting the template for program development, evaluation, and/or research. The recommendations thus can be used as a starting point to consider how psychoeducation is provided in the context of new or existing programs.

Future Directions

Because this study was conducted with small samples of settlement sector professionals and newcomer parents, additional research is needed to continue exploring avenues for developing impactful and culturally congruent MHL and other psychoeducational programs for newcomer communities. For instance, research which expands on the underlying theory and structure of recommendations resulting from this study, such as by identifying other important program values, would be beneficial. Relatedly, evaluation of the recommendations through either original program development or adaptation of elements from existing programs is necessary to determine their fit with specific cultural and community groups. For instance, the Triple P-Positive Parenting Program's multi-level stepped care system enables selection of evidence-based approaches with varying levels of intensity (Sanders, 2023). Thus, adaptation of a program such as Triple P's lower levels of intervention levels may also align well by

incorporating the community-centered values and some content areas from the program development recommendations (e.g., discussing unique challenges for newcomer children, common perspectives in the community on help and treatment).

Limitations

This study shares some of the limitations of Study 1, namely regarding sample characteristics in relation to the study context. First, because this study was conducted in English, interested participants were generally proficient in English. Despite their strong English skills, they were also not able to communicate in their first language, which potentially would have allowed them to communicate other details that were not captured in the findings. In addition, the requirement for discussing mental health (particularly in a focus group setting) inevitably would have deterred participation from individuals who could be considered key targets of the hypothetical MHL program (e.g., more stigma, less familiarity or comfort with discussing mental health). This may have also contributed to smaller focus group sizes and slower intake of prospective participants. Further, all settlement professional participants, and all but one of the newcomer participants, identified as female. This is a common limitation in research focused on child mental health and parenting programs (Gonzalez et al., 2023; Panter-Brick et al., 2014; Parent et al., 2017; Schulz et al., 2023; Tully et al., 2017), but nonetheless a notable one in terms of the generalizability of these findings to fathers' perspectives on this study's themes. Participants were diverse in several other aspects (e.g., cultural backgrounds, original countries, immigration categories, number of years lived in Canada), which helps with identification of some common perceptions among newcomers of diverse backgrounds, but also limits identification of themes specific to certain groups. Taken together, it is important to note that the perspectives of these participants do not fully represent the diverse range of experiences

that exist among newcomers to Canada (e.g., families with acute war-related trauma, with lower English proficiency, experiences of male newcomers). The inclusion of perspectives from settlement sector professionals, as well as the parent sample's broader descriptions of observations in their community, likely mitigates this limitation to some degree and helps improve the generalizability of the findings. However, future research would be necessary to identify other needs for programs tailored to specific communities (e.g., piloting and/or adaptation of programs for specific refugee groups or cultural communities).

Study 2-specific limitations pertain to focus group composition, as well as specificity of feedback received regarding the program logic model. A key recruitment challenge was organizing groups of participants with busy schedules. These scheduling challenges, as well as technical difficulties for one parent participant, necessitated scheduling of an additional focus group to increase the parent sample size. Thus, feedback from participants in this sample, while having several consistencies between the two group meetings, was fragmented in this manner and may have had differences if it was contained to one group discussion. In addition, the study likely would have benefitted from samples of other potential key stakeholders (e.g., immigrants who were raised in Canada, researchers, mental health professionals who work with newcomers), who may have provided unique perspectives in the findings. Finally, feedback received for each individual component of the program logic model was brief and more applicable to the overall program. This feedback may have been confined by time-based limitations for the groups and/or a need for a more extensive program overview (e.g., longer descriptions of program activities). However, this also could have contributed to participant confusion and/or attrition, and would likely be resource-intensive (e.g., larger time commitments and compensation required for

participants). Additional research that explores MHL program development needs for newcomer populations and can account for these limitations would be beneficial.

Conclusion

This study investigated MHL program development needs and feasibility for parents of children ages 2-12 who are newcomers to Canada. This aim was pursued through participatory focus groups with this population and settlement sector professionals. Participants provided insight into general MHL program development needs, as well as direct feedback on a draft program logic model for a hypothetical MHL program designed for this population. Findings highlighted themes surrounding pervasive influences on mental health within newcomer families (immigration-specific stressors, isolation due to language barriers, sense of turmoil and confusion in children), as well as factors that are likely to disincentivize or delay preventive action (precedence of settlement-related stressors, difficulty differentiating symptoms of mental health problems from transient stressors, stigma and fear, difficulty accessing and navigating resources). Findings also identified important guiding values for programs to be accepted and integrated into newcomer communities (community-driven facilitation, all program components being available in the community's first language, unique factors to motivate accessing the program, a family and community-based atmosphere, empowering families to discuss mental health and seek support). Based on these findings, the program logic model was reconstructed as a set of MHL program development recommendations and potential starting point for future program development and research efforts with specific cultural and community groups.

Overall, this study adds to the dearth of MHL literature that orients program development towards diverse sociocultural contexts such as newcomer parents, as well as by adopting a participatory approach to outlining needs and recommendations in this domain. Future research

that expands on these findings is needed to discern important changes to the thematic framework underlying these recommendations, as well as additional program values and content to consider. It is hoped that the recommendations will aid other researchers and community providers in the settlement, mental health, and allied sectors to offer psychoeducational programs that are tailored to different newcomer communities in the most supportive and helpful manner as possible.

Chapter 4: General Discussion

The combined objectives of this dissertation were to: 1) Expand considerations in MHL literature regarding how this concept can be conceptualized and addressed in the immigration and settlement context; and 2) Contribute towards mental health promotion and prevention strategies that are more tailored to the sociocultural contexts of newcomer families in central Canada by empowering their voices regarding key information and program development needs. These objectives were met through qualitative and participatory research methods with newcomer parents and settlement sector professionals, as well as consultation and collaboration with agencies in the settlement sector (MANSO, CMCCF).

The first study in this dissertation explored how the concept of MHL aligns with newcomer parents' unique perceptions, lived experiences, and information needs surrounding child mental health. Past research has suggested that the common approach to MHL theory, while valuable for encapsulating skills involving mental health knowledge, perceptions, and behaviour, is generally grounded in a Western biomedical view that overlooks the influence of sociocultural context on differences in how mental health is experienced (Atilola, 2015; Furnham & Hamid, 2014; Furnham & Swami, 2018; Spiker & Hammer, 2019). Relatedly, the concept of MHL and fit of this model for newcomers has scarcely been explored in research literature (Kutcher et al., 2016; Montgomery & Terrion, 2016; Na et al., 2016). Through individual interviews with parents of children ages 2-12 who were newcomers to Manitoba, this first study found themes in the following areas: 1) Lived experiences in settlement (sacrifice and/or loss resulting from leaving one's country, cultural differences and conflicts, searching for a sense of belongingness and integration, and new opportunities for security); 2) Beliefs and understanding of mental health (diverse definitions and concepts of mental health, backgrounds of observing

mental health stigma and invalidation in one's culture or country, a sense of integration with Canadian views of mental health, and the importance of parental support and modeling for child mental health); and 3) Perceptions of information and help-seeking (a principal role for parents of trying to address child mental health challenges prior to professional help-seeking, mixed caution and openness to accessing professional help, and newcomer-specific barriers that limit options for seeking information and help). A suggested implication of this study is that there are limitations to the applicability of the conventional framework of MHL to the newcomer context, considering that newcomers have distinct sociocultural experiences that complicate how their mental health and MHL skills can be understood (e.g., migratory grief, acculturative stress, lack of common language used to describe mental health). Moreover, several pervasive barriers for many newcomers (e.g., language, discrimination, immigration stress) limit access to resources that would be appropriate for supporting these skills and the mental health of their children.

The second study in this dissertation sought to understand the needs for and feasibility of developing a MHL program within the sociocultural contexts of newcomer families. Few MHL programs are adapted to specific sociocultural contexts, and no standard or established resources are tailored to newcomer populations (Ekblad, 2020; Na et al., 2016). Through participatory focus groups that included settlement sector professionals and newcomer parents, participants discussed general MHL program development needs in this context and provided feedback on a theoretical program outlined in a program logic model. The thematic framework developed from focus groups included three primary themes with their own sets of subthemes: 1) Pervasive influences on newcomer mental health (immigration-related stress and hardship, isolation created by language barriers, and a distinct sense of turmoil and confusion in children during settlement); 2) Disincentives and delays in prevention (precedence of settlement-related stressors, difficulties

differentiating symptoms of mental health problems from normative stressors, fear, stigma, and loaded terms associated with mental health, and low accessibility of resources and difficulties with navigating them); and 3) Core value of community-program integration (community-driven program facilitations, a standard for all aspects of the program to be available in the community's first language, unique factors to motivate and incentivize attendance, a family and community-based atmosphere, and empowering families to discuss mental health and seek support). These findings have useful implications for understanding gaps to be filled and content to be addressed in MHL program development (i.e., the identified influences on newcomer mental health and barriers to seeking information and help), as well as important principles in program development for MHL programs to be accepted and integrated into newcomer communities. In addition, a revised program logic model was provided as a set of program development recommendations and potential starting point for future program development and research efforts that could be adapted to individual cultural and community groups.

Combined Implications

These studies also complemented each other and have joint implications. Study 1 facilitated an in-depth, individual-level exploration of newcomer parents' conceptualizations of mental health and considerations about how MHL can be defined in cross-cultural and newcomer contexts. Study 2 was aimed towards gathering focus group perspectives on a more concentrated topic (MHL program development needs and feasibility of a program outline), which is not an environment that is suitable for this form of questioning and analysis, due to needs for time management and group confidentiality. In turn, Study 2 focused on how strategies for strengthening MHL can be more effectively implemented in newcomers' sociocultural contexts through psychoeducational programs. Additionally, findings from Study 2 helped fill in a few

gaps from Study 1 regarding some help-seeking factors among newcomers that have commonly been identified in past research literature, such as avoidance of help-seeking due to perceived lack of cultural competence among mental health providers, as well as cultural emphases on seeking community-driven supports (Wang et al., 2019). Together, these studies expounded on assumptions and limitations that have been identified in MHL research in the past decade (i.e., roots in the Western biomedical model, lack of culturally adaptive psychoeducational approaches; Atilola, 2015; Furnham & Swami, 2018; Kutcher et al., 2016; Na et al., 2016). The findings from this work can help researchers be mindful of these assumptions and seek avenues to move forward more effectively in cross-cultural and newcomer contexts.

Another important message highlighted across both studies is that psychoeducation about mental health problems (e.g., symptoms of common problems, treatment options) was broadly perceived to be valuable and necessary by newcomer participants. Themes across both studies such as the precedence of settlement-related stressors, different aspects of stigma, and a desire to preserve cultural values were perceived as potential barriers to accessing information and help and rationale for cultural adaption of resources, rather than reasons why these resources would be unhelpful. One layer to this implication is that mental health and MHL clearly must be conceptualized and addressed differently for newcomer populations, such as in the context of other relevant life circumstances (e.g., focusing on the pervasive impact of settlement-related stressors and sacrifices on mental health), and through use of strategic communication approaches (e.g., limiting clinical terminology that may be intimidating or stigmatizing). A second layer is that MHL should be approached at a community level, such as considering unique definitions and targets for MHL skills (e.g., identifying the mental health impact of a low sense of safety in one's original country) and adapting program communications to include

cultural idioms or phrases. These considerations provide examples of why innovative approaches are needed, and this research provides devices (theoretical model, program development recommendations) that can inform or provide a basis for future work in this area.

