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## Lina Saadeddin\_Supporting Transition Resilience of Newcomer Groups (STRONG) - Examining Impact of STRONG on Youth, Feasibility of Community Implementation, and Parental Engagement

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A thesis submitted in partial fulfillment of the requirements for the Master of Arts degree in Education

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## Abstract

This study investigated the feasibility of virtual Supporting Transition Resilience of Newcomer Groups (STRONG) delivered through a community agency. STRONG is a Tier-2 intervention developed to enhance resilience and coping among newcomer youth. Ten youth participants from two STRONG groups completed pre-and post-surveys and participated in a focus group to describe their experiences. Parent sessions were added to STRONG programming. Five parents completed a satisfaction survey and a focus group to share their feedback. Two clinicians and one community manager provided feedback on the implementation in two focus groups. The study used a mixed-method approach. While there were no significant increases of STRONG skills in the quantitative results, youth reported increased social connections and coping skills in the focus groups. Parents indicated satisfaction with STRONG and parent sessions and provided feedback in the focus group. The findings revealed specific implementation successes and barriers and their implications for future practice and research for community implementation of STRONG.

### **Keywords**

Mental health, intervention, group, newcomers, refugees, resilience, community, implementation, youth, parents, virtual care

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## Summary for Lay Audience

Newcomer families with refugee backgrounds come to Canada after facing several challenges from their home country, moving journey, or from their lives in their new environments. The hardships can be living in a war zone, discrimination, finding jobs, and more. These challenging situations can impact the well-being of refugees, including children and youth. Despite those hardships, newcomer youth show resilience, and their resilience can be further enhanced through community support that can be supported by community help.

Newcomers might have a more challenging time accessing mental health services to help them deal with their past and present stressors once they arrive in Canada. We collaborated with a newcomer-serving community agency to virtually deliver the STRONG program to newcomer youth. The community partnership reduced some barriers for newcomer youth to access a mental health intervention. The STRONG program builds resilience, promotes social connections, and teaches youth coping strategies to manage distress. Results from the surveys did not show a difference before and after the program in resilience, social connections or STRONG coping skills. However, the youth shared in the focus group showed that they enjoyed the celebration, breathing exercises, and sharing their story in STRONG. As well, they used some of the coping strategies in their daily life such as breathing exercises. The youth liked that STRONG was easy to access, but found the internet connection to be challenging sometimes. The youth said they would recommend STRONG to other newcomer youth to practice their English, make friendships with others, and share their story.

There were three parent sessions to familiarize parents with concepts taught to their children in STRONG. Parents filled a survey and participated in a focus group to give their feedback. Parents identified specific outcomes for their youth after program completion and also appreciated having a unique space to share their stories and connect with other parents.

We also evaluated the implementation successes and barriers of virtual STRONG in the community. Successes were linked to the strong partnership between the research and community sites, while many of the challenges were related to virtual delivery (e.g., unstable internet connections).

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## Chapter 1

### 1 Introduction

Canada is widely known for its diversity and multiculturalism. It is one of the most popular and desired destinations for migrants around the world (Holley & Jedwab, 2019). The desire to move to Canada can be attributed to its welcoming nature, as it was globally ranked as the fourth-highest accepting country for immigrants (Holley & Jedwab, 2019). One in five Canadians is foreign-born, accounting for 7.5 million of the population. Over the past five years, Canada has been home to more than 1.2 million newcomers<sup>1</sup> (Holley & Jedwab, 2019).

Between 2015 and 2018, around 122,000 refugees arrived in Canada to seek asylum (Holley & Jedwab, 2019). Specifically, Canada welcomed 29,000 Syrian refugees between 2015-2016, 85% of which were couples accompanied by children (Houle, 2018). One in three refugees arriving in Canada settled in Ontario or Quebec, which adds to about 74,000 of the refugee population (Holley & Jedwab, 2019).

The Syrian civil war negatively impacted millions of lives; many innocents were prosecuted, arrested, harassed, assaulted, and killed (Durà-Vilà et al., 2012). Many were forced to flee to neighbouring countries to seek temporary asylum. Refugees in Canada continue to face challenges during their migration journey. One of these challenges starts in the first step in seeking asylum; newcomers wait to receive the recognition of their legal resident status that ensures their individual support and benefits (e.g., economic stability, healthcare; Durà-Vilà et al., 2012). This time is often stressful for many

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<sup>1</sup> The “Newcomer” term is used to minimize the stigma and negative connotations associated with the terms “refugee” or “immigrant”. In turn, it has been argued that the use of the newcomer term has helped to increase public awareness and sensitivity towards newcomers’ integration process (Nichols et al., 2020)

applicants as they wait to be recognized and considered refugees and not denied or pushed away.

In light of refugees' challenges, the Canadian government responded with continuous efforts to support individuals and families with programs, services, and community resources (Government of Canada, 2021). However, since almost half of the Canadian refugee population consisted of children and youth (Child and Youth Refugee Research Coalition, 2018), more system-wide mental health initiatives were needed to support their well-being. The stressors and traumas experienced by each refugee child are different, given their unique experiences. The migration journey influences the transitional experience for each child differently (Pieloch et al., 2016). Thus, it is essential to apply a trauma-informed lens and culturally-sensitive services in schools and community resources for refugee children and youth. This research aimed to test the feasibility of a successful school-based initiative in the community when offered through a community agency.

## 1.1 Literature Review

Many refugees, including children seeking asylum and residency in Canada, have experienced significant adversities. Moreover, trauma during their migration journey (pre-migration, migration, and post-migration) put them at increased risks for mental health challenges and disorders (Durà-Vilà et al., 2012; Miller & Rasmussen, 2017). Some examples of adversities that refugee children and youth might have encountered include, but are not limited to, losing a loved one in persecution, death of multiple family members, witnessing violence, destruction to their homes, and gaps in education (Durà-Vilà et al., 2012; Miller & Rasmussen, 2017). Refugee children are also at risk of being separated from their caregivers during the transition to seek asylum, either by accident or because of unsafe conditions (Lustig et al., 2004). In many instances, refugee families are stationed in transit countries, and they might not have adequate sources of income, food, or shelter (Durà-Vilà et al., 2012; Miller & Rasmussen, 2017). Finally, exposure to post-migration stressors such as acculturation, racism, continued financial hardship and adjusting to a different education system can continue to impact children's mental well-being (Durà-Vilà et al., 2012; Lustig et al., 2004).

Previous research indicated various models of the settlement process of refugee families. Oduntan & Ruthven (2019) suggested a person-centred approach to integration, where the information presented to families is meant for their required needs in the settlement process. The suggestions are derived from results indicating the need for personalized supports. Efforts of integration are often associated with housing, health, education, and employment, expecting that refugee families go through the same process (Oduntan & Ruthven, 2019). However, the research showed that the same procedure is not sustainable for all refugees, and some of them dealt with emotional distress and financial instabilities despite the integration efforts (Oduntan & Ruthven, 2019).

Another approach to integration was a four-stage-based model, starting at pre-migration, where individuals gather information from online and offline resources (Shankar et al., 2016). Followed by an immediate stage where individuals acquire language, shelter, and orientation needs to help with their settlement. The third is an intermediate stage, where refugees utilize local government and organizational supports for long-term basic needs. The final stage is the integrative stage, where newcomers are expected to maintain their own needs (Shankar et al., 2016). The services accessed by newcomers are often provided by community organizations or volunteering efforts by being civically engaged (Shankar et al., 2016).

Settlement models are a helpful indication of the process of integration for newcomer families (Shankar et al., 2016). Taking a person-centred approach by providing the information needed for different individuals can be helpful (Oduntan & Ruthven, 2019). Newcomer families need the first few years to access and establish their basic needs (Kilbride & Summary, 2000). Once their basic needs are met, it may be optimal for newcomers to learn about their mental health needs and receive services and supports accordingly (Kilbride & Summary, 2000).

Culturally-informed approaches are essential to address distressed children and youth's underlying needs and forward mental health concerns to professionals due to limited recognition of the need or importance of support. In some cases where the mental health need is detected, mental health services are not sought out to avoid the risk of working with someone unfamiliar. Refugee youth might also be reluctant to access mental health

services due to language differences or lack of cultural fit (e.g., service providers imposing Westernized opinions; Colucci et al., 2015; Ellis et al., 2011). Moreover, lived experience may also contribute to significant distrust towards authorities, affecting refugee youth's support-seeking behaviours with service providers (Ellis et al., 2011).

Refugee youth may have more success in accessing mental health care with their family and community agencies (Colucci et al., 2015). Connecting newcomers, including refugee families, to community agencies and personnel, can be a strategy to decrease distrust of authority (Ellis et al., 2011). Increasing trust with authority figures is a challenge given the newcomers' experiences (e.g. fear of being detained for stating their opinion; Ellis et al., 2011). However, if the people in power (e.g., doctor, mental health provider) foster a trusting relationship, that can reduce the mistrust (Ellis et al., 2011). Providing culturally adapted services in newcomers' first languages can increase accessibility (e.g. mental health intervention; Ellis et al., 2011). Most importantly, integrating mental health services in systems like schools and resettlement-based community organizations might reduce mental health services stigma and encourage reaching out for help (Ellis et al., 2011).

## 1.2 Mental Health Interventions for Newcomer Children & Youth

There is limited research published on mental health interventions evaluated with newcomer children and youth. From the little available literature, almost all of the published studies have assessed the effectiveness of school-based mental health interventions with refugee children and youth (Erucar et al., 2018), and many of these interventions are based on cognitive behavioural therapy (CBT) principles (Ehnholt et al., 2005; Murray et al. 2008). Properly conducted CBT techniques with cultural adaptations may improve the well-being of newcomers (Hinton et al., 2012). A summary of school-based interventions evaluated with children and youth with trauma histories is presented below.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a school-based intervention developed in the United States (Jaycox et al., 2018). It is delivered individually and in groups and aims to reduce posttraumatic stress disorder (PTSD) symptoms, depression, and anxiety for students between grades 5 and 12 (Jaycox et al.,

2018). CBITS uses CBT techniques such as relaxation, problem-solving, and psychoeducation on various aspects of mental health. CBITS also has an informational session for parents (Jaycox et al., 2018). However, the program was not uniquely developed to address the needs of newcomer children and youth. The program's primary focus is to reduce Posttraumatic Stress Disorder symptoms (PTSD) in participating students (Jaycox et al., 2018).

Bounce Back is another program offered for children; it is a cognitive-behavioural, skills-building group intervention that aims to reduce PTSD symptoms in children (Langley et al., 2015). Bounce Back was developed to support children who have experienced trauma such as violence in the family, school, community (Langley et al., 2015). The program has ten sessions, and participating children learn new skills such as problem-solving skills, relaxation techniques, and building social connections (Langley et al., 2015). The clinician also conducts 2-3 individual sessions with the child to take part in a trauma narrative to help participants process their traumatic experience (Langley et al., 2015). Bounce Back offers materials and psychoeducational sessions for parents (Langley et al., 2015). The program targets children between the ages of 5-11 and not available for high school students (Langley et al., 2015).

In sum, most available school-based mental health interventions are designed to address challenges and distress associated with trauma in children and youth. Nevertheless, there is a lack of mental health interventions that are strength-based or resilience-focused to address difficult experiences. A strength-based approach can be more therapeutically beneficial by shifting the focus from participants' struggles and faults to strengths and assets (Xie, 2013; Murray et al., 2010). Moreover, taking a strength-based approach with young newcomers can support their healing process and facilitate positive integration within their new environment (Marshall et al., 2016).

### 1.3 Resilience

Resilience is the ability of a person to adapt to disturbances that are considered threats, such as traumas and adversities (Masten & Reed, 2002). Resilience is the ability to bounce back and recover from hardships or obstacles (Chuang, 2011; Este & Van Ngo, 2010). Holling (1973) first introduced resilience as an ecosystem's capacity to maintain

its original state despite perturbations. Holling's definition is technical and was used by some researchers to describe the necessity of maintaining a system's natural state (system's equilibrium; Folke et al., 2010). Resilience has also been studied from various people's experiences to understand better what makes humans more resilient. People differ in their abilities and reactions to situations; therefore, resilience is fluid and changes from a person to another and from age to age (Coutu, 2002; Masten & Reed, 2002). It is also argued that resilience is not a trait but a skill that can be acquired and improved (Coutu, 2002; Masten & Reed, 2002). If resilience is a skill, a person can develop resilience with training and education (Coutu, 2002; Masten & Reed, 2002). To add on, personal traits such as acceptance of fate and flexibility play a role in an individual's resiliency (Coutu, 2002). A person who has faith and believes that everybody has their unique fate was found to have more resilience (Coutu, 2002). Individuals who are flexible and adapt to changes when they occur are more likely to be resilient (Coutu, 2002).

## 1.4 Resilience in Children & Youth

Children's and youth's ability to withstand adversities and revert to function in the present is a process that relies upon both protective and risk factors. Protective factors enhance resilience development (e.g., supportive parents; Este & Van Ngo, 2010). Having multiple protective factors such as attending school, coping strategies, parental well-being and support, can help children develop resilience after experiencing adverse life events (Este & Van Ngo, 2010; Lustig et al., 2004). As well, religious beliefs and involvement in the community can also support the resilience of children and youth (Lusting et al., 2004). On the other hand, risk factors can hinder the process of building resilience, such as parental divorce, domestic abuse, and neglect (Este & Van Ngo, 2010). Children who are resilient feel appreciated, and have effective coping strategies that help them solve problems and make proper decisions (Este & Van Ngo, 2010).

Racism is the harmful thoughts and beliefs held against members of a specific group. Discrimination is the action produced from racist attitudes and beliefs. Xenophobia is the fear and negatively held attitudes towards people from minorities, and the belief that people from the ethnic majority are superior to those of other groups (Marks et al. 2021).

Newcomer children may experience discrimination, exclusion and harassment based on their identities during the acculturation experience (Marks et al., 2021), which hinder their mental health (Szalacha et al., 2003). Specifically, experiencing racism and discrimination can increase the risk for developing a mental illness such as depression or anxiety, lowers self-esteem, and increases feelings of injustice in children and youth from minorities (Marks et al., 2021; Szalacha et al., 2003). While children and youth who are minoritized often have many strengths to navigate these complex environmental adversities (Marks et al., 2021), it is important that system-level interventions are also put in place to reduce racist and discriminatory actions to create safer environments to promote children's and youth's resilience.

Children's resilience has been shown to be significantly promoted by the support of family, school, and community (Este & Van Ngo, 2010). Ungar (2008) found that aspects of a child's life that contribute to resilience are interrelated. For example, a child who has supportive parents and can easily access resources is more likely to exhibit greater resilience than a child with reduced parental support. Ungar (2008) also found that factors like access to resources, tolerating changes, healthy relationship skills, having a sense of identity and purpose, maintaining cultural adherence and having a meaningful role in the community can impact children's resilience.