While the two studies in this dissertation were concentrated around understanding newcomer parents' conceptualizations of mental health and psychoeducation needs, respectively, this research also has some implications for clinical practice. First, several themes in both studies diverge from standard views of mental health and help-seeking that can be rooted in the Western biomedical model and clinical training. Some findings such as participants' perspectives on key factors influencing mental health and potential reasons for not seeking help are important considerations for clinicians working with newcomers who present to clinical services, including in both psychological assessment and treatment. In addition, recent research with professionals in the health, education, settlement, and social service sectors underscored a gap along the continuum of mental health supports for resources that fall between basic information dissemination and psychological intervention, such as community-based supports (Sim et al., 2023). The implications for MHL program development in this research and the resulting program development recommendations effectively outline a psychosocial support that falls in this place on this continuum, and/or in the low-intermediate stages of intervention if viewed from the perspective of a stepped care model of health. This form of resource is likely best developed and offered in collaboration with newcomer-serving community organizations. In particular, community organizations such as those concentrated around specific cultures or ethnicities do not only offer resources to support settlement and integration, but are also often important and overlooked pre-existing sources of support for newcomers (Kirmayer et al., 2011). These organizations are thus positioned as valuable partners for implementing this form of resource.

This research also highlights an important role of mental health clinicians and researchers to contribute their knowledge and expertise not only by ensuring care for those who are seeking help, but also by sharing information with communities as a preventive strategy to help with recognizing signs of mental health difficulties, building proactive mental health strategies, understanding available options for help, and reducing stigma (Bonanno et al., 2021). This research is conceptualized as a bridge between Western psychology training and a newcomer participatory perspective to enhance our understanding and approach to MHL with this population. As such, in this research, there exists a tension between the notions that MHL is a valuable approach for encapsulating helpful mental health knowledge and skills, but also that this concept is insufficient when viewed through a lens focused on cross-cultural and newcomer contexts. Part of the value of this research was to examine avenues for reducing this tension (e.g., aspects of MHL that newcomers perceive to be important for their communities, strategies for a MHL program to be seen as more relevant to a community). The findings provide considerations for mental health professionals in Western countries that extend beyond cultural sensitivity and towards an understanding of some of the complexities in how newcomer families can interact with the mental health world (e.g., different mental health terminologies, unique mental health factors such as migratory grief), as well as how more bridges can be built through culturally adapted MHL programs (e.g., community-based structuring, emphasis on family empowerment).

Strengths and Limitations

There are both strengths and limitations to the methodological approaches adopted for these two dissertation studies and the discussed research context. A key strength of this research is its novel contributions to the MHL literature by critically evaluating and seeking solutions for limitations in the field around cross-cultural representation that have been highlighted in

approximately the past decade (Furnham & Hamid, 2014; Hurley, Swann, Allen, Ferguson, et al., 2020; Kutcher et al., 2016; Mendenhall & Frauenholtz, 2015; Reardon et al., 2017). It is also novel in that it explores the fit of the Western MHL framework for newcomer populations, who lie at this intersection of this literature gap (i.e., due to the diversity of cultural contexts comprising newcomers), which has scarcely been discussed in the literature (Kutcher et al., 2016; Montgomery & Terrion, 2016; Na et al., 2016). While suggestions have been provided in past literature regarding necessary adaptions to MHL for diverse sociocultural contexts (e.g., tailoring programs to different cultures), this research is unique in that it employed participatory qualitative approaches to identify some of these needs. The rigorous qualitative approaches to this subject in both studies represents another strength and novel contribution to the field, given several challenges with psychometric properties and inconsistent measurement that have been identified in quantitative MHL research (Hurley, Swann, Allen, Ferguson, et al., 2020; O'Connor et al., 2014; Reardon et al., 2017; Wei et al., 2015, 2016) and minimal practice of reflexivity in the limited qualitative research that does exist (Hurley, Swann, Allen, Ferguson, et al., 2020).

Notably, this dissertation did not explore MHL in the context of Indigenous peoples, who comprise a large proportion of the population in Manitoba. This research captured new considerations for MHL literature that specifically relate to the immigration and settlement context, which is distinct from the sociocultural contexts of Indigenous populations. While the findings may well align with some experiences and needs in Indigenous communities (e.g., culturally influenced concepts around mental health, need for community-centered program development), additional research would be needed to identify unique considerations such as specific mental health topics that could be the focus of program development.

An important limitation to consider for this research was that the recruitment processes largely did not reach newcomers who may face the most pervasive challenges to accessing mental health-related information and supports for their families (e.g., less experience with speaking English, less integrated with Canadian systems, more stigma or discomfort surrounding the subject of mental health). Thus, it must be acknowledged that the participants included in this research may not fully represent the perspectives of those who have the most significant difficulties with settlement in Canada (e.g., recent refugees, families experiencing more severe discrimination and isolation). However, through this research's participatory approaches to understanding what aspects of mental health and MHL are relevant and important for newcomers, and positioning and valuing participant perspectives closer to that of the researchers, it was possible for them to advocate for the broader newcomer population.

Moreover, as stated in the context of both individual studies, a wide-net approach was adopted for including newcomer parents in this research (i.e., not focused on specific immigration categories, originating countries, cultural backgrounds), which carried advantages and disadvantages. This approach allowed for in-depth exploration of some common experiences and perceptions among newcomer parents in central Canada (i.e., across different backgrounds) but also limited the potential to understand the research questions and explored themes within more specific contexts (i.e., variations based on culture, original country, immigration category). A larger sample size with different sociocultural contexts, or research that is more concentrated towards a specific context, would be necessary to draw conclusions on these grounds. A related limitation was that both studies were comprised almost entirely of female newcomers and settlement professionals. Thus, additional research that can engage male professionals, and particularly newcomer fathers, would be beneficial. Generally, the division of gender roles has

been suggested as one key influence on the distribution of parenting tasks and on fathers' lower engagement in research relating to child development and mental health (Schulz et al., 2023). However, efforts to more effectively recruit and engage ethnoculturally diverse fathers also require a systemic lens regarding the influence of culturally bound gender and parental norms (Gonzalez et al., 2023).

In addition, compared to a common approach in academic and gray literature of defining newcomers as those who have lived in Canada for up to five years (e.g., Shakya et al., 2010; Sim et al., 2023), a broader approach (i.e., 1-15 years) was employed in this research for multiple reasons. Utilizing a more flexible definition is not unprecedented in past research (e.g., Beiser et al., 2015; Caxaj & Berman, 2010; Crooks et al., 2011; Hirani et al., 2024; Selimos & George, 2018) and the psychosocial adjustments associated with settlement can persist for much longer (Crooks et al., 2011). Further, consulted agencies (MANSO, CMCCF), recommended a criterion of at least one year lived in Canada to reduce the likelihood of recruiting vulnerable participants (e.g., recent war-related trauma) who could misunderstand, be harmed, or be less able to engage with the research. This 1-15 range was also implemented to increase recruitment prospects considering other discussed limitations (e.g., studies conducted in English). Thus, this research was less concentrated around recent newcomers (e.g., up to five years lived in Canada) although the average time lived in Canada for newcomer participants was relatively close to this range (Study 1: $M = 5.4$ years; Study 2: $M = 2.9$ years), particularly for Study 2. Samples including only recent newcomers may have yielded some variations in the qualitative themes, or additional information (e.g., insights from parents who are more ambivalent about accessing mental health services for their children, suggestions for other MHL program content for recent newcomers). However, expanding this definition and inclusion criterion also carried the advantage of

recruiting some participants who had lived in Canada for longer and were able to reflect on lived experiences (e.g., stressors in their original country or pertaining to settlement in Canada) that were still relatively recent or ongoing, as well as provide longer-term observations from their interactions with others in the communities in which they had lived and worked in Canada.

Relatedly, another limitation that impacted both research studies involved smaller sample sizes and general recruitment challenges, including infrequent contact from new and prospective participants, difficulties with scheduling some participants, and some individuals who did not reply after providing consent. These challenges likely would have been more pronounced if the broader recruitment criterion for newcomer parents (i.e., living in Canada between 1-15 years) was not adopted. The qualitative nature of data collection, which requested notable time commitment from participants (i.e., a minimum of one hour), as well as for them to speak directly with the researcher(s) in an individual interview or focus group context about a potentially sensitive subject, may have also impacted the number of participants recruited. An alternative approach could have included conducting a quantitative study (e.g., secondary data analysis to evaluate mental health service use based on immigration variables, survey-based research to analyze mental health-related beliefs), which would have increased sample size(s) and potentially allowed for broader conclusions about this population. However, the overarching aims of this dissertation were to obtain in-depth data that integrates the voices of members of a marginalized population (e.g., using participants' phrasing, adapting questioning and having the opportunity to follow up on participant perspectives), which have been neglected processes in the MHL literature (Atilola, 2015; Hurley, Swann, Allen, Ferguson, et al., 2020), and for which qualitative approaches are more appropriate (Liamputtong, 2015; Ponterotto, 2010; Stein & Mankowski, 2004). Another approach that could be considered for future research is working

collaboratively with individual cultural community organizations and more settlement sector organizations (potentially across multiple provinces), which could increase recruitment prospects, allow for data collection from a wider range of key stakeholders (e.g., researchers in the sector), and strengthen capacity of resources such as translation support, assistance with adapting materials to specific cultural communities, and hosting and piloting of programs.

Future Directions

Regarding these collaborative and participatory approaches, other future research and program development that aims to unite the mental health sector with settlement and cultural community organizations is encouraged. Ongoing initiatives of this nature are valuable for integrating the different skill sets and resources available in these sectors, which ultimately is conducive to more closely meeting the needs of newcomer families in the areas of mental health promotion and prevention. In addition, the two studies in this dissertation add to a very small portion of the literature which considers MHL across diverse cultural contexts and newcomers specifically; additional research is thus important for expanding on the findings from these studies and maintaining this sociocultural lens regarding MHL. Importantly, future MHL research and program development initiatives are also likely to be most impactful when adapted to specific immigration contexts (e.g., refugees, economic immigrants, international students), cultural groups or geographic regions (including Indigenous peoples and communities), and/or individual originating countries. For instance, further efforts are necessary to better understand group-specific mental health concepts, information needs, and barriers to information and help-seeking for different newcomer communities and tailor psychoeducation approaches to these factors. The theoretical model and program development recommendations developed through this dissertation research can support or provide a foundation (e.g., expansion of the theoretical

model, program development using the guidelines) for these initiatives.

Knowledge Mobilization

On a more local and immediate level, knowledge mobilization (KMb) is an important aspect of enhancing and disseminating the findings of this research. The Social Sciences and Humanities Research Council of Canada (2023) defines KMb as "an umbrella term encompassing a wide range of activities relating to the production and use of research results, including knowledge synthesis, dissemination, transfer, exchange, and co-creation or co-production by researchers and knowledge users" (para. 5). KMb can strengthen the impact of research findings for key stakeholders (i.e., newcomer communities, immigration and settlement agencies, mental health professionals, other researchers) through participatory methods as well as use of knowledge dissemination channels that are familiar, consistent with stakeholders' needs, and/or easily-accessible (Ungar et al., 2015). This is also an important consideration as part of exiting ethics (i.e., researchers' thoughtfulness regarding how they complete research in a community context and share findings) in qualitative research (Tracy, 2010).

Several processes in this dissertation were implemented in the interest of KMb. First, obtaining consultive and recruitment support for this research via MANSO and CMCCF involved introductory presentations of the research proposal to staff and committee members (including community representatives) from these agencies, which facilitated relationship-building and feedback on including strategies for improving collaboration with participants. Further, the qualitative and participatory approach to this dissertation enabled knowledge exchange by elevating participants' voices in the development and communication of findings, in addition to sharing a summary of the research findings with participants. Post-data collection, presentations of the research findings have been and will continue to be offered to the supporting

agencies (MANSO, CMCCF) and contributing communities.

In addition, this dissertation research will be published in different formats to broaden dissemination of the findings. A 12-month open access period will be sought (i.e., a "Green" publishing option with a peer-reviewed journal) for publication of each study. This approach ensures that the research publication is publicly available through self-archiving of a pre-print version of the manuscript, followed by the full published (i.e., post-editorial) version becoming publicly available within 1 year. Another deliverable of this research includes a non-technical summary report of the findings from this research (Appendix O). This report will be freely available and offered to the supporting agencies and research participants to review and/or disseminate through any channels they may prefer (e.g., website, community social media).

These steps taken to collaborate on generating and exchanging research knowledge with newcomer families and the settlement sector are consistent with the goals of this dissertation: to expand discussion of how MHL is considered in different sociocultural contexts, as well as to move towards psychoeducational strategies that are more closely tailored to the sociocultural contexts of newcomer families. In the long term, it is hoped that sharing the findings through peer-reviewed publication and the non-technical report can assist with psychoeducational program development in central Canada and other mental health and settlement landscapes.

Conclusion

Considering that newcomer children comprise a significant and rapidly growing portion of the Canadian population, as well as the next generations of Canadians, it is critical to support their parents through mental health promotion and prevention strategies that are congruent with their cultural contexts. This dissertation critically evaluated some of the limitations that are inherent in the prevalent MHL research field for applying this concept in diverse sociocultural

contexts (e.g., lack of integration of cultural differences in symptoms, beliefs, practices). In this way, this research sought to find common ground between the notions that MHL is a valuable approach to public psychoeducation but likely requires significant modification to adequately fit cross-cultural and newcomer contexts.

Through two qualitative studies, key areas addressed on this subject included an evaluation of similarities and differences in how MHL can be conceptualized in the context of newcomer families, and a participatory approach to outlining MHL strategies that are more tailored to the sociocultural contexts of newcomer families. Findings from Study 1, compiled in a theoretical model, suggested that the common framework of MHL (Jorm, 2012; Jorm et al., 1997) has reduced applications for the newcomer context, given that newcomers often have distinct sociocultural experiences and pervasive systemic barriers to navigate, which complicate how their mental health and MHL skills can be understood. Findings from Study 2 yielded a thematic framework of MHL program development needs for newcomer parents and a related set of program development recommendations that address important content areas and community-based principles in MHL program development.

Overall, the findings offer several considerations for mental health professionals in the Western world regarding how newcomer families may interface with different concepts of mental health, as well as information and help resources. Future directions for research and program development in this domain include collaboration between the mental health sector with settlement and cultural community organizations to produce further MHL research in this domain (i.e., to better understand key mental health concepts, information needs, and barriers for different newcomer communities), and development of related programs for specific newcomer contexts (e.g., cultural groups, geographic regions, immigration categories, specific countries).

Some of these approaches could be initiated through consideration of the theoretical model and program development guidelines developed in this research. Through continued collaborative and participatory research, psychology professionals can continue to empower the voices of newcomer families, better understand and re-define MHL in this sociocultural context, and provide more compassionate and effective care.

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Appendix A: Study 1 Research Advertisement

Hello! We are researchers from the University of Manitoba, Department of Psychology. We are searching for parents who both:

1) Have a child between ages 2-12

   AND

2) Have immigrated to Canada in the past 1-15 years

If this applies to you, we hope to understand your experiences around child mental health and wellbeing, as well as differences you have noticed in how they are thought about in Canada. This research will help us develop a free program for parents to learn more about child mental health/wellbeing and help options.

Participating in this research will involve completing a 5-10-minute online survey and a 60-90-minute interview by Zoom. Your participation is **optional** and will not impact the services you are receiving.

You can receive up to $25 Amazon or Visa Gift Card for participating in this research!

If you are interested, or have questions, please contact the principal investigator, Dylan Davidson, M.A., at: davids29@myumanitoba.ca

This research is supported by Dr. Kristin Reynolds (Associate Professor, Department of Psychology) and the Health Information Exchange Laboratory. For more info, see healthinfoexchangelab.ca or contact Kristin.Reynolds@umanitoba.ca.

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus (HE2022-0081).

Appendix B: Study 2 Research Advertisement (Immigration & Settlement Professionals)

Hello! We are researchers from the University of Manitoba, Department of Psychology.

We are searching for immigration and settlement sector professionals to provide feedback on important features of a program about child mental health and help options, which would be offered to parents who are newcomers to Canada.

Participating in this research will involve completing a 5-10-minute online survey and a 90-minute focus group meeting by Zoom.

Your participation is **optional** and will not impact your status with your employer.

You will receive up to $30 on an Amazon Gift Card for participating in this research!

If you are interested, or have questions, please contact the principal investigator, Dylan Davidson, M.A., at: davids29@myumanitoba.ca

This research is supported by Dr. Kristin Reynolds (Associate Professor, Department of Psychology) and the Health Information Exchange Laboratory. For more info, see healthinfoexchangelab.ca or contact Kristin.Reynolds@umanitoba.ca.

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus (HE2023-0165).

Appendix C: Study 2 Research Advertisement (Parents)

Hello! We are researchers from the University of Manitoba, Department of Psychology. We are searching for parents who both:

1) Have at least one child between ages 2-12
   AND
2) Have immigrated to Canada in the past 1-15 years

If this applies to you, we would like to get your feedback on important features of a program for parents to learn more about child mental health/wellbeing and help options.

Participating in this research will involve completing a 5-10-minute online survey and a 90-minute focus group meeting by Zoom.

Your participation is **optional** and will not impact any services you are receiving.

You will receive up to $30 on an Amazon Gift Card for participating in this research!

If you are interested, or have questions, please contact the principal investigator, Dylan Davidson, M.A., at: davids29@myumanitoba.ca

This research is supported by Dr. Kristin Reynolds (Associate Professor, Department of Psychology) and the Health Information Exchange Laboratory. For more info, see healthinfoexchangelab.ca or contact Kristin.Reynolds@umanitoba.ca.

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus (HE2023-0165).

Appendix D: Study 1 Informed Consent Form

Informed Consent Form for Research

Dylan Davidson, B.A.A. (Hons.)
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Email: davids29@myumanitoba.ca

Dr. Kristin Reynolds, Ph.D., C. Psych.
University of Manitoba,
Department of Psychology
P313 Duff Roblin Building, 190 Dysart Rd.
Winnipeg, MB, R3T 2N2
Email: Kristin.Reynolds@umanitoba.ca

Title of Research: Child Mental Health: Experiences and Information Preferences Among Canadian Newcomer Parents

Principal Investigator: Dylan Davidson, M.A., Ph.D. Candidate
Research Advisor/Supervisor: Dr. Kristin Reynolds, Ph.D., Associate Professor
Co-Investigators: Dr. Jennifer Theule, Ph.D., Associate Professor; Dr. Leslie Roos, Ph.D., Assistant Professor; Dr. Steven Feldgaier, Ph.D.
Co-Interviewer: Yuly Johnson, B.A.
Research Assistant: Kailey Penner, B.A.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the Study:
This study will explore experiences and beliefs about child mental health and wellbeing among parents who are newcomers to Canada.

Study Procedures:
As a participant in this study, you will first complete an online background questionnaire that will take 5-10 minutes to complete. Information collected in this survey includes: age, gender identity, level of education, occupation status, marital status, ethnic and cultural identity, country of origin, and immigration status. It will also include a few brief questions regarding whether you believe your children have ever experienced a mental health problem or if they have received mental health services.

After completing the questionnaire, you will then participate in a 60–90-minute individual interview with Dylan Davidson, the Principal Investigator for this research, and Yuly Johnson, the co-interviewer. The interview will take place by Zoom videoconferencing software to maintain social distancing during the COVID-19 pandemic. The interviewers will ask about your

experiences and beliefs about child mental health and wellbeing, as well as what you think would be helpful to you to be able to learn more about child mental health and wellbeing. This will include questions about what you have seen in your community and/or in your own children, and about getting more information and help for child mental health and wellbeing.

Potential Benefits and Risks of the Research:
Your participation in this research will improve researchers' understanding of experiences and beliefs about child mental health and wellbeing among parents who are newcomers to Canada. Your contribution will also inform the development of a free program for parents who are newcomers to Canada to be able to learn more about child mental health and wellbeing.

This study will ask you questions about child mental health and wellbeing, including things you might have noticed in your own children or in your community, as well as what kind of help and information you might look for as a parent. Some people may find that thinking and talking about these topics can be uncomfortable. At the end of this consent form, a list of adult and child psychological resources are included. You can keep this list of resources if you found participating in this research to be distressing, or if you would like to keep this information for your own records.

Participant Payment:
If you choose to participate, you can receive up to $25 on an Amazon gift card or a prepaid Visa gift card. If you consent to participate in this research, you will be eligible to receive a $5 Amazon gift card via email. If you complete the questionnaire and interview you will be eligible to receive an additional $20 in compensation for your time. The full research compensation ($25) can be sent to you in an Amazon gift card via email, or a prepaid Visa gift card via physical mail, depending on your preference.

Voluntary Participation:
It is your choice to participate in this research. Participation in this research is voluntary and will NOT impact your involvement with the services or organization through which you heard about this research.

Freedom to Withdraw:
You may withdraw from this research at any time with no penalty. If you decide to withdraw from participation in this research, all data collected from you will be destroyed. If you wish to withdraw from participating during the interview, please inform the interviewers, and they will ensure that all data is destroyed and that you are compensated for your time. Please note that once data in this research has been analyzed (by approximately January 2023), it will no longer be possible to withdraw from the study and have your data destroyed.

Confidentiality:
It is important to note that the information you share in this research will be kept confidential. However, an important exception to confidentiality involves the safety of a child or other vulnerable person being put at risk. For example, suspected or unreported child abuse must be reported to Child and Family Services authorities according to Manitoba law.

Please also note that the interview will be audio and video-recorded using Zoom. However, the video recording will not be used and will be immediately deleted. The audio recording will be accessed only by the Principal Investigator to transcribe the interview into writing using online software. Audio recordings will be deleted immediately after this process is complete.

Information gathered in this research may be published or presented in public forums such as thesis-related work, journal articles, and/or conference presentations. Please note that information presented in public forums will not identify you directly. For example, you will not include your first or last name in the background questionnaire and interview, and will instead be identified by a number. Quotes from the interview may be used to provide examples of the research findings, but your individual identifying information (e.g., name, age) will not be used or revealed. Your name would instead be replaced by a number or fake name.