## 1.5 Resilience in Newcomer Children & Youth

Previously, resilience was predominantly studied through an individualistic lens and was argued to be a person's internal abilities to cope in the face of adversity, with little regard to cultural and social contexts (Ungar, 2008). More studies were conducted to look at the impact of external factors on resilience, especially in collectivistic cultures. In a cross-cultural study with individuals from collectivistic cultures, Ungar (2008) found that resilience in times of exposure to significant hardship depends on the individual's access to external resources and supports (e.g., family, friends, culture). An individual associated with a collectivist background will likely reach for external supports from trusted individuals during hardships.

The experience of being a newcomer can be challenging for children and youth's mental health. Besides the stressor of transitioning to a foreign environment, newcomers are subjected to cultural barriers such as differences in language, values, and lifestyles (Cole, 1998). The need to fit can be a priority for children and youth. The challenges to adapt to Canadian cultural norms can lead to more significant risks of isolation, depression, and delinquency (Kilbride, 2000). Most of the previous research focused on newcomer's challenging aspects of migration (Pieloch et al., 2016). For example, Cole (1998) reported a strong link between arrival from conflict-zones and increased prevalence of PTSD symptoms among newcomer youth. However, there is a bright side of the story, where PTSD symptoms also decreased as their family lives stabilized and they have integrated successfully within the new context (e.g., learned English, economic stability). Moreover, children and youth develop resilience through their experience by discovering their many strengths, which improves their mental well-being following traumatic events (Murray et al., 2008). Thus, some successes can be highlighted through their migration journeys, despite the many hardships (Cole, 1998). It is essential to promote resilience in newcomer children and youth since it is a mediator in their acculturation process and reduces psychological distress (Khawaja et al., 2017).

Resilience in refugee children and youth is crucial once they move to the host country. Thus, having sources that promote resilience post-migration is vital. One of the factors that increase resilience is the ability to speak the language of the host country. Speaking the native language of the host country helps boost self-esteem and adapt to the country (Pieloch et al., 2016). Children and youth who maintain a positive outlook and appreciation for their experiences have a higher sense of resilience (Pieloch et al., 2016). Another factor that increases resilience in refugee children and youth is the accessibility to community resources. Community resources allow newcomer children and youth to be involved in community programs that promote their agency and self-determination (Pieloch et al., 2016). Programs that empower newcomer children and youth and foster leadership may also promote their resilience. Moreover, meaning-making and hope are also argued to be mechanisms to strengthen resilience and the ability to cope in the face of adversities (Pieloch et al., 2016).



There are different approaches to promote resilience within newcomer children and youth through external resources. One approach is to engage and collaborate with parents and families. Supportive and positive family dynamics promote resilience within newcomer children and youth (Cole 1998; Pieloch et al., 2016). Schools are another external resource; a positive and safe school climate plays a role in increasing resilience within newcomer youth and children (Cole, 1998; Pieloch et al., 2016). Finally, community resources can play a factor in enhancing newcomer children and youth's resilience. Community resources can enhance youth and children's resilience by providing social activities, support and ensuring a safe space where newcomers can feel a sense of belonging and connectedness (Pieloch et al., 2016).

## 1.6 The Rationale for a New Intervention for Newcomer Children and Youth

It is crucial to have resilience-focused, strength-based and trauma-informed mental health interventions for newcomer children and youth to enhance their well-being. Promoting resilience and focusing on newcomer children and youth's strengths can help with a positive acculturation experience (Pieloch et al., 2016). Most importantly, resilience-enhancing services should be provided within safe and accessible spaces (i.e. schools or community agencies) for newcomer children and youth.

After the refugee influx in 2015-2016, the Ontario Ministry of Education requested the collaboration of School Mental Health Ontario (SMHO) to monitor and address the mental health needs of refugee students arriving in Ontario (Crooks et al., 2020a). SMHO is an intermediary organization that supports mental health programming in 72 publicly funded school boards in Ontario (Short, 2016). Moreover, SMHO provided school-wide, universal, Tier-1 strategies and resources. An example of a Tier-1 strategy is ensuring a welcoming environment for newcomers in schools. However, mental health professionals quickly realized these strategies were not sufficient for the new refugee student populations arriving in Ontario schools (Crooks et al., 2020a). Many of the students were reported to be experiencing emotional distress and behavioural challenges in the classroom. Hence, more individualized services were requested to suit the needs of newcomer children and youth (Crooks et al., 2020a).

Mental health professionals in schools across Ontario advocated for the need for a Tier-2 intervention for newcomer students (Crooks et al., 2020a). In a multi-tiered intervention framework, a Tier-2 mental health intervention is targeted to students with specific mental health needs (e.g., students struggling with anxiety in the classroom; Fazel et al., 2014). SMHO collaborated with the co-director of the US National Centre for School Mental Health (NCSMH) at the University of Maryland to explore development options for a suitable Tier-2 program. SMHO and NCSMH initially explored literature around evidence-based practices developed for immigrant youth and children and school-based mental health interventions that addressed trauma, resilience and psychosocial stressors. The literature review from both SMHO and NCSMH teams indicated no interventions developed specifically to address the pre-and-post-migration resilience or needs for newcomer children and youth. Thus, a collaborative team was formed to co-develop the Supporting Transition in Newcomer Groups (STRONG) program (Hoover et al., 2019). The team consisted of professionals from different disciplines, school and community mental health professionals working with newcomers, researchers, and members of the newcomer community (Hoover et al., 2019).

## 1.7 STRONG

STRONG is a group-based, tier-2 mental health intervention that was developed to support newcomer students experiencing psychological distress. STRONG is an evidence-informed manualized intervention aiming to ease the transition of newcomer children and youth into their host country post-migration (Crooks et al., 2020b). There are two versions of the STRONG manual, elementary and secondary, to address various developmental stages of childhood (Hoover et al., 2019).

STRONG uses strength-based and evidence-informed approaches to enhance newcomer children's and youth's mental health (Crooks et al., 2020c). The program consists of 10 one-hour-long sessions and an individual journey narrative session (Hoover, 2019). The content of STRONG is based on CBT principles (e.g. helpful thinking; Hoover et al., 2019). The core components of STRONG include fostering resilience skills, teaching cognitive behavioural skills (e.g., relaxation, problem-solving), and providing

psychoeducation regarding distress, emotions and seeking available support (e.g., peer, parent, teacher; Hoover, 2019).

The individual journey narrative session provides a safe space for participants to discuss their migration journey. The session takes a strength-based approach in discussing the participants' migration journey, allowing them to identify their internal strengths and external supports and how they have contributed to their growth and coping (Hoover, 2019). The strength-based reconstruction of the migration journey may help the youth narrate and understand their experience more cohesively. After the individual meeting with the STRONG clinician, participants are encouraged to share some of the migration journey aspects with others in the group in a subsequent group session (Hoover, 2019).

## 1.8 STRONG Evaluation Findings

Previous STRONG pilot groups were conducted in urban school districts (i.e. school boards) in southern Ontario, Canada. The results from the pilots indicated that the program enhanced resilience, increased social connections and positive self-concept in newcomer children and youth (Crooks et al., 2020c; Crooks & Smith, 2019). Youth participants also reported learning about specific coping skills taught in the program (e.g., relaxation techniques; Crooks et al., 2020c).

Clinicians felt that students improved their overall functioning, and their distress was reduced after completing the program (Crooks et al., 2020c). The clinicians also reported both personal and professional benefits resulting from facilitating STRONG (Crooks et al., 2020a). Professionally, clinicians felt more confident providing support to newcomers with their mental health concerns after learning new therapeutic strategies from STRONG. Clinicians also reported feeling more comfortable supporting newcomer children and youth with processing their journey narratives. Personally, clinicians were appreciative to have the opportunity to work with newcomer children and youth, learn about their cultural background, and hear their migration stories. (Crooks et al., 2020a).

## 1.9 Community Mental Health Interventions

Schools are argued to be an ideal setting to provide mental health services for newcomer children and youth as schools may remove some accessibility barriers (Crooks et al., 2020a; Fazel et al., 2016). However, schools may not have the capacity to provide services to all newcomer youth. Moreover, school staff may still have challenges connecting and engaging with parents (Erucar et al., 2018; Reinke et al., 2011). Parental involvement plays an important role in the school success and well-being of their children (Wang et al., 2019; Cureton, 2020). For example, Lee & Bowen (2006) found that parental involvement was connected with the child's ability to perform better academically. Newcomer parents may be disconnected from the new school system due to language or communication barriers, making it inaccessible to be involved in their child's activities (e.g. school, interventions; Cureton, 2020). Newcomer parents can face challenges such as working multiple jobs, family demands and other nonvisible struggles that make it difficult to stay engaged in their child's life (e.g. school; Este & Van Ngo, 2010; Cureton, 2020).

Implementing STRONG in a community setting could help enhance the child's connectedness to the community and make it more feasible for parents to be involved in the program. Families, especially parents, play an essential role in children's social development (Este & Van Ngo, 2010; Pieloch et al., 2016; Wang et al., 2019). Parents are considered vital for their children in building family bonds, social skills, and passing on knowledge and manners (Khawaja et al., 2017).

Parental involvement in programs can strengthen children's skills and abilities to develop confidence and resilience (Weine, 2008; Alvord & Grados, 2005). Parent involvement in the process of treatment has been linked with positive outcomes for the child (Haine-Schlagel et al., 2012). Thus, involving parents in STRONG programming and familiarizing them with the program contents may enhance the positive outcomes for their children. It will also be helpful to receive feedback from parents about the STRONG program. Collecting parents' perspectives can help the researcher better understand behavioural changes that parents may see in their children while and after participating in STRONG. Parents can bring a new perspective on intervention-related improvements in

their child (e.g. adapted new coping strategy; Goolsby et al., 2018). Parental encouragement could help in supporting children to express their emotions (Cobham et al., 2016).

In addition to parental involvement, Pieloch et al. (2016) indicated that community involvement and a sense of belonging promote resilience in some newcomer children. Este and Van Ngo (2010) highlighted that community resources such as healthy neighbourhoods, mentorship services, and providing care can directly impact children's well-being. Community support can serve as a great resource to foster parents' skills to strengthen their children's resilience (Este & Van Ngo, 2010). As well, parents' trust in community agencies can further increase the likability of participating in community-based interventions (Este & Van Ngo, 2010). Community leaders might have pre-established trust with parents in the community, which eases their accessibility to various community programming.

## 1.10 Impact of the COVID-19 Pandemic

The spring of 2020 brought forward the first wave of COVID-19, a contagious virus from the coronavirus family of viruses that impacted people globally. The global pandemic has had adverse effects on individuals and families, including increases in mental health challenges like anxiety, depression, stress caused by various factors (McBeath et al., 2020; Courtney et al., 2020). Factors such as social isolation, lack of interpersonal interactions, and health worries and anxieties about possibly catching the COVID-19 virus might have contributed to increased mental health problems (McBeath et al., 2020).

The beginning of the lockdown provoked fear within people in society. Some considered this pandemic a traumatic event that violated people's safety and was associated with intense emotions (Brusadelli et al., 2021). The impact of the pandemic on newcomer youth and their families is still not studied extensively. However, self-quarantine and lockdown from everyday daily activities can impact those who have lived through similar highly restrictive situations. The physical distancing measures enacted to reduce the spread of COVID-19 might have appeared similar to the restrictions placed during refugee families' journeys. Furthermore, the pandemic might have intensified feelings of social isolation and financial burden because of the physical distancing and stay-at-home

orders. With respect to services, the pandemic also suspended various in-person interventions for children and youth. Thus, given the increases in stressors and risks for poor mental health, there was a dire need for interventions to pivot for virtual delivery (Courtney et al., 2020).

### 1.11 Rationale and Purpose of the Research

The purpose of this study is to examine the virtual implementation of STRONG through a community agency, the impact of STRONG on youths, and the feedback from parents on the STRONG program and parent sessions. This research study aimed to expand the scope and accessibility of STRONG reach by delivering it virtually through a community agency, with the help of both the community agency and research sites. The study measured the impact of STRONG on resilience, social alienation and development of STRONG skills in youth. In addition, three-parent sessions were added to the STRONG program. We collected parents' feedback about the STRONG program and parent sessions.

The research questions are as followed:

- 1) What was the impact of STRONG community programming on newcomer youth?
- 2) What were the implementation successes and challenges of implementing STRONG virtually in the community?
- 3) What are parents' perceptions of the STRONG program?
- 4) What was the utility of the newly developed parent sessions for STRONG?

In the next few chapters, the methods, results and discussion will be further outlined and explained in means to answer the abovementioned research questions.

### 1.12 Researcher Positionality

I was a newcomer to Canada, and I immigrated to Canada in 2011 with my family. After moving to Canada, I had my own mental health struggles due to social isolation and feeling like I did not belong in my new community. My individual experience and knowledge of the impacts of the migration journey on newcomer youth motivated me to

support the newcomer community to help them navigate and deal with their own mental health challenges.

Prior to starting my graduate education, I used to work in the community agency that I collaborated with for my Master's research. I co-facilitated girls' groups at schools and I was a youth group facilitator in the Strengthening Families Program. As an employee of the community agency, I was trained to be a STRONG program clinician. When I began my graduate studies, I had the opportunity to conduct my Master's thesis at the Centre for School Mental Health, the research site, which has had previous connections to the community agency. The director of the CSMH, Dr. Claire Crooks, my co-supervisor, was awarded a Public Health Agency of Canada grant to evaluate the feasibility of STRONG in Ontario schools. Through this funded project, there was also a scope to expand the evaluation of STRONG in the community. Given my existing relationship with the community agency and my previous clinical and personal experience of supporting the newcomer community in the London area, I was enthusiastic about having the opportunity to take a more applied role in my research and collaborate with the agency to implement STRONG. Upon consultation with my supervisors, we decided I would be one of the co-clinicians for STRONG, but we took appropriate steps to minimize the effects of this dual role: researcher and clinician, as detailed in the Methods chapter.

## Chapter 2

### 2 Method

The study used a pragmatic mixed-methods approach, utilizing qualitative (i.e., focus group data) and quantitative measures (i.e., parents' survey, youths' survey). The use of both qualitative and quantitative measures was important for integrating and solidifying the study's outcomes. The qualitative design gave the participants a chance to reflect on their involvement, and allowed the researcher to explore the uniqueness of the youth's experiences and impact carried from the program. On the other hand, quantitative scores measured the impact of STRONG on participants before and after the intervention.

The study was conducted in partnership with the Centre for School Mental Health (CSMH) at Western University (research site), and a community not-for-profit organization. The community partner serves newcomer individuals and families in London and surrounding regions in Ontario, Canada, particularly those experiencing integration challenges or those who have migrated from conflict and war zones. The organization incorporates a culturally integrative family safety response model in their provision of services, in which individuals' and families' cultures, values, and migration backgrounds are prioritized to develop and implement appropriate integration measures into Canada (Baobaid et al., 2015). The organization's primary clientele are individuals and families of diverse Muslim backgrounds, especially those with domestic and gender-based violence experiences.

#### 2.1 Participants

Three groups of participants were involved in this study: youth participating in STRONG, their parents, and the clinicians implementing the program. The researcher of this study was one of the program clinicians. Two virtual STRONG groups were implemented in the community by the research and community sites. Each group had five female participants, and their ages ranged from 12-14 years old. The community site manager recruited the youth and connected with parents and teachers through outreach in community networks. However, the manager indicated that she faced recruitment challenges due to the pandemic, mainly because schools moved to virtual learning and



many school stakeholders could not reach students or their parents. The youth participants were part of other newcomer social groups organized by the community site manager in various schools. The manager also indicated there was interest amongst mothers and girls in the community, and the mothers also referred other newcomer families to the program. The parent sessions were piloted for the second virtual group and included five mothers. The same two clinicians implemented both of the STRONG groups.

## 2.2 Materials

**STRONG Survey.** The youth completed a STRONG survey that included three different measures that assessed resilience, STRONG skills, and social alienation, respectively before and after the group. The survey also has a demographic section consisting of questions about youth's age, gender, ethnic background, country of birth, time lived in Canada and circumstantial conditions (see Appendix A).

**Resilience.** Resilience was measured using the Connor Davidson – Resilience Scale – 10 (CD-RISC-10; Connor & Davidson, 2003; see Appendix A). The CD-RISC-10 is intended for use with individuals from ages 10-65. CD-RISC-10 consists of 10-item scored by participants on a Likert scale, and responses ranging from “Not True at All” (0) to “True Nearly All the Time” (4). An example of a CD-RISC item is “I am able to adapt when changes occur”. The range of scores can vary from 0 to 40, with higher scores indicative of being more resilient (Connor & Davidson, 2003).

The CD-RISC-10 has been used to measure youth resilience globally and has been translated into 77 languages, including Arabic. (Connor & Davidson, 2003). The scale was available in Arabic and English in this study, and youth participants chose their preferred language to complete the scale. All youth participating in the study preferred using the English version. Connor and Davidson (2003) reported excellent test-retest reliability ( $r = .87$ ) for the measure. Furthermore, multiple studies with different population samples found that CD-RISC-10 has demonstrated good internal reliability with the lowest score of  $\alpha = 0.81$  and the highest of  $\alpha = 0.92$  (Connor & Davidson, 2003). Another study found the CD-RISC-10 to have an internal reliability score of 0.85, which affirms its reliability (Campbell-Sills & Stein, 2007). It was also showed to have good

construct validity, predictive validity, and sensitivity to change across various studies and interventions in diverse populations (Connor & Davidson, 2003). The CD-RISC-10 has been used in the pilot evaluation for STRONG (Crooks et al., 2020c).

***STRONG Skills Measure.*** The second part of the STRONG survey included the STRONG skills 10-item questionnaire. The research site's researchers developed the questionnaire to measure the skills gained from the STRONG program by the youth participants (Crooks et al., 2020c; see Appendix A). The measure has a Likert scale rating style to assess the youth's knowledge (e.g. I understand common reactions to stress) and self-efficacy (e.g. I can distinguish unhelpful from helpful thoughts). The STRONG skills measure has high face validity since it reflects each skill taught from the STRONG manual (Crooks et al., 2020c). The pilot evaluation of STRONG found the skills measure to have high internal reliability ( $\alpha = .91$  at time 1; Crooks et al., 2020c).

***Social Alienation.*** The third part of the STRONG survey included a 15-item social alienation measure, Jessor & Jessor Social Alienation Scale (JJSA; Jessor & Jessor, 1977; Appendix A). The measure has 15-items on a Likert scale measure ranging between "Strongly Agree" and "Strongly Disagree". The raw scores of the items from each item and final scores can range from 15 (low alienation) to 60 (high alienation; Safipour et al., 2010). The JJSA's initial English version has high reliability and validity and was adapted to other languages such as Arabic, French and Swedish. The scale has high internal reliability ( $\alpha = 0.81$ ), and based on the high spearman-brown coefficient of 0.82; it showed good test-retest reliability (Safipour et al., 2010).

**Youth focus group.** Upon intervention completion, a focus group for youth participants was conducted to collect their feedback about the STRONG program. The questions included what they liked or disliked about STRONG, suggestions for improvement and whether they would recommend this program to other newcomer children and youth (see Appendix B). The focus group took around 60 minutes and was conducted virtually via Zoom. A STRONG team member from the research site facilitated the focus group with youth. Additional language support in Arabic was provided whenever they asked for certain concepts to be translated and explained.

**Parent Survey.** Parent participants were asked to fill out a survey after the completion of the final parent session. The parent survey was co-developed by the researcher, supervisors, and support of the research site team. The survey asked parents' feedback regarding two aspects: 1) the STRONG program and 2) the adjunct parent sessions developed for this study. The survey consisted of statements and open-ended questions to seek feedback from parents on the abovementioned topics of the evaluation. The survey was offered in Arabic, as well as English (see Appendix C).

**Parent focus group.** The parents who participated in the second STRONG group were invited two weeks after the final session for a focus group. The focus group took around 60 minutes to complete and took place online via ZOOM. A STRONG team member from the research site facilitated the focus group in Arabic. The purpose of the focus group was to provide an opportunity for parents to expand on their perspectives and provide specific examples in sharing their feedback about the STRONG program (e.g., perceived benefits for their children) and the parent sessions (see Appendix D).

**Clinician focus group.** The clinicians took part in two focus groups, one after completing each STRONG cohort (see Appendix E). The STRONG clinician and the site manager from the community agency and the researcher (the second clinician of the STRONG groups) participated in the focus groups together. The clinician and site manager from the agency were aware that the focus groups were being conducted as part of the researcher's Master's thesis. The focus groups took around 60 minutes to complete and were facilitated by a STRONG team member from the research site online via ZOOM. The clinicians shared their feedback about the implementation of STRONG in the community. The feedback addressed different aspects of the implementation, the successes, the challenges, the impact on the youth, and the supports that eased the implementation process of STRONG.

**Intervention.** The researcher site and community partner implemented two STRONG groups consecutively; each group consisted of five youth participants and two clinicians. The clinicians remained the same for both groups. One of them was the researcher of this study, who is a counselling psychology student, previously worked at the community agency and have personal experiences as a newcomer. The second clinician was a social worker from the partnering community agency, who has vast experience working with

newcomers. The clinicians received weekly clinical supervision for each of their sessions in STRONG with the youth.

The program consisted of 10 sessions covering the topics from STRONG’s manual (see Table 1). The clinicians consulted with their clinical supervisor to adapt the content and make it developmentally and culturally relevant when it was deemed important for both groups. The secondary manual was used by clinicians for the first group. At the end of each group, an in-person event was hosted to celebrate the youth’s success in completing STRONG. The in-person celebration followed the public health procedures of safety to prevent contracting COVID-19.

In the second group, the clinicians and their supervisor combined the secondary and elementary manual contents to respond to the participants’ developmental needs. The content in the secondary and elementary manuals is very similar. However, the provided presentation (i.e. pictures), examples, and game at the end of the program are different based on the group participants’ ages.

Each participant had an individual journey narrative session. In addition to engaging in strength-based storytelling of their migration journey, they were also screened for PTSD symptoms to see if follow-up care was needed by youth after program completion. Furthermore, Arabic supports were provided by the implementation team whenever youth needed it (e.g., to ease the explanation or to name specific emotional experiences). The clinicians combined the sessions where youth share parts of their individual narratives (i.e., sessions 8 and 9; see Table 1) due to the small number of participants in each group.

**Table 1.**

*STRONG Sessions from the Secondary Manual*

Session	Topic
1	My Inside Strengths and Outside Supports
2	Understanding Stress
3	Common Stress Reactions and Identifying Feelings

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4	Measuring and Managing Feelings
5	Using Helpful Thoughts
6	Steps to Success
7	Problem Solving
Between Sessions 4-8	Individual Session
8 + 9	My Journey Part I + Part II
10	Graduation

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**Parent Sessions.** The researcher, with support and consultation from her supervisors, and the research site team, co-developed the parent sessions. These parent sessions familiarized parents with the STRONG program’s focus and content (see Table 2). Participating parents also practiced some of the coping strategies that their youth were learning in the program. These sessions aimed to create an interactive and culturally sensitive platform for parents to discuss their youth’s stories, strengths, and ongoing challenges. One of the STRONG clinicians facilitated the parent sessions in Arabic, the participating parents’ first language.

The parents were advised to attend the virtual sessions in a private space to ensure their comfort and safety. The parent sessions were designed to take about 45 minutes to an hour. After each session, parents were welcomed to have individual conversations with the STRONG clinicians about any questions or concerns regarding their children’s participation in the STRONG program.

**Table 2.**

*Description of the Parent Sessions*

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<b>Session</b>	<b>Timing</b>	<b>Aims and Focus</b>
Orientation Session	Prior to STRONG start point	Provide information about the STRONG content, research

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		aspect, and included a breathing exercise
Middle Session	Mid-point of STRONG – after session 5 and before session 6	Provide information about the journey narrative session, provide psychoeducation regarding a cognitive coping strategy, and included a breathing exercise
Exit Session	Post STRONG completion	Provide information on community resources, virtual resources, and included a breathing exercise

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## 2.3 Procedure

A CSMH research staff member administered the study surveys and conducted the focus groups. The staff member also obtained research consent from participating youth and parents. The community site obtained programming consent from parents for youth's participation in virtual STRONG. The community organization's manager contacted parents via telephone to introduce the purpose of the STRONG program. The parents were community members that had pre-established relationships with the site through other programs. The manager connected with parents of youth who she thought would benefit from the STRONG program. Furthermore, some parents had informed the site manager of their children's mental health needs and the benefit of building more social connections and enrolling in community programs. Thus, referral forms were completed by the manager for each of the youth and listed how STRONG could be beneficial.

Initially, the manager used the original school-based referral form provided by the research site. However, it was evident that the referral form was not helpful in the community agency's recruitment process (see appendix F). The referral form had a section that requested specific school-related information that the manager could not answer. In the second STRONG group, the research site created an additional community referral document (appendix G). The newly developed document allowed the manager to

comment on the youth's reason for referral more in-depth. Moreover, the manager stated the reason for referral in the form (e.g. enhance social skills, emotional regulation). The manager still filled the initial referral form and disregarded the school-related information.

The program was explained to the parents by the community site manager, and the necessary details were provided (e.g. start date, end date, location, parent sessions). The information was provided again in the Orientation Session by the clinician. Parents of the second STRONG participants were invited to attend adjunct parent sessions of the program and participate in two research activities to evaluate the STRONG program and parent sessions.

### **Ethics and Research consent**

The evaluation protocols were all approved by the University's Non-Medical Research Ethics Board.

#### ***Parent Consent***

The research tasks and activities were explained thoroughly to parents during the parent orientation session by the researcher in Arabic for both groups. The research content and tasks (i.e. letter of information, consent forms, surveys, focus groups) were translated to participants' first language, Arabic, to ensure complete understanding when signed. The team member from the research site met individually with each parent after the orientation session to privately go over the consent form. The parents were informed that participation in the program did not mandate participation in the research. In other words, children could take part in the intervention without being participants in the study. Similarly, parental attendance or participation in the research activities was not mandatory for their child to participate in the STRONG program. The parents provided verbal consent for their children's participation in the research (see Appendix H).

#### ***Youth***

Youth involved in the research were between the ages of 12-14; hence, an assent form was obtained from all the participants (see Appendix I). The STRONG team member responsible for the research tasks met individually with participants after the first

STRONG session, presented the letter of information and obtained their consent. The research activities were explained in their desired language, English or Arabic, and that they can take a part of STRONG without participating in the research.

### ***Clinician Consent***

The clinicians filled out the clinician consent form virtually (see Appendix J). The research activities (i.e. focus group) were explained to the two clinicians before the STRONG groups took place. The clinicians emailed the consent form to the STRONG team member. The partner site manager was invited to participate in the focus group to elaborate on the recruitment process and implementation of STRONG through a community agency.

This study's researcher was one of the clinicians of STRONG and had a pre-existing relationship with the community site based on previous professional experience in the agency. The researcher worked with the other facilitator and manager from the community site in different community group settings, making the researcher familiar with implementing and facilitating programs in the community. The researcher also spoke Arabic and is from the same ethnic background as the participants, and this linguistic connection might have made it easier for participants and their parents to build rapport with the researcher-clinician. To reduce possible coercion or bias, all research tasks related to obtaining consent or collecting data were conducted by a different team member from the research site, who also spoke Arabic.

### **Programming procedure**

The programming schedule, including the research tasks, was outlined on a calendar completed by the research site to ensure the clarity of the process and procedures. The research and community site met prior to the STRONG groups to finalize the calendar. The implementation team met after the groups to debrief the details of recruitment and the process of implementation.

The two STRONG groups were offered consecutively in summer 2020. Two sessions were held weekly for five weeks for both groups. The STRONG clinicians met weekly with their clinical supervisor to discuss sessions' materials and debrief the sessions. The



research and community site met before and after the implementation to discuss and reflect on the details of the implementation and change the strategies as needed for future groups (e.g., recruitment, calendar of the program and research activities, completion of research and program materials).

The STRONG clinicians met with youth participants individually before starting the program to prepare them for the virtual meetings on ZOOM and answer any questions about the program. The clinicians had a checklist document to go over specific information with the participants to ensure their safety and readiness for the program virtually. The information on the checklist document is further explained in this section. The initial meeting introduced the clinician to the participant, explained STRONG materials and program expectations (i.e. attending sessions, virtual participation, content). The clinicians informed the participants of what they need to participate in the program (e.g., a private space if possible, headphones, access to a smartphone, laptop, or tablet that can connect them to the ZOOM application, what to do if they got disconnected). Additionally, the clinician stated that there will be a shared symbol if the youth wished not to participate in any discussion and that a safety check-in will be conducted if needed. The checklist also informed the youth of the research aspect of the program. Before the second group, participants were informed by the clinicians of the parent aspect of the program. The participants received STRONG packages from the community partner manager that included snacks, headphones and a STRONG workbook that the youth used during the program. One of the clinicians created a Snapchat group to ease the connection with participants, mainly to send them the ZOOM links for the virtual meetings.