All data will be securely stored in password-protected files on a University of Manitoba-based server, accessible only by the Principal Investigator, the Research Advisor/Supervisor, and the Research Assistant. Please note that this server is hosted by Microsoft Data Centers located in Toronto and Quebec City. All research material will be kept until this research has been published (by December 2024), following which it will be destroyed.

Questions or Concerns:

If you have any questions about this study, please do not hesitate to contact the Principal Investigator, Dylan Davidson, at davids29@myumanitoba.ca. You may also contact the research supervisor, Dr. Kristin Reynolds, at Kristin.Reynolds@Umanitoba.ca.

Statement of Consent:

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way. This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus.

If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or HumanEthics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I,_____(spoken name), have read the above information and hereby consent to participate in this study.

☐ By checking this box, I consent to be audio and video recorded during the interview. I recognize that the video recording will be immediately deleted, and the audio recording will be deleted immediately after it has been transcribed into writing.

_____ _____

Participant's Signature Date (Day/Month/Year)

Are you interested in receiving a summary of the findings once the study is completed (approximately January 2023)? If so, please provide written consent below and an email or mailing address to send you the summary.

I,_____(spoken name), am interested in hearing about the findings of this research, and these findings can be sent to me at: _____ (email or mailing address).

_____ _____

Participant's Signature Date (Day/Month/Year)

This research study is one part of a larger research project. The larger project focuses on developing a program that provides information on child mental health for parents who are newcomers to Canada. If you would be interested in being contacted for the next part of this research, please indicate how you would like to be contacted below. **Please note that agreeing to be contacted for the next phase of this research is not a binding agreement; you can decline to participate when you are contacted:**

I,_____(spoken name), am interested in being contacted to potentially participate in the next phase of this research. I can be contacted at: _____ (email or mailing address).

_____ _____

Participant's Signature Date (Day/Month/Year)

IF YOU OR A LOVED ONE ARE HAVING THOUGHTS OF HARMING YOURSELF OR OTHERS, OR ARE IN CRISIS:

- WRHA CRISIS RESPONSE CENTRE at 817 Bannatyne Avenue or WRHA MOBILE CRISIS SERVICE at 204-940-1781 (24 hours/7 days a week)
- KLINIC COMMUNITY HEALTH CENTRE CRISIS LINE (24 hours/7 days a week) at 204-786-8686
- MANITOBA PREVENTION & SUICIDE SUPPORT LINE (24 hours/7 days a week) at 204-784-4097 OR 1-877-435-7170
- MACDONALD YOUTH SERVICES: YOUTH MOBILE CRISIS TEAM: (204) 949-4777

FOR CHILDREN TO CALL:

- KIDS HELP PHONE: 1-800-668-6868

MENTAL HEALTH RESOURCES:

- ANXIETY DISORDERS ASSOCIATION OF MANITOBA: Suite 100 – 4 Fort Street; Phone: 204-925-0600
- MOOD DISORDERS ASSOCIATION OF MANITOBA: Suite 100 – 4 Fort Street; Phone: 204-786-0987
- KLINIC COMMUNITY HEALTH: 870 Portage Avenue; Phone: (204) 784-4090
- CANADIAN MENTAL HEALTH ASSOCIATION: 930 Portage Ave; Phone: 204-982-6100
- AURORA FAMILY THERAPY CENTRE – Trauma-focused therapy for newcomers to Manitoba; Phone: 204-786-9251; Email: aurora@uwinnipeg.ca; Web: http://www.aurorafamilytherapy.com
- MANITOBA FARM RURAL, & NORTHERN SUPPORT SERVICES – Free counselling for anyone living on a farm, or in a rural or Northern community; Phone: 1-866-367-3276; Web: https://supportline.ca/
- MANITOBA PSYCHOLOGICAL SOCIETY – Find a psychologist: http://members.mps.ca/

CHILD MENTAL HEALTH FOCUS:

- WRHA CHILD AND ADOLESCENT CONSULTATION: 204-787-7469
- MANITOBA ADOLESCENT TREATMENT CENTRE: 120 Tecumseh Street; Phone: 204-477-6391
- MANITOBA PARENT ZONE: Phone: 1-877-945-4777

MENTAL HEALTH SUPPORTS FOR COVID-19:

- MANITOBA GOVERNMENT: https://manitoba.ca/covid19/bewell/index.html
- ANXIETY DISORDERS ASSOCIATION OF MANITOBA – Support line for COVID-19: 204 925 0040

Appendix E: Study 2 Informed Consent Form (Immigration & Settlement Professionals)

Informed Consent Form for Research

Dylan Davidson, B.A.A. (Hons.)
University of Manitoba,
Department of Psychology
P404 Duff Roblin Building, 190 Dysart Rd.
Winnipeg, MB, R3T 2N2
Email: davids29@myumanitoba.ca

Dr. Kristin Reynolds, Ph.D., C. Psych.
University of Manitoba,
Department of Psychology
P313 Duff Roblin Building, 190 Dysart Rd.
Winnipeg, MB, R3T 2N2
Email: Kristin.Reynolds@umanitoba.ca

Title of Research: Program Development Needs for a Child Mental Health Information Resource for Canadian Newcomer Parents

Principal Investigator: Dylan Davidson, M.A., Ph.D. Candidate
Research Advisor/Supervisor: Dr. Kristin Reynolds, Ph.D., Associate Professor
Co-Investigators: Dr. Jennifer Theule, Ph.D., Associate Professor; Dr. Leslie Roos, Ph.D., Assistant Professor; Dr. Steven Feldgaier, Ph.D.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the Study:
The purpose of this study is to obtain feedback on an outline of a program for parents who are newcomers to Canada. Your feedback will help to revise the outline and understand important features of a program that provides information about child mental health and help options.

Study Procedures:
As a participant in this study, you will first complete an online background questionnaire that will take 5-10 minutes to complete. Information collected in this survey includes: age, gender identity, level of education, brief information about your occupation, and ethnic and cultural identity.

After completing the questionnaire, you will then participate in a 90-minute focus group led by Dylan Davidson, the Principal Investigator for this research. The focus group will take place by Zoom videoconferencing software to maintain social distancing during the COVID-19 pandemic. The focus group discussion will revolve around what you and other professionals in the settlement sector believe are important features of a program focused on providing information to newcomer parents about child mental health and wellbeing, and your feedback on an outline

for this program. The program outline will be sent to you by email or mail depending on your preference.

Potential Benefits and Risks of the Research:
The immediate benefit of this research involves having your voice heard in improving researchers' understanding about key features of a program that would help newcomer parents to be able to learn more about child mental health and wellbeing.

This study will include discussion about child mental health and wellbeing, as well as challenges that newcomer parents might face. Some people may find that thinking and talking about these topics can be uncomfortable. At the end of this consent form, a list of adult and child psychological resources will be included that you may keep if you found participating in this research to be distressing or would like to keep this information for your own records.

Participant Payment:
If you choose to participate, you can receive up to $30 on an Amazon gift card. If you consent to participate in this research, you will be eligible to receive a $5 Amazon gift card via email. If you complete the questionnaire and focus group, you will be eligible to receive an additional $25 on the Amazon gift card as compensation for your time.

Voluntary Participation:
It is your choice to participate in this research. Participation in this research is voluntary and will NOT impact your involvement with any service or organization through which you heard about this research.

Freedom to Withdraw:
You may withdraw from this research at any time with no penalty. If you wish to withdraw from participating during the online questionnaire or before completing the focus group, please inform the Principal Investigator, Dylan Davidson, and he will ensure that all data is destroyed and that you are compensated for your time. Please note that once data in this research has been analyzed (by approximately the end of August 2023), it will no longer be possible to withdraw from the study and have your questionnaire data destroyed. If you wish to withdraw during the focus group, please disconnect from the meeting and contact the Principal Investigator to let him know that you wish to withdraw. However, please note that if you have already completed your participation or begun participating in the focus group, the audio information and feedback you have provided during the focus group cannot be destroyed, as it will be combined with other participants in your focus group.

Confidentiality:
It is important to note that the information you share in this research will be kept confidential. However, an important exception to confidentiality involves the safety of a child or other vulnerable person being put at risk. For example, suspected or unreported child abuse must be reported to Child and Family Services authorities according to Manitoba law.

Please also note that the focus group interview will be audio and video-recorded using Zoom. However, the video recording will not be used and will be immediately deleted. The audio

recording will be accessed only by the Principal Investigator to transcribe the interview into writing using online software. Audio recordings will be deleted immediately after this process is complete.

Information gathered in this research may be published or presented in public forums such as thesis-related work, journal articles, and/or conference presentations. Please note that information presented in public forums will not identify you directly. For example, you will not include your first or last name in the background questionnaire and focus group, and will instead be identified by a number. Quotes from the focus group may be used to provide examples of the research findings, but your individual identifying information (e.g., name, age) will not be used or revealed. Your name would instead be replaced by a number or fake name.

All data will be securely stored in password-protected files on a University of Manitoba-based server, accessible only by the Principal Investigator and the Research Advisor/Supervisor. Please note that this server is hosted by Microsoft Data Centers located in Toronto and Quebec City. All research material will be kept until this research has been published (by December 2025), following which it will be destroyed.

Please note that, due to the inclusion of other group members, confidentiality cannot be guaranteed for spoken information provided during focus groups. Please be mindful of this before sharing any private or sensitive personal information to the group. Please also be respectful of others group members' right to privacy and confidentiality and do not share information that they may provide within the context of the group meeting. You and all other focus group participants will be required to sign an oath of confidentiality prior to your focus group participation.

Questions or Concerns:

If you have any questions about this study, please do not hesitate to contact the Principal Investigator, Dylan Davidson, at davids29@myumanitoba.ca. You may also contact the research supervisor, Dr. Kristin Reynolds, at Kristin.Reynolds@umanitoba.ca.

Statement of Consent:

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way. This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus.

If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or HumanEthics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I,_____(spoken name), have read the above information and hereby consent to participate in this study.

☐ By checking this box, I consent to be audio and video recorded during the focus group. I recognize that the video recording will be immediately deleted, and the audio recording will be deleted immediately after it has been transcribed into writing.

_____ _____

Participant's Signature Date (Day/Month/Year)

Oath of Confidentiality:
ALL participants, including yourself, must sign this oath as confirmation that you will respect others' rights to privacy and confidentiality.

I,_____(print name), have read the above information and pledge to respect my fellow focus group members' rights to privacy and confidentiality by not disclosing their name, or the personal information that they share, outside the context of this focus group

_____ _____

Participant's Signature Date (Day/Month/Year)

Are you interested in receiving a summary of the findings once the study is completed (approximately September 2023)? If so, please provide written consent below and an email or mailing address to send you the summary.