The program manager delivered a parent package with several resources: STRONG flyer for parents, relaxation activities from STRONG, and research consent forms. The primary source of contact for the parents was the community site manager. The community site manager contacted parents from the STRONG groups and provided information regarding the time and ZOOM meeting links (i.e. place) of all parent meetings. The community site manager made sure that the timing worked for parents, despite their busy schedules. If a parent could not attend a meeting, the manager would reschedule a time for both the parent and facilitator of the parent session to meet and go over the content.

## 2.4 Data Analysis

The quantitative analysis was conducted on the 26th version of IBM's Statistical Package for the Social Sciences (SPSS). A paired sample t-test was conducted to examine whether youth participants reported changes in their resilience, STRONG skills, and social alienation from pre- to post-STRONG. Descriptive analysis (e.g., mean ratings) was used to examine the quantitative information from the parents' surveys.

The focus group data were transcribed, coded and analyzed into themes using thematic analysis. The thematic analysis approach identifies, analyzes, and reports themes or patterns in data (Braun & Clarke, 2006). The researcher adopted a realist method of analysis, where participants reported their experiences and meaning from the study, and themes were then generated through their responses in focus groups. Themes are patterns that capture essential aspects of the data in connection to the research question, and they can be on an explicit level (semantic) or an interpretative (latent) level in the data (Braun & Clarke, 2006).

The researcher followed the six-step approach for thematic analysis from Braun & Clarke (2006). The researcher and a STRONG team member listened to the focus group recordings and transcribed the discussion using an online transcription program, Trint (<https://trint.com/>). The parent focus group was conducted in Arabic. The researcher listened, translated and transcribed the parent focus group content. After the transcription was completed, the researcher and her research supervisor worked independently to develop two codebooks, each on their own, to analyze the data. The coders read through the youths', parents' and clinicians' transcripts independently and highlighted both semantic and latent themes connected to the research questions throughout the groups. The researcher and her supervisor developed data-driven codes to create the codebooks using a five-step model (DeCuir-Gunby et al., 2011). First, reducing raw information by finding themes from focus groups' transcripts. Second, identify subsample themes. Third, compare themes across subsamples. Fourth, create the codes, and finally, determine the reliability of the codes. The researcher and supervisor developed multiple documents with themes, subthemes and codes for each section (i.e. youth, parents, clinicians) independently, and the documents were then compared for any similarities. The

procedure was done to ensure inter-rater reliability. The themes were listed based on the participants' feedback in the focus groups and focus group questions (see Appendix B, D & E). After the themes have been finalized, the researcher matched the themes and codes.

## Chapter 3

### 3 Results

The impact and implementation experience of the virtual STRONG program as evaluated in this study are described in this section. Specifically, the findings are divided and explained in the following categories: 1) youth impact and experience; 2) parents' feedback, and 3) clinicians' implementation experience. Whenever applicable, quantitative and qualitative data were integrated to answer the research questions of the study.

#### 3.1 Youth Impact and Experience

Ten youth took part in the two STRONG groups implemented in the community, and their demographics are described in Table 3. The impact of the STRONG program on youth was assessed using quantitative and qualitative approaches. The study investigated potential increases in resilience, STRONG skills (e.g., deep breathing) and decreases in social alienation after completing STRONG as reported by youth participants.

**Table 3.**

*Demographic information of the youth participants in the two STRONG groups*

Demographic	Total number of participants (n=10)
<b>Gender</b>	
Female	10
<b>Age</b>	
12	5
13	4
14	1
<b>Country/Region of Birth</b>	
Lebanon	1
Palestine	1

Syria	8
<b>Ethnicity</b>	
Arab	8
Kurdish	2
<b>Duration in Canada</b>	
Two years or longer	10
<b>Living Arrangement</b>	
A home with one or more parents or guardians	10

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Quantitative analyses were conducted to examine youth's perceived increases in resilience. As shown in Table 4, analyses conducted with paired sample t-tests revealed no significant changes in resilience, STRONG skills and social alienation as reported by youth participants from pre-to-post-intervention.

**Table 4.**

*Pre- and post-intervention scores on resilience, STRONG skills and social alienation*

Outcome	Before STRONG		After Strong		n	95% CI for Mean Difference		t	p
	M	SD	M	SD					
Resilience	2.42	0.68	2.66	0.83	10	-0.66	1.14	0.60	0.56
STRONG skills	4.14	0.50	3.92	0.47	10	-0.59	0.15	-1.36	0.21
Social alienation	2.75	0.20	2.57	0.35	10	-0.42	1.03	-1.96	0.08

The responses from the youth's focus groups were integrated to further explore the impact of completing the STRONG groups on the youth. The four main themes from the focus groups were (a) favourite STRONG activities, (b) virtual programming had pros and cons, (c) applying learned STRONG skills in real-life scenarios, and (d) perceived benefits of STRONG for newcomer youth. The themes reflected the youth's experience with the STRONG program and its utility for other newcomer youth (see Table 5).

### **Favourite Activities from STRONG**

During the focus groups, youth described their favourite activities and content from the STRONG program. Youth discussed these activities and contents when they were invited to reflect on aspects of the program that were most enjoyable or memorable for them.

The majority of the participants endorsed the in-person celebration as their favourite activity of the program. For example, one participant responded, "The party, because we get we got to meet everyone in person that was like the best thing ... was great making new friends" (Participant 5, Youth Focus Group 2). Another participant stated, "My best activity, like my favourite is when we met, because we got to see each other in person and it was really fun" (Participant 2, Youth Focus Group 1).

During the in-person celebration, STRONG clinicians and participants shared a meal and engaged in recreational activities like arts, crafts and games. Due to the restrictions placed for COVID-19, there were reduced opportunities for the youth to interact and play with peers. Hence, the probable social isolation made the in-person celebration extra memorable for the youth, and they ended the program on a fun and positive note.

Furthermore, there might have been a recency effect, in that the in-person celebration occurred the week before the focus groups, making it very fresh in their minds.

Some youth also shared that they enjoyed learning about the relaxation exercises. The relaxation exercises were breathing and muscle relaxation activities. Many of the youth specifically liked the *deep breathing* and *my calm place* exercises (Hoover, 2019). *Deep breathing* is slowly breathing in and out to regulate your emotions and calm down. Similarly, *my calm place* invites participants to mindfully imagine a calming atmosphere by deep breathing and picturing a safe place of the youth's choosing. One participant

shared, “My favourite activity we did was the deep breathing thing and my calm place ... because they like they helped me with stress and when I am, like, mad” (Participant 1, Youth Focus Group 1).

Lastly, a couple of participants stated that having the opportunity to share their stories at STRONG was also one of their favourite aspects of the program. The youth shared their stories with clinicians and other members of the group after the journey narrative session. One participant said, “Share our story ... how we came to Canada and how we used to live in another country and how we, like, became strong by doing all of that” (Participant 3, Youth Focus Group 1). During the individual journey narrative session, participating youth were encouraged to find strengths from their journey, reflect on their external supports, and choose a part of their stories to share with the bigger group. After sharing with the group, other youth and clinicians reflected and highlighted resilience from each story. The journey narrative session is understood to be a crucial aspect of STRONG programming. Taking a strength-based approach to cohesively organize their migration story, share it with peers, and get their strengths reinforced might have contributed to their growing resilience.

### **Using learned STRONG skills in real-life scenarios**

When asked what youth learned in the program, they mentioned various STRONG skills, including using helpful thoughts, goal-setting, and developing problem-solving steps. However, for breathing exercises, they shared different examples of how they have already begun to use breathing exercises in real-life scenarios. The youth indicated using the breathing exercises in different situations like managing stress in the classroom, anger management, or coping with surgery nervousness. One participant said “I’ve used the deep breathing one ... Not because I was stressed. So me and my sister are doing a surgery next week and I have a test, I don’t know. so, yeah, I use that” (Participant 2, Youth Focus Group 2).

Another participant’s response when asked what STRONG coping strategies she used from STRONG was, “Deep breathing ... I do it sometime, like if I’m in a bad time and I’m really stressed I don’t want to yell and I don’t want to do something, then I just breathe in and breathe out” (Participant 2, Youth Focus Group 1). These response

examples illustrate high acceptability for the breathing exercises learned from STRONG and easy-to-learn self-regulation strategies to deal with stressful situations.

### **Virtual participation had pros and cons**

Youth discussed their experience of participating in STRONG virtually. From their responses, it was clear that the virtual experience had both benefits and drawbacks. The benefits of virtual participation were easier accessibility and enhancing ease for emotional vulnerability. The drawbacks were internet connectivity issues and barriers to non-verbal communication.

In terms of easier accessibility, there was no need for physical attendance, so parents did not have to travel to bring their children to the group site. Instead, participants joined the STRONG sessions using their devices (e.g. laptop, phone, tablet) from home, and this flexibility might have helped ease parents' minds with demanding schedules. One youth shared, "You didn't have to, like, find a way to get there, like if we were doing it in person. Yeah. Like you said on the phone, it's easier" (Participant 1, Youth Focus Group 1). The community site manager ensured that the participating youth had access to an electronic device. Furthermore, before the program began, the clinicians connected with participants and their parents to give them an orientation on how to virtually participate and encouraged the youth to attend the sessions from a private space, if possible.

Another strength of virtual participation was an enhanced sense of safety for the youths to express their emotions. Some youths shared that it felt safe to express emotions in the session because of the ability to mute the microphone or turn off the camera when they were sharing sensitive information, especially during the individual journey narrative session. One participant said, "It was good, because when I told my journey, like, I, I kind of started crying. So I just, like, muted myself a couple of seconds and then like, no, nobody noticed. So that was good" (Participant 3, Youth Focus Group 1).

One of the drawbacks of virtual programming was poor internet connectivity. In both focus groups, youth identified poor or unstable internet connectivity to be a problem for them. Internet connectivity issues likely were frustrating as it was beyond their control to fix it. One youth said, "Sometimes there is like bad WIFI. Sometimes it will cut, and that was the problem. We solved it, and we tried to join every time" (Participant 4, Youth



Focus Group 1). Nonetheless, the youth often would log in again or re-start the Zoom application to continue their effort to participate in the STRONG sessions.

Youth also shared that participating in the program made it difficult to communicate non-verbally. Youth perceived that group members and clinicians would have understood them better if the sessions were in person, where they can perceive both body language and facial expressions. Some of the youths found that virtual participation hindered their expression and caused some misunderstandings. A few of the youth inferred that in-person connections were their preference because it would help clear communication. One participant said, “You can’t explain your expressions online but like when you’re in person you can express it I mean, explain it more like with your body.” (Participant 2, Youth Focus Group 3). This drawback is understandable given that English is the second language for the youth, and they might still be developing their conversational fluency in English.

### **Perceived Benefits of STRONG for Newcomer Youth**

The youth also discussed how STRONG might benefit other newcomer youth. When participants were asked if they would recommend STRONG to other newcomer youth, the responses were clear with “yes” and “of course”; every participant agreed that she would recommend the program. Youth elaborated that participating in STRONG might help newcomer youth practice English, deal with their stress better, provide a space to share their own opinions, and listen to others’ ideas and perspectives.

According to the youth, STRONG was a helpful place to practice their English. One participant shared her personal experience of coming to Canada with limited English comprehension, and thus a program like STRONG would be helpful to learn and practice English. Another participant added, “Yeah, I recommend it to the other students. First thing, the language will help them, too. And sometimes the thing that we will all talk English, sometimes Arabic, like we will understand something” (Participant 4, Youth Focus Group 1).

Some participants indicated that STRONG would help other newcomer youth to learn about stress management and different coping strategies. During the conversation, other participants also added they have not learned about stress management and coping in

their school at their home or transit country. Thus, a program like STRONG would be particularly helpful for other newcomer youth. A few of the youth also shared that some activities in STRONG might motivate other newcomer youth to be strong and brave. One participant stated, “I would tell them STRONG is about activities or even strategies, if they’re mad or they’re kind of sad, they can try it. they can be better and I tell them that it means you should stay strong.” (Participant 4, Youth Focus Group 2).

Finally, youth shared that a program like STRONG can help other newcomer youth to express their opinions and hear and learn other youths’ experiences and perspectives. One of the youth said, “And you will have a lot of fun. ... Because you get to talk about your opinion about stuff because they would ask a question and then you talk about your opinion and hear different people’s opinion because not everyone has the same opinion” (Youth Focus Group 1). One participant noted that STRONG could help build connections and allow a person to speak up, she said that STRONG is “a pretty good program because you meet new people, talk more if you’re too shy” (Youth Focus Group 2)

## 3.2 Parent’s Feedback

### **Parents’ Perceptions of STRONG**

Parents from the second STRONG group participated in the study and provided feedback (n=5). The parent survey scores and their responses in the focus group were integrated to answer the research questions: their perception of the STRONG program and the utility of the newly added parent sessions. The mothers’ responses ranged from *Agree* or *Strongly Agree* for almost all the statements on the parent survey (M=4.48, SD=0.32).

In the focus group, mothers described the utility of the STRONG program and the changes they have observed in their children after program completion and provided recommendations for additional content and activities that, in their opinion, would augment STRONG.

### ***Utility of STRONG for their children***

The first theme was the utility of STRONG for their youth. The mothers responded with aspects of STRONG that helped their daughters. For example, mothers shared that STRONG was useful in teaching their daughters about emotional management and positive aspects of their migration journey and providing further exposure to virtual learning (to help them prepare for virtual school). The psychoeducation provided in STRONG familiarized the youth with their emotions and how to manage them.

In addition, according to the mothers, a notable utility of STRONG was the opportunity it provided for their children to build social connections during times of isolation due to the COVID-19 pandemic. A couple of the mothers commented that STRONG was offered at a crucial time when their children had limited interactions with other peers.

The program was really nice; it gave the girls a chance to get to know each other in a time they needed it. During the pandemic, they were almost isolated and far. They had no social relationships, and they made friendships from this program, which is an important point (Mother 3, Parent Focus Group).

### ***Observed changes in youth***

Mothers identified changes and growth in their daughters as a result of participating in STRONG. The mothers noticed improved personal qualities and increased interpersonal interactions in their children, and the use of learned STRONG skills at home. Examples of improved personal qualities that the mother shared included growth in independence, sense of responsibility, leadership, and problem-solving skills. One of the mothers said, “Even with my daughter with her sister, anything that happens, she would say okay let us see how we can solve this problem. For example, she would take on the role of the leader, let us do that or that. She takes the leader role” (Mother 2, Parent Focus Group).

In terms of increased interpersonal interactions, mothers shared that they noticed increases in conversation initiations among their youth while participating in the sessions over the course of the program. Plus, a couple of mothers also observed that their daughters interacted more with their family members at home. One of the mothers’

stated, “My daughter became more social and she has more contact with her siblings now” (Mother 3, Parent Focus Group).