I,_____(spoken name), am interested in hearing about the findings of this research, and these findings can be sent to me at: _____

_____ _____

Participant's Signature Date (Day/Month/Year)

IF YOU OR A LOVED ONE ARE HAVING THOUGHTS OF HARMING YOURSELF OR OTHERS, OR ARE IN CRISIS:

- WRHA CRISIS RESPONSE CENTRE at 817 Bannatyne Avenue or WRHA MOBILE CRISIS SERVICE at 204-940-1781 (24 hours/7 days a week)
- KLINIC COMMUNITY HEALTH CENTRE CRISIS LINE (24 hours/7 days a week) at 204-786-8686
- MANITOBA PREVENTION & SUICIDE SUPPORT LINE (24 hours/7 days a week) at 204-784-4097 OR 1-877-435-7170
- MACDONALD YOUTH SERVICES: YOUTH MOBILE CRISIS TEAM: (204) 949-4777

FOR CHILDREN TO CALL:

- KIDS HELP PHONE: 1-800-668-6868

MENTAL HEALTH RESOURCES:

- ANXIETY DISORDERS ASSOCIATION OF MANITOBA: Suite 100 – 4 Fort Street; Phone: 204-925-0600
- MOOD DISORDERS ASSOCIATION OF MANITOBA: Suite 100 – 4 Fort Street; Phone: 204-786-0987
- KLINIC COMMUNITY HEALTH: 870 Portage Avenue; Phone: (204) 784-4090
- CANADIAN MENTAL HEALTH ASSOCIATION: 930 Portage Ave; Phone: 204-982-6100
- AURORA FAMILY THERAPY CENTRE – Trauma-focused therapy for newcomers to Manitoba; Phone: 204-786-9251; Email: aurora@uwinnipeg.ca; Web: http://www.aurorafamilytherapy.com
- MANITOBA FARM RURAL, & NORTHERN SUPPORT SERVICES – Free counselling for anyone living on a farm, or in a rural or Northern community; Phone: 1-866-367-3276; Web: https://supportline.ca/
- MANITOBA PSYCHOLOGICAL SOCIETY – Find a psychologist: http://members.mps.ca/

CHILD MENTAL HEALTH FOCUS:

- WRHA CHILD AND ADOLESCENT CONSULTATION: 204-787-7469
- MANITOBA ADOLESCENT TREATMENT CENTRE: 120 Tecumseh Street; Phone: 204-477-6391
- MANITOBA PARENT ZONE: Phone: 1-877-945-4777

MENTAL HEALTH SUPPORTS FOR COVID-19:

- MANITOBA GOVERNMENT: https://manitoba.ca/covid19/bewell/index.html
- ANXIETY DISORDERS ASSOCIATION OF MANITOBA – Support line for COVID-19: 204 925 0040

Appendix F: Study 2 Informed Consent Form (Parents)

Informed Consent Form for Research

Dylan Davidson, B.A.A. (Hons.)
University of Manitoba,
Department of Psychology
P404 Duff Roblin Building, 190 Dysart Rd.
Winnipeg, MB, R3T 2N2
Email: davids29@myumanitoba.ca

Dr. Kristin Reynolds, Ph.D., C. Psych.
University of Manitoba,
Department of Psychology
P313 Duff Roblin Building, 190 Dysart Rd.
Winnipeg, MB, R3T 2N2
Email: Kristin.Reynolds@umanitoba.ca

Title of Research: Program Development Needs for a Child Mental Health Information Resource for Canadian Newcomer Parents

Principal Investigator: Dylan Davidson, M.A., Ph.D. Candidate
Research Advisor/Supervisor: Dr. Kristin Reynolds, Ph.D., Associate Professor
Co-Investigators: Dr. Jennifer Theule, Ph.D., Associate Professor; Dr. Leslie Roos, Ph.D., Assistant Professor; Dr. Steven Feldgaier, Ph.D.

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the Study:
The purpose of this study is to obtain feedback on an outline of a program for parents who are newcomers to Canada. Your feedback will help to revise the outline and understand important features of a program that provides information about child mental health and help options.

Study Procedures:
As a participant in this study, you will first complete an online background questionnaire that will take 5-10 minutes to complete. Information collected in this survey includes: age, gender identity, level of education, occupation status, marital status, ethnic and cultural identity, country of origin, immigration status, and immigration category. It will also include a few brief questions regarding whether you believe your children have ever experienced a mental health problem or if they have received mental health services.

After completing the questionnaire, you will then participate in a 90-minute focus group led by Dylan Davidson, the Principal Investigator for this research. The focus group will take place by Zoom videoconferencing software to maintain social distancing during the COVID-19 pandemic. The focus group discussion will revolve around what you and other parents believe are important features of a program focused on providing information to parents about child mental health and

wellbeing, and your feedback on an outline for this program. This will include discussion about what you have seen in your community and/or in your own children, and about getting more information and help for child mental health and wellbeing. The program outline will be sent to you by email or mail depending on your preference.

Potential Benefits and Risks of the Research:
The immediate benefit of this research involves having your voice heard in improving researchers' understanding about key features of a program that would help newcomer parents to be able to learn more about child mental health and wellbeing.

This study will include discussion about child mental health and wellbeing, and challenges you might have faced as a parent. Some people may find that thinking and talking about these topics can be uncomfortable. At the end of this consent form, a list of adult and child psychological resources will be included that you may keep if you found participating in this research to be distressing or would like to keep this information for your own records.

Participant Payment:
If you choose to participate, you can receive up to $30 on an Amazon gift card. If you consent to participate in this research, you will be eligible to receive a $5 Amazon gift card via email. If you complete the questionnaire and focus group, you will be eligible to receive an additional $25 on the Amazon gift card as compensation for your time.

Voluntary Participation:
It is your choice to participate in this research. Participation in this research is voluntary and will NOT impact your involvement with any service or organization through which you heard about this research.

Freedom to Withdraw:
You may withdraw from this research at any time with no penalty. If you wish to withdraw from participating during the online questionnaire or before completing the focus group, please inform the Principal Investigator, Dylan Davidson, and he will ensure that all data is destroyed and that you are compensated for your time. Please note that once data in this research has been analyzed (by approximately the end of August 2023), it will no longer be possible to withdraw from the study and have your questionnaire data destroyed. If you wish to withdraw during the focus group, please disconnect from the meeting and contact the Principal Investigator to let him know that you wish to withdraw. However, please note that if you have already completed your participation or begun participating in the focus group, the audio information and feedback you have provided during the focus group cannot be destroyed, as it will be combined with other participants in your focus group.

Confidentiality:
It is important to note that the information you share in this research will be kept confidential. However, an important exception to confidentiality involves the safety of a child or other vulnerable person being put at risk. For example, suspected or unreported child abuse must be reported to Child and Family Services authorities according to Manitoba law.

Please also note that the focus group interview will be audio and video-recorded using Zoom. However, the video recording will not be used and will be immediately deleted. The audio recording will be accessed only by the Principal Investigator to transcribe the interview into writing using online software. Audio recordings will be deleted immediately after this process is complete.

Information gathered in this research may be published or presented in public forums such as thesis-related work, journal articles, and/or conference presentations. Please note that information presented in public forums will not identify you directly. For example, you will not include your first or last name in the background questionnaire and focus group, and will instead be identified by a number. Quotes from the focus group may be used to provide examples of the research findings, but your individual identifying information (e.g., name, age) will not be used or revealed. Your name would instead be replaced by a number or fake name.

All data will be securely stored in password-protected files on a University of Manitoba-based server, accessible only by the Principal Investigator and the Research Advisor/Supervisor. Please note that this server is hosted by Microsoft Data Centers located in Toronto and Quebec City. All research material will be kept until this research has been published (by December 2025), following which it will be destroyed.

Please note that, due to the inclusion of other group members, confidentiality cannot be guaranteed for spoken information provided during focus groups. Please be mindful of this before sharing any private or sensitive personal information to the group. Please also be respectful of others group members' right to privacy and confidentiality and do not share information that they may provide within the context of the group meeting. You and all other focus group participants will be required to sign an oath of confidentiality prior to your focus group participation.

Questions or Concerns:

If you have any questions about this study, please do not hesitate to contact the Principal Investigator, Dylan Davidson, at davids29@myumanitoba.ca. You may also contact the research supervisor, Dr. Kristin Reynolds, at Kristin.Reynolds@umanitoba.ca.

Statement of Consent:

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way. This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus.

If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or HumanEthics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I,_____(spoken name), have read the above information and hereby consent to participate in this study.

☐ By checking this box, I consent to be audio and video recorded during the focus group. I recognize that the video recording will be immediately deleted, and the audio recording will be deleted immediately after it has been transcribed into writing.

_____ _____

Participant's Signature Date (Day/Month/Year)

Oath of Confidentiality:
ALL participants, including yourself, must sign this oath as confirmation that you will respect others' rights to privacy and confidentiality.

I,_____(print name), have read the above information and pledge to respect my fellow focus group members' rights to privacy and confidentiality by not disclosing their name, or the personal information that they share, outside the context of this focus group

_____ _____

Participant's Signature Date (Day/Month/Year)

Are you interested in receiving a summary of the findings once the study is completed (approximately September 2023)? If so, please provide written consent below and an email or mailing address to send you the summary.

I,_____(spoken name), am interested in hearing about the findings of this research, and these findings can be sent to me at: _____

_____ _____

Participant's Signature Date (Day/Month/Year)

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- CANADIAN MENTAL HEALTH ASSOCIATION: 930 Portage Ave; Phone: 204-982-6100
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- MANITOBA FARM RURAL, & NORTHERN SUPPORT SERVICES – Free counselling for anyone living on a farm, or in a rural or Northern community; Phone: 1-866-367-3276; Web: https://supportline.ca/
- MANITOBA PSYCHOLOGICAL SOCIETY – Find a psychologist: http://members.mps.ca/

CHILD MENTAL HEALTH FOCUS:

- WRHA CHILD AND ADOLESCENT CONSULTATION: 204-787-7469
- MANITOBA ADOLESCENT TREATMENT CENTRE: 120 Tecumseh Street; Phone: 204-477-6391
- MANITOBA PARENT ZONE: Phone: 1-877-945-4777

MENTAL HEALTH SUPPORTS FOR COVID-19:

- MANITOBA GOVERNMENT: https://manitoba.ca/covid19/bewell/index.html
- ANXIETY DISORDERS ASSOCIATION OF MANITOBA – Support line for COVID-19: 204 925 0040

Appendix G: Demographic & Background Questionnaire for Parents (Studies 1 & 2)

Date: _____

Age: _____

Gender Identity: _____

Highest Level of Education (pick one)**:**

☐ Less than High School ☐ High School ☐ Certificate/Diploma

☐ 2-year University ☐ Bachelor's ☐ Master's/Doctorate

Occupation Status (pick one)**:**

☐ Full-time ☐ Part-time ☐ Stay-at-home parent

☐ Retired ☐ Unemployed ☐ On disability

If currently employed, please list occupation: _____

Marital Status:

☐ Single ☐ Common law ☐ Married

☐ Widowed ☐ Separated ☐ Divorced

Race/Ethnicity:

☐ Arabic (e.g., Egyptian, Jordanian, Palestinian, Saudi Arabian) ☐ Black

☐ Chinese ☐ Filipino ☐ Indigenous (e.g., First Nations, Métis, Inuk (Inuit))

☐ Japanese ☐ Korean ☐ Latin American (e.g., Costa Rican, Columbia, Chilean)

☐ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)

☐ Southeast Asian (e.g., Vietnamese, Cambodian, Laotian, Thai, etc.) ☐ White

☐ West Asian (e.g., Afghan, Azerbaijani, Iranian, Uzbek, etc.)

☐ Other: _____

Immigration Status:

☐ Immigrant (Permanent Resident / Landed Immigrant)

☐ Non-Permanent Resident

☐ Refugee / Asylum Claimant

☐ Other: _____

Immigration Category:

☐ International Student

☐ Nominee

☐ Sponsorship

☐ Refugee / Asylum Claimant

☐ Other: _____

How many years have you lived in Canada? _____

Where did you live before moving to Canada? _____

Questions About Your Children:

Are you a parent or guardian to any children ages 2-12 (check all that apply)?

☐ Parent ☐ Guardian

How many children do you have in total? _____

Do you believe any of these children have ever experienced a mental health problem?

☐ Yes ☐ No

If 'Yes', please briefly describe the problem(s) and age of the child:

_____

_____

Have any of your children accessed mental health services?

☐ Yes ☐ No

If ‘Yes’, please briefly describe the problem(s) and age of the child:

_____

_____

Appendix H: Demographic & Background Questionnaire

for Immigration & Settlement Professionals (Study 2)

Date: _____

Age: _____

Gender Identity: _____

Highest Level of Education (pick one)**:**

☐ Less than High School ☐ High School ☐ Certificate/Diploma

☐ 2-year University ☐ Bachelor's ☐ Master's/Doctorate

Occupation Title and Role: _____

_____

_____

Number of years in position: _____

Race/Ethnicity:

☐ Arabic (e.g., Egyptian, Jordanian, Palestinian, Saudi Arabian) ☐ Black

☐ Chinese ☐ Filipino ☐ Indigenous (e.g., First Nations, Métis, Inuk (Inuit))

☐ Japanese ☐ Korean ☐ Latin American (e.g., Costa Rican, Columbia, Chilean)

☐ South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)

☐ Southeast Asian (e.g., Vietnamese, Cambodian, Laotian, Thai, etc.) ☐ White

☐ West Asian (e.g., Afghan, Azerbaijani, Iranian, Uzbek, etc.)

☐ Other: _____

Appendix I: Study 1 Interview Protocol

I will be asking you to speak about some of your experiences with your children ages 2-12 today. What are the ages of the children you will be speaking about in the interview?

1) In your child(ren), what are the some of the most important things you look for to see how they are doing in terms of their wellbeing?
    a. What kinds of challenges are there in your community that can impact the wellbeing of your child(ren)?
    b. How has moving to Canada impacted the wellbeing of your child(ren)?

2) If you were to notice that the wellbeing of your child(ren) is lower, what would you do?
    a. What kinds of help would you look for outside of your home?
    b. Would you ever consider accessing professional mental health care for your child(ren) (e.g., psychologist or counsellor)? Why/why not?

3) What sort of information would you look for to help you better understand challenges with your child's wellbeing?
    a. Where have you looked/would you look if you needed more information about your child's wellbeing?
    b. Do you think there would be challenges with finding or accessing the information that you need? What kinds of challenges?

4) In my work, we use the terms mental health and mental health problems to describe what we've been talking about… How does that fit with your interpretation of child wellbeing?
    a. Have you noticed differences in how child wellbeing and mental health are thought about and discussed in Canada?
    b. Have you noticed differences in how taking care of or getting help for child wellbeing and mental health are thought about and discussed in Canada?

Appendix J: Study 1 Interview Protocol (Revised)

I will be asking you to speak about some of your experiences with your children ages 2-12 today. What are the ages of the children you will be speaking about in the interview?

1) What does wellbeing, or mental health, mean to you?
2) In your child(ren), what are the some of the most important things you look for to see how they are doing in terms of their wellbeing?
    a. What kinds of challenges are there in your community that can impact the wellbeing of your child(ren)?
    b. How has moving to Canada impacted the wellbeing of your child(ren)?
3) If you were to notice that the wellbeing of your child(ren) is lower, what would you do?
    a. What kinds of help would you look for outside of your home?
    b. What sort of information would you look for to help you better understand?
    c. Would you ever consider accessing professional mental health care for your child(ren) (e.g., psychologist or counsellor)? Why/why not?
        i. How would you feel about your child(ren) talking to a professional about their feelings/how they are doing?
        ii. What would make/at what point would you feel a need to access this help?
    d. Do you think there would be challenges with finding or accessing the information or services that you would need? What kinds of challenges?
4) In my work, we often use the term mental health to describe what we've been discussing. Was mental health discussed often in your home country/culture?
    a. Have you noticed differences in how child wellbeing and mental health are thought about and discussed in Canada?
    b. Have you noticed differences in how taking care of or getting help for child wellbeing and mental health are thought about and discussed in Canada?
    c. Have you noticed stigma/taboo around discussing mental health in your home country/culture?
5) Were there any other questions that you were expecting, but we didn't discuss?

Appendix K: Study 2 Focus Group #1 (Immigration & Settlement Professionals) Protocol

Today, I will be asking you for feedback on a preliminary model for a short program that would provide key information about child mental health and help options for parents who are newcomers to Canada. The model is organized by the program's potential outcomes, outputs or measures of progress, activities, and inputs or resources required. I'd like to gather your feedback on changes or additions to be made to each section of the program model, based on your experiences in your profession.

1) What are your thoughts on the potential outcomes or results for participants in this program?
    a. How do you think this program could have a meaningful impact on newcomer parents?
    b. How feasible/relevant do you think this program is to the needs of newcomer parents?
    c. What changes could be made to increase the program's feasibility and relevance?
    d. Are there other important outcomes that are not achievable here or that this program should focus on? Which?
2) What are your thoughts on the current outputs (i.e., direct products of the program)?
    a. What additional outputs would be helpful to consider? How could these be measured?
3) What are your thoughts on the value of the listed activities and discussion points?
    a. How do you think that these activities and discussions could benefit parents who are newcomers to Canada?
    b. How realistic/feasible are the current activities? Will they allow sufficient time?
    c. What other activities could or should be included?
4) What are your thoughts on the current inputs and resources required?
    a. How realistic are the existing inputs?
    b. What additional inputs are required or not covered here?

Appendix L: Study 2 Focus Group #2 (Parents) Protocol

Today, I will be asking you for feedback on a draft outline for a short program that would provide key information about child mental health and help options for parents who are newcomers to Canada. The model is organized by the program's potential outcomes, outputs or measures of progress, activities, and inputs or resources required. I'd like to gather your feedback on changes or additions to be made to each section of the program model, based on your experiences as a parent and as someone who comes from a culture outside of Canada.

1) What are your thoughts on the potential outcomes or results for participants in this program?
    a. How do you think this program could have a meaningful impact on parents in your community?
    b. Do you think you would participate in this program if it were offered? Why?
    c. How relevant do you think this program is to the needs of parents who are newcomers?
    d. Are there other potential outcomes that we have not considered or that this program should focus on? What might they be?
2) What are your thoughts on the current outputs (i.e., direct products of the program)?
    a. What additional outputs or opportunities for feedback would be helpful?
3) What are your thoughts on the value of the listed activities and discussion points?
    a. How do you think that these activities and discussions could benefit you and other parents?
    b. How realistic are the current activities? Will they allow sufficient time?
    c. What other activities could or should be included?
4) What are your thoughts on the current inputs and resources required?
    a. How realistic are the existing inputs?
    b. What additional inputs are required or not covered here?

Appendix M: Program Logic Model (Original)

Inputs	Activities	Outputs	Outcomes
Personnel • Agency/non-profit interested in hosting/administering program • Community interest from potential participants (parents who are newcomers) • Program facilitator(s) (e.g., counsellor, psychologist, social worker, community mental health worker) **Financial** • Wages for administration (e.g., booking participants, advertising) and facilitators • Office supplies (computers, printing, etc.) • Transportation costs for facilitators/participants • Printing of materials and potentially flyers **Resources** • Information sheets or PowerPoint printouts • Facilitator guide/agenda printout • Rating/feedback forms • Private group meeting/conference room	**What is "Mental Health"?** • Can be a very Westernized concept, definitions can vary • Discuss: What does "mental health" mean/look like in your community? **Mental Health in Children** • Discuss: Why to consider mental health in children? • Signs of positive mental health • Symptoms of anxiety, ADHD, depression, etc. • Discuss: Potential impact of newcomer context – integration, isolation, trauma, discrimination **What Can Parents Do?** • Model healthy thinking/behaviour (e.g., identifying emotions) • Look for signs/symptoms of problems • Provide emotional support • Advocate and look for help • Discuss: Other helpful strategies?	**Program Feedback** • Verbal feedback and closing thoughts period at end of session • Rating scale about helpfulness of session • Open-ended feedback on rating form **Program Engagement** • Sign-ups to program (i.e., number, consistency) • Attendance by participants who signed up • General sense of engagement by facilitators **Post-program** • Program materials/information provided for review • Provide follow-up materials for potential further reading/info • Keep mental health resource list to help family/friends access help	**Mental Health Literacy** • Increased knowledge about key signs/symptoms around child mental health • More positive perceptions of potential benefits of mental health services/help-seeking **Improved Self-efficacy** • Increased confidence about how best to support child • Feeling prepared about where to seek help if needed **Knowledge Transfer** • Spreading of program information/knowledge • Potential word-of-mouth about program to community/social networks

Time • Advertising/promotion of program (e.g., social media, newsletter, posting flyer) • Training and/or preparation of facilitators • Securing meeting space depending on agency/organization offering program • Attending program session(s) (both facilitators and participants) • Optional reviewing of materials by participants after the program	**Help Options** • Differences between social worker, counsellor, psychologist, psychiatrist • Potential benefits of psychotherapy • Discuss key resources in Manitoba • Review and provide resource list to participants **End Discussion & Questions** • Ask facilitator questions and/or share thoughts • Provide feedback about program		

Appendix N: MHL Program Recommendations and Revised Program Logic Model

Guiding Values for Community-Program Integration

Community-Based Structure: Program has clear, close ties with the target community.

- Facilitators have lived, representative experience (e.g., member of community, shared cultural background, experience as a newcomer).
- Consider training peer providers (e.g., community leaders, traditional healers) and allied professionals (e.g., social work, nursing).
- Easily found and accessed by community members (e.g., advertised through local social media communities, community associations).
- Hosted at or embedded in a familiar community site (e.g., community centre, health centre where other services are accessed).

Native Language Standard: Program is offered in the primary language/dialect of the target community to maximize comfort and engagement.

- All program levels, such as advertising and promotion, materials, facilitation, feedback processes, program development and research, etc.

Family & Community Atmosphere: Program atmosphere should evoke a feeling of participating in a community activity.

- Program messaging (e.g., naming of the program, advertisements) is not communicated with a clinical or mental health-focused approach.
- Educational, but fun and family friendly (e.g., incorporating a potluck, inclusion of children directly or at a nearby supervised space).
- Varied and interactive activities (e.g., discussion and participation, self-directed and cooperative activities, parent-child activities).
- Less emphasis on clinical terms (e.g., depression, anxiety); incorporate culturally relevant terms/phrases/idioms, highlight potential links to clinical terms.

Family Empowerment: An underlying program process (i.e., for facilitators to consider) of empowering families with both information and confidence.

- Normalization and stigma reduction efforts (e.g., open discussions, case examples) in addition to psychoeducation content.
- Participatory approach to any program development, adaptation of existing programs, and/or research by including members from the target community.

Unique Motivators & Incentives: Consider potential motivators and anticipated needs for attendance and engagement from the target community.

- Examples: Assistance with childcare, food, transportation; different times available (e.g., evening/weekend); part of local health/community centre.
- Culture/community-specific features (e.g., peer facilitator, cultural terms) that demonstrate tailoring to the community, recent newcomers, etc.