### ***Acceptability of the Individual Journey Narrative Session***

Acceptability of the individual journey narrative sessions varied among the five mothers. A few saw the journey session as an opportunity for a deeper, enriching reflection of the youths’ migration journey, but one mother had considerable reservations about making their child talk about their past stories rather than moving forward with resettling in Canada.

The mother argued that the journey narrative session was not needed in the program. It would have been better to avoid the migration journey’s negative memories and eliminate mention of the past. One mother said, “I am not saying to not talk about the reason we left; I am talking about the details that our kids might have been through” (Mother 2, Parent Focus Group).

On the other hand, another mother said that it was important for the youth to explore their journey narrative and highlight their strengths during the journey. She said, “You have to give them the strength that the experiences happened to us, and now we are in this situation and to give them hope and strength to stand in the face of difficulties” (Mother 1, Parent Focus Group)”. There was a slight tension between the mothers regarding the acceptability of the journey narrative session, as some saw it as beneficial, and others thought it might not be as helpful to revisit past stories. The tension can be attributed to different experiences faced by youths and their families during their migration journey, which can impact their perspective on revisiting various aspects of their stories.

### ***Recommendations for STRONG***

The mothers had a few suggestions to augment the STRONG program. First, mothers recommended more home practice for their children. They wanted their children to have more structured activities and exercises to practice after every STRONG session. For example, a mother said, “Every time you provide the child with more tasks, their confidence increases because they feel like they are more responsible” (Mother 3, Parent Focus Group).

Second, some mothers asked to add intervention content on learning to accept others' opinions, beliefs, and values. Mothers stated that adding such content might be helpful to reduce bias and prejudice about people from diverse cultural backgrounds. One mother said, "I would like them to learn more about involvement within society and the fluentness of thoughts; these are the things that I like" (Mother 1, Parent Focus Group). By fluentness of thoughts, the mother meant open-mindedness; she would hope for that to be taught to the girls.

### **Utility of the Parent Sessions**

Mothers (n=5) reported high satisfaction with the parent sessions on the survey (M=4.48; SD=0.32). The analysis of the open-ended responses suggested that mothers were happy to be involved in STRONG with their youth. The mothers were appreciative of the parent sessions and space where they could be heard and share their feedback about the program and their youth's progress.

### ***Helpfulness of the parent sessions***

Mothers were invited to provide feedback about whether they found the parent sessions helpful. Specifically, most mothers found it beneficial to be coached on doing the breathing exercises from STRONG and having a safe and accessible space to share their perspectives and connect with other newcomer mothers. One mother commented, "The biggest thing that I enjoyed is the exercises that we did. I really enjoyed them" (Mother 1, Parent Focus Group).

The mothers appreciated a safe space to connect with other mothers and have their voices heard. One mother stated, "You know we are busy with kids and family and the house. Sometimes you feel that you are listening to everyone and no one is listening to you, so this was an opportunity for us to express ourselves" (Mother 3, Parent Focus Group).

Facilitating the parents' sessions in Arabic, mothers' first language, likely made the parent sessions more comfortable and accessible. For example, one of the mothers stated, "I want to say that the most comforting thing for me in these sessions was the language. You know we were very comfortable" (Mother 4, Parent Focus Group). Having the option to express themselves in Arabic likely helped them provide details about their

experiences rather than trying to translate them into English. It is also usually easier for people to talk about sensitive topics in their first language.

### ***Recommendations for STRONG Parent Sessions***

Mothers also shared recommendations for additional STRONG parent session content. In particular, all mothers wanted more than three parent sessions. They thought that the three sessions were not sufficient to get well familiarized with the program. One mother stated, “I honestly felt like they were too little, to be honest. I wished there would be more sessions and get to know the program more. Three were not enough” (Mother 2, Parent Focus Group).

Parents further wanted these additional parent sessions to learn more about emotional management (e.g., becoming aware of one’s emotions, appropriately expressing them) and having more parent-child activities. One mother suggested that the parent sessions could be a helpful platform to improve the parent-child relationship, “I would have liked an activity that can strengthen the parent’s relationship with the child ... This is so important to see how is their behaviour with their parents and how their parent's behaviour is with the children” (Mother 3, Parent Focus Group).

## **3.3 Clinicians’ Implementation Experience**

Two clinicians and a manager from the partner site (i.e., the implementation team) participated in a focus group after each intervention group to discuss their implementation experience and provide recommendations for future STRONG groups. Because of the small number of interviews with clinicians and implementors, and the possibility that quotes could potentially be identifying, an added step of member checking was added in that participants were asked to review the results and provide their approval for the data included. No changes were requested. Four themes were identified from their focus group responses: (1) drivers of implementation success, (2) perceived impacts of STRONG, (3) challenges of implementation and (4) recommendations for future implementations.

### *Drivers of Implementation Success*

The first theme is drivers of implementation success, where the clinicians and the manager shared what made the virtual implementation of STRONG in the community successful. First, clinical supervision was identified to be crucial for implementation success. Clinical supervision guided the clinicians in making the STRONG content and activities more applicable and relevant to participating youth's lived experience, realities and developmental levels. Clinical supervision also helped the clinicians better understand how to continuously adapt the STRONG content and skills within the context of newcomer experience to make the intervention more culturally-sensitive. One clinician's reflection highlighted the uniqueness of the supervision experience:

I think that the unfortunate truth is that sometimes when we're doing cultural adaptations or deliveries to cultural groups, the facilitators, if they have some proximity to those to that identity, cultural identities and whatnot, there's a lot of expectation that you know, in supervision, we're doing some of the teachings because perhaps you know the supervisor may lack a bit of that cultural humility or that cultural knowledge or those pieces or the awareness or understanding. And that's been some of my experience in the past. And so to have [clinical supervisor] with so much of her own lived experience and openness and approach to supervision was absolutely phenomenal. (Participant 1, Clinician Focus Group 2)

Second, the implementation team perceived a strong partnership between the research and community site as the next driver of the implementation success. The research site provided the programming materials, provided logistics and clinical supervision. For example, the research site initiated the creation of a calendar that outlines the timeline of both STRONG groups to further clarify the implementation process. The research site also provided Arabic STRONG flyers for the community partner to share with the parents. On the other hand, the community partner had existing relationships with newcomer families, recruited the youth participants, and connected with parents. The research and community sites each brought specific strengths and expertise that contributed to the successful implementation of these STRONG groups.

One of the clinicians mentioned:

There was a lot of trust and respect for everyone that was involved, and I think a lot of thoughtfulness to the process. And so I think it made it easy to work and know that everyone's intention was the best intention and that there was trust to be able to move forward with the process and manage delays. (Participant 1, Clinician Focus Group 1)

Another driver to the success of the implementation through a community agency was having clear pathways to engage with parents. The community partner manager was the main point of contact with the youth's parents, and she was able to connect them with the clinicians at any point needed. The research site also provided translated materials to ensure understanding of STRONG content (e.g. parent letters). The clinicians also found the parent sessions a helpful avenue to connect with parents by keeping them up to date with presented materials to their youth and answering any questions they might have. The community site manager shared:

I think the overall engagement of moms, I thought that is a solid addition both for girls, but I think also in terms of thinking about if you're doing if you're thinking about STRONG and this is sort of a community-based implementation of STRONG that there are opportunities for further background or further support in terms of engagement with moms. So it was really interesting to hear that ... when they did some of the relaxation exercises with moms that moms were engaged and so when you think about, is there something that we can build off and maybe gear towards parents or towards mothers, that there are elements of STRONG that were, some of what the daughters are learning might be interesting for the moms to learn as well, both for their own personal benefit, but also in terms of the role as parenting with daughters. And so that's something I think that definitely became more evident or something that we're giving more thought to in this group, which I think is great. (Participant 3, Clinician Focus Group 2)

Finally, having clinicians who have had previous professional and personal experience supporting newcomer communities enhanced the implementation of the STRONG



groups. Professionally, both clinicians have provided group programming and individual supports with newcomer youth. On a personal level, the clinicians have experienced firsthand the understanding of racism and islamophobia. One of the clinicians was once a newcomer to Canada, and the other clinician grew up as an ethnic minority. The lived experiences of clinicians were perceived to help relate with participating youth and parents, build rapport and develop meaningful connections. One clinician reflected on this driver of success to the program and added:

Having like personal lived experience, and especially for [another facilitator] as herself being an immigrant, there were many instances where [another facilitator] shared personally and that she could relate exactly to what we were talking about in the curriculum and exactly what the girls were talking about as well. I was born here, but I do have experience in terms of going between [home country], my heritage country and Canada. (Participant 2, Clinician Focus Group 1)

### ***Perceived Impacts of STRONG***

The second theme captured the clinicians' reflections on the perceived impacts of STRONG on the participating youth and clinicians, both personally and professionally. First, the clinicians described the growth that they have seen in the youth while participating in STRONG. They elaborated that youth were perceived to be growing more in their confidence, leadership skills, and being supportive of their peers in both STRONG groups. One clinician said, "I think that I could see a sense of, like, confidence and leadership flourishing in a lot of the girls." (Participant 1, Clinician Focus Group 2)

As well, clinicians shared that youth were using learned STRONG skills in their day-to-day lives. One clinician stated, "one [participant] had even said that she was experiencing something frightening at her home one day and that she had used the deep breathing to help regulate herself." (Participant 2, Clinician Focus Group 1)

Second, clinicians discussed that they experienced professional growth and personal benefits in the process of implementing STRONG. Professionally, the clinicians further understood the mental health needs in newcomer youth in connection to their resilience. The clinicians initially thought that the youths' high levels of resilience reduced their

need for a program like STRONG. However, after the journey narrative sessions, the clinicians further recognized the youths' strengths and STRONG's usefulness for enhancing the youths' emotional awareness and regulation. One clinician stated that the need for this program is essential, even if it does not look like it is

We realized that, in fact, even well-adjusted girls that are presenting as very well-adjusted do have mental health needs and do have different issues that they're dealing with ... So I think that that was something that stood out to me.

(Participant 2, Clinician Focus Group 1)

On a personal level, the clinicians reflected on the connections and relationships developed with the youth, primarily through the journey narrative session. These connections were helpful for providing further suitable support for the youth's needs. One clinician said

After we did the journey narrative, which was I think one of one of the big successes that we didn't mention earlier, even the girls that I didn't necessarily interview with, that [the other facilitator] did, I was still able to hear about their narratives. And I think that really helped me make sense of their personality you know, and so many things. (Participant 2, Clinician Focus group 1)

### ***Challenges of Implementation***

The clinicians identified factors that hindered the implementation experience of delivering STRONG. The challenges were technological issues, accompanied by home-based responsibilities for youth participants and the demanding schedules for parents.

First, technological issues were identified by clinicians to be the primary challenge of the virtual implementation of STRONG in the community. The internet connectivity was weak for some participants, and that was out of anyone's control. One clinician elaborated,

We had, issues like technical issues throughout each session, but I would say we were able to resolve them. And in part, it was because a lot of the girls were well connected to each other and very comfortable reaching out to each other.

(Participant 2, Clinicians Focus Group 1)

Second, home-based responsibilities of the youth might have weakened their participation in virtual STRONG. Some youth had to take care of their younger siblings during STRONG sessions while their parents were at work. One clinician reflected on that as a distraction for the youth,

There were different distractions and mainly siblings. And so for one participant, in particular, I think every session she was caretaking for her younger sibling, which in itself created like a distraction more for her than us. .... I found that it definitely impacted her engagement, as of course, that's expected if you're child-minding. (Participant 2, Clinician Focus Group 1)

The final challenge in the implementation was finding proper timings for parents, given their demanding schedules. There were no parent sessions in the first STRONG group, given the parents' busy schedules. However, the clinicians still connected with parents before the program to explain it before it started. In the second group, the community manager arranged the parent sessions to match the parents' availability. Notably, the parent sessions had to be rescheduled many times to ensure optimal attendance. The community manager stated in response to reaching out to parents from the first group:

A mid-term update [parent session] was a little bit harder to schedule based on their busy schedules and other commitments at home with their kids. So I think that that is a bit of a challenge, and I don't think it's because parents aren't interested in learning or hearing, I think it's just finding the appropriate timing or process or medium that makes it easy. (Participant 1, Clinician Focus Group 1)

### ***Recommendations for Future Implementation of STRONG***

The implementation team also provided recommendations for future STRONG groups in the community. The first recommendation was to create a separate community referral form. Community organizations may not have access to knowledge about participants' social (e.g., friendships at school), interpersonal or mental health needs (anxiety, withdrawal), that the original STRONG referral form asks for school-based implementation. The recruitment for these community groups mainly depended on whether newcomer parents were interested in having their child participating in a program like STRONG.

And with these programs like so maybe for some students based on prior relationships with schools where they were sort of already identified as students of interest ... in terms of addressing some of the questions in the referral form. But the other students, as some of the other girls are participants, I think was really just through community connections ... I think maybe that's sort of more comprehensive assessment leading into the program with a little bit harder in this instance to obtain. (Participant 1, Clinician Focus Group 1)

The second recommendation is to incorporate holistic evidence-based care into STRONG. In this community implementation, the clinicians adjusted the manual content based on each STRONG participants' needs. Clinicians and their clinical supervisor added examples and activities to meet youth's developmental needs—especially examples of scenarios that meaningfully connect with youth participants' lived experience, culture, and spirituality. The clinicians suggested individualizing contents and examples based on each group's needs, such as extending or changing a particular activity. One clinician stated

There is a recommendation ... to adjust based on, for example, the age of the girls in terms of just explaining the materials ... we could not always stick to the manual in terms of examples, we had to integrate our own examples sometimes (Participant 2, Clinician Focus Group 2).

## Chapter 4

### 4 Discussion

Newcomer youth and families often face barriers to accessing mental health supports in the community (Colucci et al., 2015). In an effort to minimize some of the accessibility barriers, we examined the feasibility of implementing STRONG virtually with newcomer youth whose families had pre-existing connections with a community organization. Specifically, the study examined youth impacts, implementation successes and barriers, and the feasibility of engaging newcomer youth. Three parent sessions were added by the research site team, and we conducted a preliminary evaluation of their utility. In this chapter, the study's discussion and implications are described.

#### 4.1 Impact on Newcomer youth

The STRONG program in the community provided a structured virtual space for newcomer youth to participate in a resilience-focused mental health intervention. While there were no significant quantitative changes in youth-reported resilience, STRONG skills, or social alienation from pre-to-post-STRONG, the lack of statistically significant findings might have been in part because of the small sample size. Furthermore, there is a need to further test and develop measures. The youth rated themselves very highly on the resilience measure prior to the intervention (i.e., higher than 4 out of 5).