Inputs	Activities	Outputs	Outcomes
Personnel • Agency/non-profit interested in hosting/administering program • Community member participation (enough sign-ups to run program) • Facilitator(s) (e.g., mental health or settlement professionals, peer providers) • Other potential staff (e.g., admin support, researchers or program evaluators, childcare) **Financial** • Wages for non-volunteers: administration (e.g., booking participants, advertising), facilitators, other staff (e.g., supervisors for children) • Office supplies (computers, printing, writing materials, etc.) • Transportation: Costs for facilitators, vouchers for participants • Food/drink considerations **Time** • Advertising of program (e.g., social media, newsletter, flyer) • Facilitator training/preparation • Booking/managing sign-ups • Preparing materials (e.g., printouts, feedback forms) • Securing spaces (1-2 rooms for program, potential childcare) • Attending program session(s) (facilitators and participants) • Optional reviewing of materials by participants after the program • Program development and/or research time	**What is "Mental Health"?** • It can be a very Westernized concept, definitions can vary • What does "mental health" mean/look like in your community? • Emotional challenges for newcomers (e.g., language barriers, family separation, culture shock, permanent residency) **Mental Health in Children** • Signs of positive mental health • Signs/symptoms of common problems (e.g., anxiety, ADHD) • Unique challenges for newcomer children (integration, isolation, discrimination, language) • Common stressors for newcomers vs. distinct mental health challenges • Developmentally normal behaviours vs. distinct mental health challenges **What Can Parents Do?** • Model emotional awareness (e.g., identifying emotions) • Model emotionally supportive and secure relationships • Look for signs/symptoms of problems, gather information • Advocate and look for help **Help Options** • Differences between professionals (e.g., psychologist, psychiatrist) • Potential benefits of psychotherapy • Community perspectives on help/treatment • Local resources (including options e.g. newcomer-oriented, first language) • Review and provide resource list **End Discussion & Questions** • Ask facilitator questions and/or share thoughts • Provide feedback about program	**Program Feedback** • Multiple format options (e.g., paper, electronic) • Verbal feedback at end of sessions • Ratings + qualitative feedback for individual sessions • Feedback at pre-, post-, follow-up (e.g., 3/6/12 months) • Testimonials for other community members **Signs of Engagement** • Sign-ups to program (i.e., number, consistency) and attendance • Review/discussions by facilitators **Post-Program Products** • Program materials provided for review • Provide follow-up materials for potential further reading/info • Keep mental health resource list to help family/friends access help	**Mental Health Literacy** • Signs of common child mental health problems • Indicators of positive mental health in children • Stressors in newcomer context for children • Developmentally normal behaviours • Different help strategies and resource options **Empowerment & Stigma Reduction** • Increased confidence about how best to support child • Confidence about when to seek help and options (e.g., culture-specific, as well as more general options). • Increased comfort with discussing mental health • Normalization of challenges with mental health **Knowledge Transfer** • Spreading of program information/knowledge • Word-of-mouth about program to community/social networks

University of Manitoba

Canadian Newcomer Parents: Perspectives on Mental Health Information and Program Needs

Research Report

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Ethical Approval

This research was approved by the Research Ethics Board at the University of Manitoba, Fort Garry Campus (HE2022-0081, HE2023-0165).

SUMMARY

Intro

- Mental health literacy (MHL) skills involve knowledge about mental health and how to help others with difficulties. These can be useful for parents because they provide care for their children.
- For newcomers, cultural differences and major life changes during settlement can lead to unique risks or causes for mental health difficulties in children.
- Most mental health/MHL strategies are not adapted to the needs of newcomer communities..

Goals

- 2 studies to get feedback from newcomer parents and settlement professionals.
- Find new ways of understanding MHL in diverse cultural contexts and with newcomer families.
- Find new strategies for mental health education and community support for newcomer families.

Research Methods

- Interviewed parents of children (ages 2-12) who were newcomers to Manitoba to understand:
  - Beliefs about mental health and links to their social/cultural experiences
  - Challenges with finding information/support about child mental health
- Focus groups with a) Immigration/settlement professionals, b) Newcomer parents. Discussed:
  - How a MHL program about child mental health could fit their social/cultural contexts
  - Their feedback on an outline of this type of program

Findings

- Interviews highlighted parents' lived experiences in settlement, beliefs/understanding of mental health, and perceptions of seeking information/help. This demonstrated the complexity of MHL in this context.
- Focus groups highlighted important community program values. Feedback helped to rework the program outline into recommendations for future MHL programs based on these values.

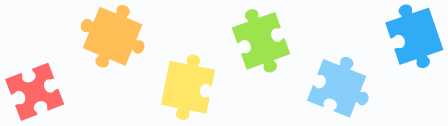
Conclusion

- This research showed that MHL needs to be defined and discussed differently for newcomers. It also provides directions for community MHL programs for newcomer families to help fill this gap.

INTRO

Child Mental Health

- Childhood is an important stage of life where we develop social, emotional, and life skills.[1]
- Common mental health challenges like anxiety, depression, and trauma can disrupt these skills.[2]
- Early support for these difficulties can promote healthier development.[3,4]



Newcomer Context

- Newcomers to Canada make up a large part of the population. Stressors during immigration and settlement can lead to unique risks or causes for mental health difficulties in children. Examples:
  - Major life changes: Separation or loss of family, experiences of war, changes in income or social status, less social support, language barriers, and discrimination.[5–8]
  - Inequities in social and health services.[9] Examples: Cost of services, limited available information, services only available in English, access to childcare, location of services, and transportation.[6]
  - Mental health stigma can prevent parents from looking for information or help.[6,10,11]
  - There are very few mental health resources that are designed for newcomer families.[12]
- These things require us to change how we understand mental health for newcomer families.

Mental Health Literacy (MHL)

- Mental health literacy (MHL) involves knowledge about mental health and how to help others with difficulties.[13] These can be useful skills for parents because they provide care for their children.
- Many educational strategies have focused on MHL to promote awareness and prevent difficulties.[14]
- Newcomer families have diverse cultural backgrounds and unique stressors. The qualities and needs for MHL skills in newcomer parents then must also be unique and different.
- Most mental health and MHL strategies are not adapted to the needs of newcomer communities.[15] Adapting them to these contexts is needed to make them more relevant and accessible.[6,16]
- This is also important because of Canada's stated values around multiculturalism.[17]

RESEARCH FOCUS

- **2 studies** to get feedback from newcomer parents and settlement professionals:
    - Find new ways of understanding MHL in diverse cultural contexts and with newcomer families.
    - Find new strategies for mental health education and community support for newcomer families.

STUDY 1 INTRO

Goals

- Explore newcomer parents' beliefs about mental health and social and cultural experiences, to understand how relevant the MHL approach is for them.
- Understand challenges that newcomer parents might face with finding information or support about child mental health.

Research Method

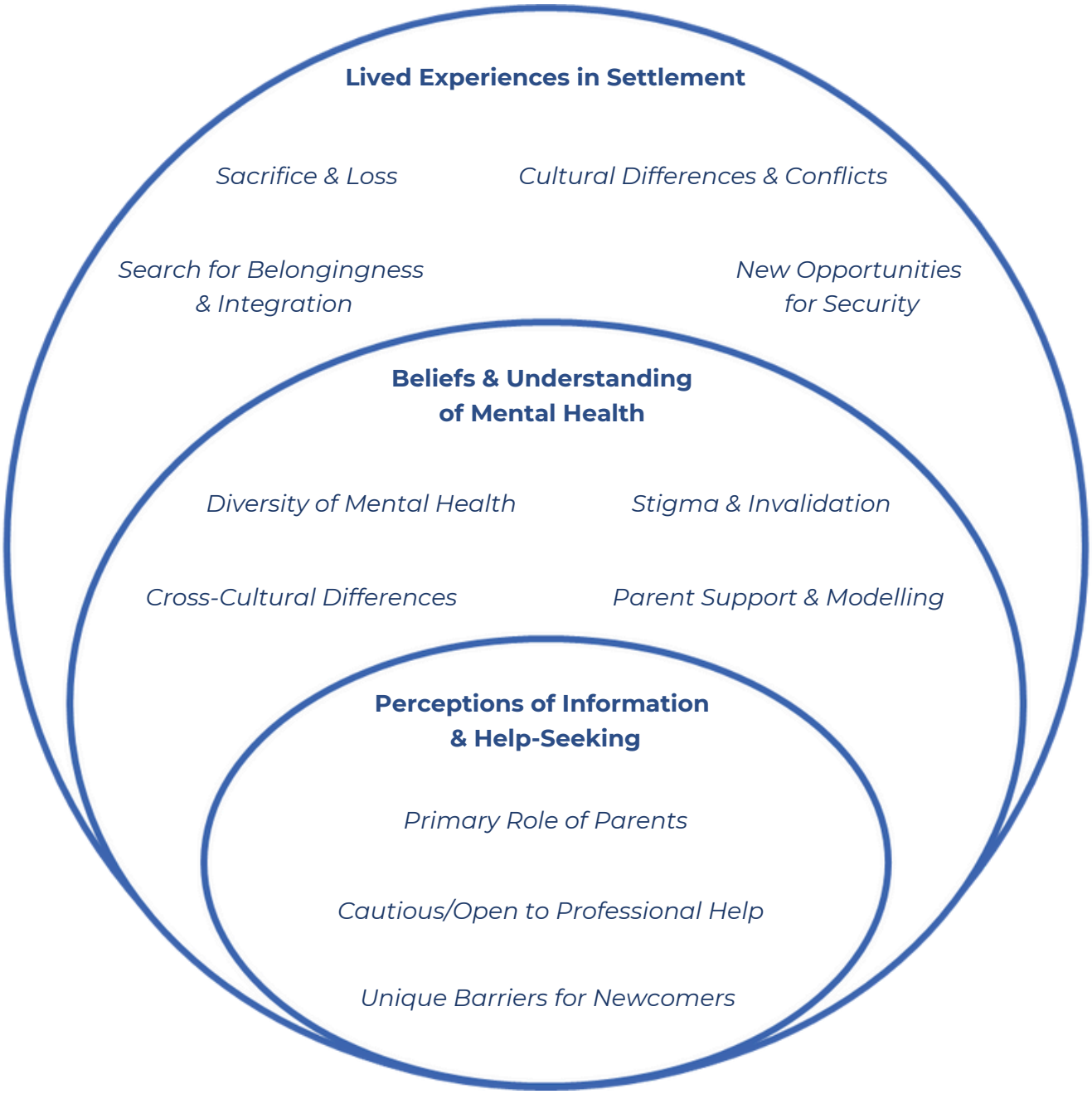
- Interviewed 10 parents of children (ages 2-12) who were newcomers to Manitoba, Canada.
- Research was advertised through community agencies, electronic newsletter, and word of mouth.
- Interview discussions focused on:
  - Definitions of mental health
  - Signs of child mental health/difficulties
  - What to do about signs of difficulties
  - Available info on child mental health/treatment
  - Differences they have noticed in these areas in Canada

Key Participant Info

- Average age: 36
- All were female/mothers
- Average time lived in Canada: 5.4 years
- 9/10 completed some form of post-secondary education
- 7/10 were permanent residents
- 3 international students, 3 provincial nominees, 2 refugees, 2 sponsorship
- Half identified as Latin American; the rest African, Arabic, Black, Chinese
- Originally from Bolivia, China, Columbia, Dominican Republic, Ecuador, Egypt, Nigeria, Uganda

STUDY 1 FINDINGS

- This model shows the most common *themes* and **categories of themes**.