In contrast to the quantitative findings, youth reported various benefits of participating in STRONG during the focus group. The participants shared their favourite activities from STRONG, newly acquired coping skills, and recommended STRONG for other newcomer youth. The youth indicated that STRONG was a place to make friendships, share their stories and opinions, and hear from other newcomer youth. The findings echo the impacts of previous STRONG pilots on newcomer youth, where participants reported enjoying the program, gaining coping skills and developing a sense of belonging (Crooks et al., 2020c). The implications of these results indicate that providing a mental health intervention through a community agency is helpful for newcomer youth.

The qualitative results indicated increased social connections within the youth during the COVID-19 pandemic. It is essential to keep this pandemic's current situation in context to interpret the study's findings. The restrictions put in place as a result of the COVID-19 likely impact youth's mental well-being. The pandemic disrupted structured activities (e.g. school), reduced the quality of peer interactions affecting friendships and other relational assets and increased overall social isolation (Courtney et al., 2020). In conversations with the community partner manager, we learned that many newcomer parents were concerned about how isolated their youth were.

The virtual implementation of STRONG addressed various needs for newcomers during the pandemic, such as building friendships and learning coping skills. Virtual STRONG created an avenue for the youth to learn and apply coping strategies that can help increase their inner strengths, such as using deep breathing to manage stressful situations. Clinicians leading the groups invested their efforts to ensure that the youth understood STRONG concepts, coping skills, and when their use can be utilized. Clinicians ensured the youths' understanding by asking if they needed to clarify concepts and provided explanations as needed during sessions. Some youth offered to explain concepts to one another. It is important to note that the clinicians were culturally aware of the youth's backgrounds and were mindful of the examples they shared with the group.

The youth stated in the focus groups that they learned coping strategies, relaxation exercises and other skills virtually (which interestingly, was not reflected in the pre- and post-intervention scores on the STRONG skills measure). In the future, it is essential to continue emphasizing body-based practices like deep breathing, as the youth indicated using them in their day-to-day life (e.g. school, home, stressful situations).

## 4.2 Services for Newcomer Parents

The pre-established trust between the community site and members of the newcomer community enhanced the accessibility of the program for newcomer youth and families. This finding confirms previous research suggesting that the trust between parents and community agencies can increase the likability of participating in community-based interventions (Este & Van Ngo, 2010).

The study findings highlighted parents' satisfaction with the STRONG program and the newly added parent sessions. Examining the impact of STRONG on newcomer youth from another informant (i.e., parents) was important in understanding the potential changes and growths that others observe in youth in different settings as a result of participating in the program. Overall, the parents highlighted the utility of STRONG for their youth, especially during the global pandemic. Parents shared observations of benefits from STRONG on their youth, such as increased social connections, teaching relaxation techniques to siblings at home, taking a leadership role to solve problems and more. The parents also provided feedback on additional content for STRONG, such as lessons on acceptance to reduce prejudice within the youth.

Notably, having parent sessions provided an explicit mechanism for STRONG parents to be involved with the intervention. Past research indicated that parents are essential for assisting their children and youth in maintaining their mental well-being and resilience (Cureton, 2020; Courtney et al., 2020; Pieloch et al., 2016). Parental involvement in interventions has been shown to enhance the intervention's impacts on their youth (Haine-Schlagel et al., 2012). The sessions were also designed to expand the parents' knowledge of STRONG's content and purpose and provide intentional ways to connect with the clinicians and other newcomer parents. In past research, Cureton (2020) highlighted that newcomer parents have limited opportunities for involvement with their children's school-based services due to barriers such as language differences. As such, the implementation team in the study used various approaches to reduce accessibility barriers. The community site manager reached out to the mothers to find a time suitable in their schedules for the parent sessions. Members of the research and community sites were flexible with rescheduling the parent sessions or providing the information individually, which was essential to ensure that the parents' attendance was not preventing them from doing something else of a higher priority (e.g. working, taking care of children).

Newcomer parents' inconsistent attendance to appointments or sessions should not be immediately interpreted as their disinterest or lack of engagement with their children's services or program. Despite their busy and hectic schedules, the newcomer mothers in the study wanted more parent sessions for STRONG. They expressed interest and

curiosity to learn more about the program and do activities with their children. In the future, it might be helpful to add individual and group drop-in sessions to accommodate the parents' needs and differing schedules. STRONG developers may also consider augmenting the parent sessions by adding content on trauma, emotion regulation, and parent-child communication.

The COVID-19 pandemic has had negative impacts on parents, with the increased expectations of providing care at home, assisting with virtual schooling, processing losses, dealing with their own mental and financial stressors (Courtney et al., 2020). These added responsibilities might have taken a toll on newcomer parents' mental health, who might have to work multiple jobs to ensure financial stability and have less access to economic and social resources (e.g. strong internet, electronic devices). Hence, newcomer parents might need resources and services that can assist them during the pandemic to take some of the responsibilities off of their plates. The community partner and clinicians from the research site provided the parents with a list of resources that they can access in the community or at home during the last parent session to help in times of need.

The mothers in the study also wanted more information about the narrative journey session and mental health. One particular mother had reservations about their child retelling their story from the past. It is understandable that for some newcomer parents moving to Canada symbolizes moving forward, and in their perception, remembering past events might hinder their resettlement process. In the future, it may be helpful to provide psychoeducation on trauma and strength-based approaches to reconstructing challenging experiences in parent sessions. Specifically, providing psychoeducation about the benefits of talking about trauma as a way that highlights the youth's inner strengths and facilitates healing (Miller et al., 2019). Further, it may be helpful for parents to know that youth sharing their hardships with professionals allows a place for their stories to be validated while emphasizing their unique roles and resilience (Miller et al., 2019). Hence, mental health professionals facilitating parent sessions should spend time and engage in appropriate rapport-building exercises to develop trust with parents and be clear about their credentials and experience.



### 4.3 Virtual Implementation Experience in the Community

Overall, the research found that the implementation experience of virtual STRONG through a community agency was positive from the perspective of all stakeholders. Given the impact of the COVID-19 on youth's mental well-being, Courtney et al. (2020) urged researchers and practitioners to prioritize the delivery of mental health interventions online. The need was recognized to be more urgent for youth who are at-risk due to systemic adversities, like newcomer youth. Even in virtual programming, implementers maximized their efforts to make the intervention space culturally sensitive and promote a sense of belonging and connectedness, (Pioloch et al., 2016). STRONG's main focus is youths' resilience and providing them with appropriate sociotherapy to help enhance their well-being. The clinicians also provided cultural adaptations with the youth to facilitate a sense of belonging. The implementation team took steps that made the intervention process safe and relevant virtually, such as: providing parent packages that eased the youths' understanding of lessons and home practice and calling parents and youth prior to the program to introduce themselves and the program. The clinicians also used various engagement tools to ensure the understanding of participants to session contents and extended or changed certain activities to suit virtual implementation.

The virtual success of the program can also be attributed to its structured base. STRONG is a manualized intervention, and clinicians used the manual as the primary source of guidance to sessions. Clinicians followed the guidelines from the manual and adapted some of the content to suit the group members' developmental needs and unique experiences. The findings suggest that clinicians should be aware of their group members' backgrounds, experiences, and ages and provide adaptations to deliver suitable material. In future research, it is recommended that clinicians and clinical supervisors are mindful of the participants' experiences and developmental stages to provide the best practice to newcomer children and youth.

The strong partnership between the research and community sites largely contributed to the success of the virtual STRONG groups. Past research suggests that a strong collaboration between researchers and community stakeholders is necessary to deliver programs in the community (Chambers & Azrin, 2013). The results suggested that

partnering with a community agency that serves newcomer youth and families helped reduce some accessibility barriers to the newcomer population.

Community organizations have committed, and hardworking staff but often are overwhelmed with many responsibilities on their plate and have limited funding (Paulsen, 2003). The research site supported the community site by providing funding for STRONG implementation that helped with hiring staff, printing translated materials for participants and covering other costs of delivering the program (e.g., program packages for youth). The research site also outlined the logistics with the community-site manager, provided a clinician and clinical supervision. The community site has connections and a trusted reputation within the community. The community site manager recruited newcomer youth and parents to the program. These findings support the existing literature and highlight collaborative and supportive partnerships are essential in successfully bringing new programs to the community.

The STRONG clinicians' and clinical supervisor's existing cultural competence was essential while running the STRONG groups. Further, their cultural understanding enhanced their thoughtfulness regarding the newcomers' experiences and assisted with providing suitable care. This implies for future STRONG practices to highlight the importance of cultural competence while facilitating STRONG and incorporating it in training future clinicians.

In connection to culturally competent practices, it would be helpful to incorporate aspects of the community-centred evidence-based practice (CCEBP) approach to future community implementations (Serrata et al., 2017). The clinicians from the community implementation made modifications and adaptations to the STRONG manual to better suit the participant's experiences. Adopting clients' needs aligns with the community-centred evidence-based practice (CCEBP) approach (Serrata et al., 2017). Moreover, the CCEBP approach combines evidence-based practice (EBP) with culturally relevant evidence from community members to best deliver an intervention (Serrata et al., 2017). The CCEBP approach addresses the modifications needed in culturally specific community-based work (Serrata et al., 2017). This model can help STRONG in the future because it

prioritizes community expertise and provides the clients with culturally appropriate services and materials.

#### 4.4 Strengths of Research

The study possessed multiple strengths that would not have been possible if it was not for the research and community site teams. First, the biggest strength was implementing the mental health intervention on a virtual platform in the community. The virtual implementation took time and planning. This research study provided a safe and accessible mental health platform where youth felt connected during an isolating period. The implementation team decided on a small group number to ensure and manage all members' safety and participation. The additional parent component also provided a place for the parents to connect and express themselves during the pandemic. The clinicians and clinical supervisor provided cultural and developmental adaptations to various aspects of the program content to ensure best practices were delivered to newcomer youth.

#### 4.5 Limitations and Future Directions

Despite the various strengths of the present study, it has some limitations, which are essential to consider and interpret. Some of these limitations provide important directions for future research.

##### **Youth Characteristics**

The youth sample size was small, thus, the results of the present study should be interpreted with caution. Only two virtual STRONG groups were implemented through a community agency for this evaluation. Each group had five participants; having smaller groups allowed the clinician to individually check in with youth about their understanding of concepts. Plus, the groups had a small enough number to have thoughtful conversations and allow the participants to reflect on their examples during sessions. A number higher than five youth might have been harder to control, reach out, and allow everyone to share within the hour. The number was suitable on a virtual platform; however, the STRONG groups can have 10 participants in a physical setting. It

would be helpful for future virtual implementations to study the impact of STRONG on more groups or evaluate whether a larger group size moderates the virtual impact of STRONG on youth.

The youth participants were also all females from the middle east, despite the initial proposal of piloting one female and one male group in the community. Mothers of the participating youth enthusiastically responded when the organization promoted the program within their networks. The community site manager also indicated that newcomer parents would be more comfortable with an all-girls group for their daughters to take part in on a virtual platform. Future STRONG evaluation can examine whether youth impact and program experience differ between same-gender and mixed-gender groups.

Future research needs to investigate the impact of STRONG on newcomers from different ethnic backgrounds. The youth in the study were pre-adolescents or older children (i.e., elementary-aged). Thus, it would help future STRONG evaluators to explore the impacts on older adolescents and younger children and observe the groups' dynamics. It is important to evaluate the impacts of STRONG contents and coping strategies on different age populations to gauge the effectiveness of the content on different newcomer groups.

The quantitative results of the study might have been limited by response shift bias. Response shift bias is a phenomenon that occurs when the participants' understanding of the concept being measured (e.g. emotional regulation) changes between the pre and post-test as a result of the intervention or educational program (Drennan & Hyde, 2008). For example, the youth believes they fully understand how to manage their stress, but they recognize that they can still improve their stress management skills after the program. At pre-test, many of the youth ranked their resilience and coping skills pretty high, suggesting that they might have either overestimated or misperceived what those skills were. For example, during the intervention, it was clear that STRONG was one of the first platforms to introduce thoughts, emotions, physiological sensations, and interconnectedness to the participants. It is also important to note that the research site

provided Arabic support to participants during the survey administrations to ensure their understanding of the questions.

Nonetheless, the sample size was small, and it is harder to attain statistical significance with smaller group sizes. The information from the focus groups gave the researcher a different insight, indicating the perceived utility of STRONG skills after the intervention.

### **Parent Characteristics**

The study also had a small sample size for parents, where only parents from the second STRONG group participated in the research. Parents from the first community group had overwhelming schedules and multiple demands, and thus, they were not able to attend the sessions.

### ***Demographics***

The mothers in the second group were all middle eastern, and sharing similar backgrounds likely strengthened their rapport and relatability. However, future parent sessions can further explore the feedback and perspectives of parents from different ethnicities. It is important to note that different migration experiences, hardships, and cultural attitudes can alter the STRONG program's perceptions.

The community site manager's first point of contact for the youth in these groups was the mothers, which might have influenced the all-mother participation in the group. The mothers taking part in the sessions were comfortable with an all-female and group facilitators with the same ethnic background. Future research could explore group dynamics, perceptions and feedback on STRONG and the parent sessions from both parents or mixed-gender parent groups.

### **Implementation**

The implementation of STRONG through a community agency had limitations and delimitations outlined below. Limitations are potential restrictions to the research study caused by factors out of the researcher's control (Theofanidis & Fountouki, 2018). The limitations in this study entailed the dual position of the researcher being the clinician in the intervention and implementing a limited number of STRONG groups in the community. Delimitations are the limitations set by the researcher to facilitate the process

of the study (Theofanidis & Fountouki, 2018). Delimitations of this study included the challenges that might have impacted the implementation experience of STRONG due to pivoting it virtually implementing STRONG.

The main limitation of STRONG's implementation in the community was the dual role that the researcher took as both the clinician and the researcher of this study. The researcher took precautions with the assistance of the research site team to ensure ethical data collection and unbiased data analysis. The research tasks (i.e. focus groups, surveys) were completed with participants by a team member from the research site. The researcher and her supervisor also conducted data analysis to reduce bias and enhance transparency. While this is a limitation, there was a helpful point of view for the dual role. The researcher-clinician had experience facilitating groups with newcomer youth and families at the partner community agency, which familiarized her with community group implementation. The researcher also spoke Arabic and identified with the same ethnic background as the participants, which increased her cultural awareness of the participants' experiences.

Although the present results support the virtual implementation of STRONG in the community, there were several applicable delimitations. The researcher chose to implement the program virtually due to the pandemic, rather than waiting until the pandemic was over. This decision was made based on the crucial need for a mental health intervention for newcomer youths in the community.

It was the first experience for both the research and community sites to deliver STRONG online. Virtual implementation required extensive time for preparation, actual delivery, and debriefing after each session. For example, if one of the participants or clinicians has poor connectivity with the internet network, it can interfere with the flow of the lesson for everyone in the group. If the call disconnects from one of the youth, one clinician has to reach out to their parent or to the youth to ensure their safety; an interference that is unlikely to occur during in-person sessions.

Further, the sessions can take a longer time online; in the second STRONG group, the implementation team decided to extend the length of the sessions to 90 minutes. The team made this change to allow more time for youth to grasp concepts and participate

comfortably. There were times in the first group where the sessions went overtime to ensure the youth understood the concepts and coping strategies clearly. In future research of virtual implementation, it would be helpful for clinicians to be aware of the time and use their clinical judgment while conducting sessions to prioritize main concepts if they ran out of time.

### **Conclusion**

Despite these limitations and delimitation, the present study has enhanced the understanding of the virtual implementation of STRONG in the community for newcomer youth, specifically during a global pandemic. As well, it indicated the need for more services directed to newcomer parents in the community. Finally, it highlighted the effectiveness of having a solid partnership between the research and community sites to complete a successful implementation.

## Chapter 5

### 5 Summary

In summary, this research contributes to understanding the need for STRONG in the community for newcomer youth and parents. The researcher's goal was to evaluate the feasibility of an accessible mental health intervention for newcomer youth in the community. It investigated the feasibility of implementing a Tier-2 mental health intervention, STRONG, on a virtual platform through a community agency. It also measured the impact of the STRONG program on newcomer youth's resilience, social alienation and STRONG skills. Finally, it explored parents' feedback of the intervention and newly developed parent sessions.

The results indicated that it is feasible and valuable to implement STRONG virtually, but a strong partnership between the research and community sites is needed. Youth benefitted from STRONG by building social connections during the global pandemic. Likewise, mothers indicated satisfaction with both STRONG and the parent sessions. Mothers indicated perceived benefits on their children from the program and enjoyed having an inclusive and safe platform to be engaged with other newcomer mothers. Overall, the virtual implementation of STRONG with the additional parent sessions helped newcomer youth and parents in the community.



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# Appendices

## Appendix A

STRONG Survey – Pre-Post<sup>2</sup>

Pre-STRONG Survey

Student name (first and last) \_\_\_\_\_

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<sup>2</sup> Kindly refrain from using the CD-RISC out of this study, it is not permissible unless purchased.

## STRONG Youth Survey (For Students Ages 11+)

This survey includes questions about how you cope with stress; positive mental health and well-being; social supports; self-esteem; who you might seek support from; and questions about your identities. There are no right or wrong answers. Take your time and please answer each question based on what you really think. All of your answers will be kept private. Your name is not included on any part of this survey and it will not be used in any report. Completing this survey is voluntary. At any time, you can choose not to answer this survey. If you are not comfortable answering a question just go on to the next one. Completing the survey has no influence on your participation in any other programs.

This survey has four sections, labelled A, B, C, and D. In each section, please read the statements carefully, then write an "x" in the box that best indicates your answer.

### Part A.

Please mark an "x" in the box that best indicates how much you agree with the following statements as they apply to you over the last month. If a particular situation has not occurred recently, answer according to how you think you would have felt.

	Statements	Not true at all	Rarely true	Sometimes true	Often true	True nearly all the time
1	I am able to adapt when changes occur.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	I can deal with whatever comes my way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	I try to see the humorous side of things when I am faced with problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Having to cope with stress can make me stronger.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	I tend to bounce back after illness, injury, or other hardships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	I believe I can achieve my goals, even if there are obstacles.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Under pressure, I stay focused and think clearly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	I am not easily discouraged by failure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	I think of myself as a strong person when dealing with life's challenges and difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	I am able to handle unpleasant or painful feelings like sadness, fear and anger.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Part B.**

Please mark an "x" in the box that best indicates how much you agree with the following statements as they apply to you over the last month.

	Statements	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
1	I am able to identify my strengths.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	I can identify people and/or places where I can receive support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	I understand common reactions to stress.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	I understand how to reduce my stress.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	I understand how to relax and stay calm.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	I can identify and manage my feelings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	I can distinguish unhelpful from helpful thoughts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	I understand how thoughts, feelings, and actions are connected.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	I understand how to set goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	I understand how to problem solve.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Part C.** Please mark an "x" in the box that best indicates how much you agree with the following statements.

	Statements	Strongly Agree	Agree	Disagree	Strongly Disagree
1	I sometimes feel that the teens I know are not too friendly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Most of my academic work in school seems worthwhile and meaningful to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	I sometimes feel uncertain about who I really am.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	I feel that my family is not as close to me as I would like.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	When other teens I know are having problems, it's my responsibility to try to help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	I often wonder whether I'm becoming the kind of person I want to be.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	It's hard to know how to act most of the time since you can't tell what others expect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	I often feel left out of things that others are doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Nowadays you can't really count on other people when you have problems or need help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Most people don't seem to accept me when I'm just being myself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	I often find it difficult to feel involved in the things I'm doing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Hardly anyone I know is interested in how I really feel inside.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	I generally feel that I have a lot of interests in common with the other students in this school.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	I often feel alone when I am with other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	If I really had my choice I'd live my life in a way that I do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Part D.**

1. What is your age? \_\_\_\_\_
2. What is your gender? \_\_\_\_\_
3. What is your country of birth? \_\_\_\_\_
4. What is your race/ethnicity? \_\_\_\_\_
5. How long have you lived in Canada? Please mark an "x" in the box below that best indicates your answer:
  - Less than three months
  - Four to seven months
  - Eight to eleven months
  - One year or longer
  - Two years or longer
6. What best describes where you live? A home includes a house, apartment, trailer, or mobile home. Please mark an "x" in the box below that best indicates your answer:
  - A home with one or more parent or guardian
  - Other relative's home
  - A home with more than one family
  - Friend's home
  - Foster home, group care, or waiting placement
  - Hotel or motel
  - Shelter, car, campground, or other transitional or temporary housing
  - Other living arrangement



## Appendix B

### Participants Focus Group Questions

#### STRONG Focus Group Protocol and Questions for Participants

Facilitator introduces self.

[Introductory script]. We are here today for a focus group about the STRONG program and your experiences with us. A focus group is a conversation where I have some questions and you can answer them and respond to other students' answers. You do not need to answer every question. It is important that information shared in this focus group is kept confidential. Do you have any questions before we begin?

The first questions are about the STRONG program.

1. To begin, what was your favourite activity or the best memory you have from the STRONG program?
2. What were the most important coping skills and/or strategies you learned from the program?
3. What did you not like about the program or what did you find challenging or unhelpful? What could be done to improve that part of the program?
4. How was your experience with completing the STRONG program online?
5. Would you recommend the STRONG program to other students who are new to Canada, and if so, how would you describe your experience with the program to them?

\*Summarize main points

6. Is my summary of our group's discussion accurate or have I missed any important points?

Final Question

7. Is there anything you didn't get a chance to say that you would like to share?

## Appendix C

## STRONG Parent Survey



# STRONG

Supporting Transition Resilience of Newcomer Groups

## Parent/Caregiver Survey

Please mark the answer that best describes your experience

Part A. Please check (✓) the box that is the best answer.

Questions	Strongly Disagree 1	Strongly Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
This program has been helpful to my child.					
I would recommend this program to the parents/caregivers of other newcomer children.					
Since participating in this program, my child seems more resilient					
Since participating in this program, my child is better able to manage their emotions					
Since participating in this program, my child has more positive interactions with other people					
Since participating in this program, my child uses problem solving strategies					
This program has helped my child at home.					
This program has helped my child in school/community					



**Part B.**

1. Please check of the circle in the range below in response to each question:

	Strongly disagree				Strongly agree
	1	2	3	4	5
The information provided at the parent/caregiver sessions helped me to understand my child better	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The strategies I learned about in the parent/caregiver sessions helped me to support my child better when they are having challenges at home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would have liked more parent/caregiver sessions (i.e., more than 3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The facilitators were knowledgeable about the content of the parent/caregiver sessions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The parent/caregiver sessions were an important part of the STRONG program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The parent/caregiver sessions were well organized and easy to understand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I received helpful materials / handouts as part of the caregiver sessions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The parent letters were clear and helpful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Is there something you would like to add about the parent/caregiver sessions that can help us in the future? (what did you like, dislike, would like to see more of, etc.)

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**Part C. Answer the following questions based on your reflection of the program**

1. The most noticeable change I have seen in my child (if any) is

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2. The most helpful aspect of the program for me was

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3. The most important thing that my child has taken away is

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4. In the future, I hope that my child

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5. Please feel free to share any other thoughts or recommendations about STRONG

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6. Please feel free to share any other thoughts or recommendations about the parent/caregiver sessions

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## Appendix D

### Parents Focus Group Questions

#### STRONG Focus Group Protocol and Questions for Parent/Caregiver Participants

The facilitator introduces themselves.

[Introductory script]. We are here today for a focus group about the STRONG program and your experiences with us. A focus group is a conversation where I have some questions, and you can answer them and respond to other parents'/caregivers' answers. You do not need to answer every question. It is important that the information shared in this focus group is kept confidential. Do you have any questions before we begin?

The first questions are about the STRONG program.

1. To begin, what did you like most about the STRONG program?
2. What did you think of the topics of the sessions done with your child? (A follow-up statement can be: based on the weekly parent letters your child might have shared with you that summarizes the content of the sessions)
3. Is there something that you felt was missing from the STRONG program, that you wanted your child to learn more about? If so, what additional skills/topics do you wish the program offered to your child?
4. Can you comment on any changes you noticed in your child at home after being a part of STRONG?
  - a. What new skills are they using at home?
  - b. Have you noticed any differences in ways that your child is interacting with you, siblings, and other family members? If so, how are these interactions different?
5. Would you recommend the STRONG program to other families who are new to Canada, and if so, how would you describe your experience with the program to them?

Now I have some questions about your experience as a parent/caregiver in the parent's/caregiver's sessions

6. What did you like about the parent/caregiver sessions?
7. What did you enjoy learning from the sessions?
8. What did you not like about the parent/caregiver sessions?
9. What would you change about the parent/caregiver sessions (e.g., length, number of sessions offered, more or less structured)?
10. What other recommendations do you have for the parent's/caregiver's sessions?

\*Summarize main points

11. Is my summary of our group's discussion accurate or have I missed any important points?

Final Question

12. Is there anything you didn't get a chance to say that you would like to share?

## Appendix E

### Clinician Focus Group Questions

#### STRONG Evaluation

##### Clinician Focus Group Questions

*Preamble:*

Thank you for agreeing to participate in this focus group. We are interested in collecting your experience and wisdom based on your involvement in the initial pilot of the STRONG program. Please remember that it is important to maintain confidentiality of what is discussed in this focus group so that participants can feel safe to express any views and experiences. Are there any questions?

1. Overall, what were the biggest successes of the STRONG pilot?
2. What were the biggest challenges?
3. Do you have any specific examples of progress that you observed among participants?
4. Did this experience change the way you think about the mental health needs of newcomer youth and what is effective? In what way?
5. Can you describe the support you received? Can you tell me about the recruitment/referral process?
6. Are there additional supports that would be helpful for implementing this programming?
7. How was your experience facilitating the STRONG intervention virtually?
8. Do you have any recommendations for improving the STRONG program?
9. What advice would you give to clinicians just starting to use STRONG?
10. Is there anything else you want to share with us about the pilot?

Version date 07/22/2020

## Appendix F

## STRONG Referral Form A

**STRONG Referral Form****About STRONG**

**STRONG** is intended for newcomer students who are experiencing difficulties functioning or coping and/or who may benefit from additional skill development.

**Newcomer Status - STRONG** is recommended for students who have migrated to a new country. Although newcomers are generally defined as those who arrived in the last five years, eligibility for **STRONG** does not depend on a specific time period since arrival.

**About this form**

The questions on this form help the STRONG clinician understand whether STRONG is a good fit for an individual student. The person completing this form should have some familiarity with the student. Please complete the questions to the best of your ability. If you are unsure, please select "?" to indicate "don't know".

**About the Referral**

Student name and age: \_\_\_\_\_

What is your relationship with the student? \_\_\_\_\_

How did you hear about STRONG? \_\_\_\_\_

**Student's Background**

What is the students' first language? \_\_\_\_\_

When did the student arrive in this country? \_\_\_\_\_

When did the student enroll in this school? \_\_\_\_\_

**Students' Current Functioning**

Is the student exhibiting difficulties in any of the following areas?

Academics			
Attendance	Yes	No	?
Grades	Yes	No	?
Classwork completion	Yes	No	?
Homework completion	Yes	No	?
Peer relationships			
Hard time making and/or sustaining friendships	Yes	No	?
Participation in activities	Yes	No	?
Family relationships	Yes	No	?
Relationships with other adults (teachers, community members)	Yes	No	?

Is the student exhibiting behaviour issues at school, home and/or community?

Disruptive behaviour	Yes	No	?
Absenteeism/Avoidance	Yes	No	?
Lack of participation	Yes	No	?



## STRONG Referral Form

Does the student appear:

Sad	Yes	No	?
Anxious	Yes	No	?
Isolated/Withdrawn	Yes	No	?
Fearful, distrustful, apprehensive	Yes	No	?
Inattentive	Yes	No	?
Hyperactive	Yes	No	?
Impulsive	Yes	No	?
Angry/hostile/destructive	Yes	No	?

Physical problems:

Is the student complaining of physical problems (e.g., headaches, stomach aches)?	Yes	No	?
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### Student's Strengths

What are some of the student's strengths?

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### Other Circumstances

We would like to know about other circumstances to help us better understand the student's experience:

Does the student have stable housing?	Yes	No	?
Does the student experience food insecurity?	Yes	No	?
Can the student converse in English or French?	Yes	No	?
Does the student have additional health considerations?	Yes	No	?
Does the student have other significant role responsibilities (like childcare, part-time employment, etc.)	Yes	No	?

Other comments

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Appendix G

STRONG Referral Form B



STRONG Recruitment Form

Name	
Role at Organization	
Name of Organization	
Date	



	Participant Name	Age/ Grade	Reason(s) for Recruitment <i>(i.e. What could be further enhanced through participation in STRONG?)</i>	Has the participant been previously involved in youth programming at your organization? If so, please specify.	Participants' Areas of Strengths	Additional Comments
1						
2						

## Appendix H

### Guardian Letter of Information & Consent Form



**Project Title:** Supporting Transition Resilience of Newcomer Groups (STRONG): A school-based intervention to promote wellbeing

**Document Title:** Verbal Consent form for guardians

**Principal Investigator:**

Claire Crooks, PhD, Director of Centre for School Mental Health  
Faculty of Education, Western University

#### Letter of Information About the Study

**Invitation to Participate**

You are invited to participate in a research study because your child is participating in the STRONG program for newcomers at their school.