- The next page includes more details about *themes*.

STUDY 1 FINDINGS

Lives Experiences in Settlement

- ***Sacrifice & Loss:*** Major life changes and losses due to immigration: 1) Grief about leaving home and separation from family and friends. 2) Sacrifices and related stress, such as changes in career and social status, approval for permanent residency, and worries about child and family services.
- ***Cultural Differences & Conflicts:*** Discomfort with different values in Canadian society and how it affects children. Some parents felt like they had to preserve or defend their cultural values in Canada.
- ***Search for Belongingness & Integration:*** Challenges for families with feeling belongingness and integration in Canada. This included how language barriers were emotionally difficult for children. It also included how experiences of discrimination and bullying impacted child self-esteem.
- ***New Opportunities for Security:*** The main benefits of moving to Canada for some participants: 1) More security in the parent-child relationship, such as better communication and emotional awareness. 2) Some participants felt more freedom and safety compared to their original countries.

Beliefs & Understanding of Mental Health

- ***Diversity of Mental Health:*** Mental health was described in diverse ways. This included many different definitions and key signs of mental health. It also included comments about "mental health" not having a single term or clear identity in their original country or culture.
- ***Stigma & Invalidation:*** Participants described major mental health stigma they had noticed in their original country or culture. Examples: Mental health challenges are not real or make someone crazy.
- ***Cross-Cultural Differences:*** Mental health seemed to be more discussed and have more resources in Canada compared to their original country. This motivated some to want to learn more.
- ***Parent Support & Modelling:*** Child mental health is affected by the parent's ability to: 1) Demonstrate healthy thinking/behaviour; 2) Develop secure and supportive relationships with them.

Perceptions of Information & Help-Seeking

- ***Primary Role of Parents:*** It is important to first work on child mental health difficulties as a family. This includes looking for unusual behaviours or emotions in children and finding information. It also includes defending and advocating for children from threats to their wellbeing like bullying.
- ***Cautious/Open to Professional Help:*** Participants were all open to professional mental health services for their children in the future if necessary. Some were enthusiastic about getting this help if needed. Others felt it would be a last resort, such as due to privacy concerns.
- ***Unique Barriers for Newcomers:*** There is limited information available on mental health and few resources for newcomers. Examples: Difficulty finding information through the immigration centre and online information in different languages, and most resources are only in English.

STUDY 2 INTRO

Goals

- Understand how a MHL program about child mental health could better fit the social and cultural contexts of newcomer parents.
- Get feedback on an outline of this type of program.

Research Method

- Focus groups with:
  1) Immigration and settlement professionals (5 total)
  2) Parents of children (ages 2-12) who were newcomers to Manitoba (8 total)
- Study 2 was also advertised through community agencies, electronic newsletter, and word of mouth.
- Focus group discussions: How realistic, useful, and relevant is the program in the outline? How could it benefit you or those in your community? Would you access it?

Key Participant Info

Professionals

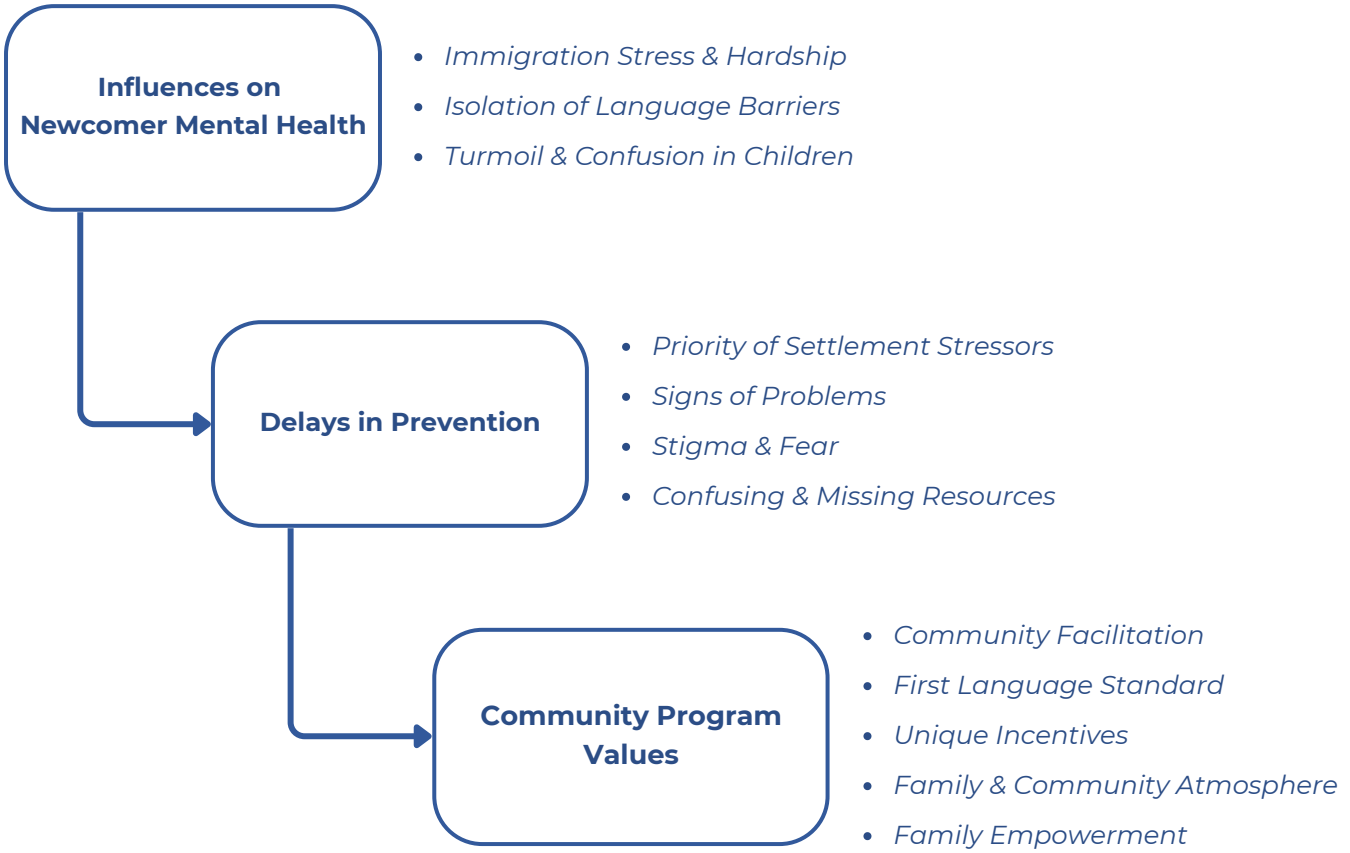
- Average age: 46
- All were female
- All had Bachelor's degree or higher
- Job titles: Settlement Facilitator, Project Coordinator, Program Coordinator
- All previously immigrated to Canada (Germany, Kuwait, Mexico, Russia, Ukraine)

Parents

- Average age: 38
- Mostly female, 1 male
- Most had post-secondary degree
- Ethnic identities: African, Black, Latin American
- Average time lived in Canada: 2.9 years
- 6/8 were permanent residents
- 5 international students, 2 sponsorship, 1 provincial nominee
- Originally from Columbia, Ecuador, Mexico, Nigeria, Peru

STUDY 2 FINDINGS

- This model shows a hierarchy of **main themes** and *subthemes* from the focus group discussions.



- **Influences on Newcomer Mental Health:** Some major contributions to mental health challenges in newcomer families, which would be important to focus on in a MHL program.

- **Delays in Prevention:** Seeking information or help for these and other challenges is less likely or difficult for multiple reasons. These reasons might delay parents from accessing resources that could provide information or help with child mental health.

- **Community Program Values:** These are important features for a MHL program to draw interest and help get around the above reasons for delay. These values were seen as necessary for a program to be focused on individual communities and be successful.

- The next page includes more details about *subthemes*.

STUDY 2 FINDINGS

Influences on Newcomer Mental Health

- ***Immigration Stress & Hardship:*** Examples: Separation from family, less support, difficulty adapting to Canada, confusing and long immigration process, and new careers and schools.
- ***Isolation of Language Barriers:*** Language barriers create isolation, stigma, less sense of belonging, and difficulty understanding and communicating emotions to others.
- ***Turmoil & Confusion in Children:*** Children face unique challenges. Examples: Confusion, anger, and sadness about not choosing to immigrate, and being even more affected by family separation.

Delays in Prevention

- ***Priority of Settlement Stressors:*** Life as a newcomer and parent is busy. It is hard to put time and energy into learning more about mental health unless there is a serious current problem.
- ***Signs of Problems:*** Not knowing or being confident about signs of mental health difficulties makes it hard to look for information or help. It is hard to know the difference between specific mental health challenges, versus normal emotional changes during settlement or as children develop.
- ***Stigma & Fear:*** This prevents families from looking for information or help. Worries about attention from police or child and family services, and certain terms including “mental health”, play a big role.
- ***Confusing & Missing Resources:*** Current resources are often not helpful or cannot be accessed by many newcomers. Examples: Low information about where to get information or help, expensive services, no access through health coverage and insurance, or not available in primary language.

Community Program Values

- ***Community Facilitation:*** A program would need to have clear ties with the community to feel more relevant and safe. People leading the program should have a similar cultural background or be from the community. Program should be offered at a familiar place and be easy to find and join.
- ***First Language Standard:*** Every part of the program (advertising, handouts, speech) should be offered in the primary language of the community to improve interest and impact.
- ***Unique Incentives:*** The program in the outline was seen as valuable but would need other features to draw enough interest and stand out. Examples: Help with childcare, food, transportation.
- ***Family & Community Atmosphere:*** The educational parts of the program would feel more trustworthy, safe, and engaging if it feels like a community activity. Examples: Potluck or sharing food, including children in the program, using few clinical or academic terms (to reduce stigma).
- ***Family Empowerment:*** The program should focus on empowering parents through a combination of education, normalizing, and lowering stigma. Examples: Open discussions, stories about people.

CONCLUSION

Implications

- Mental health literacy (MHL) needs to be defined and addressed differently for newcomers. Different mental health topics and communication strategies need to be considered.
- MHL programs with newcomers must be approached at a community level, such as communicating mental health information using cultural sayings, and considering specific community challenges..
- Education about mental health was seen as important, despite cultural differences and significant barriers for newcomers. This justifies more work towards culturally adapting MHL resources.
- There are few mental health resources for newcomers that fall between basic information and psychological treatment.[18] This research provides directions for community resources to fill this gap.
- Study 2 program outline was reworked into recommendations based on the feedback. It can be used as a starting point for future research/program design for individual cultural and community groups.

Limitations

- This research was conducted in English and participants did not speak in their first language.
- We did not look at differences for specific cultures, countries, or immigration categories.
- We used a wide definition of “newcomers” to recruit parents: 1-15 years lived in Canada. However, participants generally were still fairly new to Canada (5 or less years).
- There was a small number of participants and some challenges with recruiting them.

Future Research

- More research to help re-define MHL in the social/cultural contexts of newcomers.
- More research to better understand unique mental health challenges and information and program needs for specific groups (cultures, countries, immigration categories).
- Research and program development that unites the mental health and settlement sectors.

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