**Purpose of Letter**

This letter provides information so you can make an informed decision about participating in this research.

**Purpose of Study**

We are studying the STRONG program to learn how well it worked, to identify any challenges, and to look for possible improvements. We want to know whether students are engaged in the program, and if they learn how to cope with stress.

**Inclusion Criteria**

If you have a child participating in a STRONG group, you are eligible to participate in this study.

**Study Procedures**

As part of the STRONG program, the group leader will collect some information about your child from the person who refers your child to the program. If you agree on this consent form, this information will be shared with our research team. **Information about your child will be kept confidential.**

Students will be asked to complete surveys that ask about their resilience and wellbeing. These surveys will be provided in English, French or Arabic depending on your child's preference. Students will complete the survey online. Your child will complete the online survey during the first and last session of the STRONG program. During the sessions, your child will receive an electronic link to the survey.

Your child will also be invited to participate in a discussion group at the end of the STRONG program. The discussion group will take place over Zoom, a video conference software, with a research staff member. Your child will be instructed to keep your video off throughout the duration of the discussion group and the video file will be deleted immediately following the focus group. If your child participates in the discussion group, they can choose not to answer any questions they are not comfortable answering. If you are not willing or comfortable in having your child being audio-recorded, then please know that you do not have to provide consent for your child to participate in the discussion group.

The discussion group will last approximately 1 hour. It is mandatory for the discussion groups to be audio-recorded to accurately capture participants' responses. The information provided in the discussion group will be reported as summarized group data and will not be linked to your child's



identifiable information. Direct quotes may be used in the reported findings but will not be linked to your child's identifiable information.

If you agree to participate in this study, you will be asked to:

1. Allow the group leader to share why the child was referred to the STRONG program.
2. Give permission for your child to complete surveys before the STRONG program starts and at the end of the program
3. Give permission for your child to participate in a discussion group if one is held on ZOOM

#### **Possible Risks and Harms**

There are no known or anticipated risks or discomforts associated with participating in this study. It is possible that your child might feel bored completing the surveys or feel some stress if it is difficult for them to read the survey questions.

#### **Possible Benefits**

There are no personal benefits for participating in this study. The information you provide will help us improve group interventions for newcomer youth.

#### **Voluntary Participation**

Participation in this study is voluntary. You child can still participate in the STRONG program if you decide not to participate in the study. You do not lose any legal rights by signing this consent form. If you decide to withdraw from the study, the information that was shared by the group leader prior to you leaving will still be used. No new information will be shared without your permission.

#### **Confidentiality**

All data collected will remain confidential. Only study researchers will have access to the information. Your child's surveys will be collected anonymously through a secure online survey platform called Qualtrics. Qualtrics uses encryption technology and restricted access authorizations to protect all data collected. In addition, Western's Qualtrics server is in Ireland, where privacy standards are maintained under the European Union safe harbour framework

The researchers cannot guarantee confidentiality of the information shared in discussion groups. The discussion group will be facilitated through the use of a third-party online video conferencing software called Zoom. Since this is a third-party software, your child's confidentiality cannot be guaranteed. However, researchers will put in place several measures to help protect their confidentiality by enabling features in Zoom that allow only permitted participants. Zoom automatically records both audio and video files. Immediately following the focus group, the video files will be destroyed. Audio files will be used for transcription and destroyed after transcription has been completed. The researchers will remind participants to respect the privacy of other participants and not repeat what is said in the discussion group. If the results are published, your name will not be used. All data collected from this study will be destroyed after seven years. Representatives of the University of Western Ontario Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research.

#### **Compensation**

Your child will be provided a \$20 gift card for completing each survey, as well as another \$20 gift card for participating in the discussion group.



#### **Consent**

To indicate your consent, please sign the attached consent form.



### Verbal Guardian Consent Form

**Project Title:** Supporting Transition Resilience of Newcomer Groups (STRONG): A school-based intervention to promote wellbeing

**Principal Investigator:** Claire Crooks, PhD, Director of Centre for School Mental Health Faculty of Education, Western University

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1. Do you confirm that I have read you the Letter of Information, that you understand what I have read, and that all of your questions have been answered to your satisfaction?

Yes

No

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2. Do you give permission for the group leader to share why your child was referred to the STRONG program with the research team?

Yes

No

3. Do you give permission for your child to complete the survey before and after STRONG programming?

Yes

No

4. Do you give permission for your child to participate in the discussion group via Zoom?

Yes

No

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Guardian's Name:

---

Child's Name

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Date:

---

Time

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Your Name (person recording consent):



Signature  Date

My signature means that I have explained the study to the participant named above. I have answered all questions.

Was the participant assisted during the consent process?

Yes  No

If yes, the person signing below acted as a translator for the participant during the consent process. The translator attests that the details in this form were accurately translated and the participant has had any questions answered.

Name of person translator

Signature  Date

Language Used

## Appendix I

## Assent STRONG Letter of Information &amp; Consent Form



Project Title:

**Supporting Transition Resilience of Newcomer Groups (STRONG): A school-based intervention to promote wellbeing**

Document Title:

**Youth assent form for students (for students ages 11 to 17)**

Principal Investigator:

Claire Crooks, PhD, Director of Centre for School Mental Health  
Faculty of Education, Western University

**Letter of Information About the Study**

**Invitation to Participate**

You are invited to participate in this research study because you are participating in the STRONG program.

**Purpose of Letter**

This letter provides you with information to help you decide if you want to be part of this research.

**Purpose of Study**

We are studying the STRONG program to learn how well it works. We want to know whether students like the program, and if helps them feel more connected to school and less stressed.

**Inclusion Criteria**

You can participate in this study because you are participating in the STRONG program.

**Study Procedures**

As part of the STRONG program, the group leader collects some information about your involvement. **This information is kept confidential.** You will be asked to complete a brief survey at the beginning of the group and again at the end as part of the program. This survey asks about your feelings, behaviours, and strengths.

If you agree to participate in this study, you will be asked to allow the group leader to share the information they have collected about your involvement in the program with our research team.

If you agree to participate in this study, you will also be asked to complete additional surveys at the beginning and end of the program. These surveys will be completed the week before the STRONG program starts and the week after it ends at the same day and place that the group is held. It will take about 30 minutes to complete the surveys each time.

If a researcher comes to your school. You might be invited to participate in a discussion group with other youth from the STRONG group. and the discussion group would be about your experience in STRONG. The discussion group would take about 45 minutes and it would be

audio recorded to help researchers remember everything students say. If you take part in a discussion group, you do not need to answer every question and your answers are not connected to you individually but as a group. If you do participate in a discussion group, please keep everything that is said private.

**Possible Risks and Harms**

There are no known risks or discomforts associated with participating in this study. The information is being collected anyway as part of the STRONG program. Your participation does not involve extra steps for you.

**Possible Benefits**

Your information will help the program to be improved. There are no personal benefits for participating in this study.

**Voluntary Participation**

Participation in this study is voluntary. You can decide not to participate in the study and still be part of the STRONG program.

**Confidentiality**

Any information shared with researchers will be kept private.. Researchers are looking at the information of a group of students all together and not individuals.





## **Supporting Transition Resilience of Newcomer Groups (STRONG): A school-based intervention to promote wellbeing**

### **Principal Investigator:**

Claire Crooks, PhD, Director of Centre for School Mental Health  
Faculty of Education, Western University

### **Youth Assent Form**

**I have read the Letter of Information. I understand what I have read. All my questions about this study have been answered. I agree to participate in this study. I have kept a copy of this letter and this permission form.**

Please initial beside all that apply:

\_\_\_\_\_ **I give my permission to the STRONG group leader to share information about why STRONG was recommended for me with the research team**

\_\_\_\_\_ **I agree to participate in a survey at the beginning and the end of the STRONG program**

\_\_\_\_\_ **I agree to participate in a discussion group if one is held at my school**

Signature \_\_\_\_\_

Date \_\_\_\_\_

## Appendix J

### Facilitator STRONG Letter of Information & Consent Form



**Project Title:**

Supporting Transition Resilience of Newcomer Groups (STRONG):  
A school-based intervention to promote wellbeing

**Document Title:**

Consent form for facilitators to participate in surveys and/or focus groups

**Principal Investigator:**

Claire Crooks, PhD, Director of Centre for School Mental Health  
Faculty of Education, Western University

#### Letter of Information

**Invitation to Participate**

You are invited to participate in this study because you facilitated one of the STRONG groups for newcomer children and youth who are experiencing trauma symptoms.

**Purpose of Letter**

The purpose of this letter is to provide you with information required for you to make an informed decision regarding your participation in this research.

**Purpose of Study**

We are conducting a study of the STRONG program to look at how well it worked, as well as identifying specific challenges and room for improvement.

**Inclusion Criteria**

Individuals who are facilitated or co-facilitated one of the pilot groups are eligible to participate in this component of the study.

**Study Procedures**

If you agree participate in this study, you will be asked to:

1. **Complete session tracking sheets about the program implementation.** You will be asked to share your session tracking sheets. You will be provided with a template for these and there are to be completed with no identifying data for group participants. You will be provided with a courier account to send these securely to the research team.
2. **Complete an online implementation survey when you are finished your group.** You will be sent a link to the survey once you have completed the STRONG group. The survey takes 5-15 minutes to complete and includes questions about successes and challenges regarding the pilot of the STRONG program.
3. **Participate in an audio-taped focus group with co-facilitator(s)** This focus group will take place after the end of the program. It will provide an opportunity for facilitators to share strategies that worked well and recommendations for change. The focus group will take place over Zoom, a video conference software, with a research staff member. By consenting to participate in the focus group you are also consenting to be audiotaped. The focus group is expected to last 60 minutes.



### **Possible Risks and Harms**

There are no known or anticipated risks or discomforts associated with participating in this study.

### **Possible Benefits**

Participating in the focus group might provide an opportunity to hear how other facilitators addressed challenges with the pilot. Data provided by you will help us identify important considerations for developing appropriate trauma interventions for newcomer youth.

### **Voluntary Participation**

Participation in this study is voluntary. You may refuse to participate or answer specific questions. You may also choose to complete only one or two parts of the study with no effect on your future participation in the STRONG program. You do not waive any legal rights by signing this consent form. If you decide to withdraw from the study, the information that was collected prior to you leaving will still be used. No new information will be collected without your permission.

### **Confidentiality**

Your survey will be collected anonymously through a secure online survey platform called Qualtrics. Qualtrics uses encryption technology and restricted access authorizations to protect all data collected. In addition, Western's Qualtrics server is in Ireland, where privacy standards are maintained under the European Union safe harbour framework.

The focus group will be facilitated through the use of a third-party online video conferencing software called Zoom. Since this is a third-party software, your confidentiality cannot be guaranteed. However, researchers will put in place several measures to help protect confidentiality by enabling features in Zoom that allow only permitted participants. Zoom automatically records both audio and video files. Immediately following the focus group, the video files will be destroyed. Audio files will be used for transcription and destroyed after transcription has been completed.

Confidentiality cannot be guaranteed in focus groups, but the focus group participants will be reminded of the importance of confidentiality. All data collected will remain confidential and accessible only to the investigators of this study. If the results are published, your name will not be used. Only unidentified quotes will be utilized. All information collected for the study, including surveys, will be stored securely in my office for a period of seven years. All data collection from this study will be destroyed after seven years. Representatives of the University of Western Ontario Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research.

### **Publication**

Any reports and publications will be distributed to all individuals involved with the STRONG program, regardless of whether they participate in this research.

This letter is yours to keep for future reference.

Sincerely,



**Supporting Transition Resilience of Newcomer Groups (STRONG): A school-based intervention to promote wellbeing**

**Principal Investigator:**

Claire Crooks, PhD, Director of Centre for School Mental Health  
Faculty of Education, Western University

**I have read the Letter of Information and understand what I have read. All questions have been answered to my satisfaction and I agree to participate in this feasibility study. I have kept a copy of this letter and this permission form.**

Please initial beside all that apply:

\_\_\_\_\_ **I agree to participate in an online implementation survey following the completion of the STRONG pilot**

\_\_\_\_\_ **I agree to provide my session tracking data following the STRONG pilot**

\_\_\_\_\_ **I agree to participate in a 60-minute focus group with other facilitators from the STRONG pilot**

\_\_\_\_\_ **I agree to the use of unidentified quotes obtained during the study in the dissemination of this research**

Participant name: \_\_\_\_\_

Signature and date \_\_\_\_\_

If you are participating in this study, please provide an email so that we can send you the link to the survey, the courier information, and the details about the focus group. Your email will be kept confidential and stored separate from study data.

Participant Email: \_\_\_\_\_

Name of person obtaining consent: \_\_\_\_\_

Signature and date: \_\_\_\_\_

My signature means that I have explained the study to the participant names above. I have answered all questions.

## Curriculum Vitae – Lina Saadeddin

### **Educational History**

**Faculty of Education, Western University, London Ontario** **September 2019 – Present**  
*Masters of Arts in Counselling Psychology*

- **Awards & Scholarships:** Scotiabank Graduate Award for Studies in Violence Against Women and Children, SSHRC - Canada Graduate Scholarships-Master's (CGSM) 2020-2021, Masters Entrance Scholarship for the 2019-2020

**Brescia University College, Western University, London Ontario** **June 2018**  
*Honours Bachelor of Arts, Specialization in Psychology*

- **Publication:** Undergraduate thesis: “First-impression Attitudes Towards People from Minorities and Different Cultures and its Relationship between Empathy and Self-esteem”
- **Distinctions, Awards & Scholarships:** Dean’s Honor List (2015-2018), Brescia Entrance Scholarship, Brescia University College Student Council Recognition Award, Ursuline Sisters Community Engagement Award

### **Research Experience**

**Research Assistant** **October 2019 – April 2021**  
*Centre for School Mental Health, Faculty of Education, Western University, London Ontario*

**Research Assistant** **October 2019 – December 2019**  
*Applied Psychology, Faculty of Education, Western University, London Ontario*

**Research Assistant** **October 2017 – April 2018**  
*Kuiper Lab, Western University, London Ontario*

**Research Assistant** **March 2017 – April 2018**  
*Personality and Emotion Development Lab, Western University, London Ontario*

### **Professional Experience**

**Intern Counsellor** **September 2020 – Present**  
*Fanshawe College Counselling Centre, London, Ontario*

**Social Support and Integration Worker** **October 2018 – July 2020**  
*Muslims Resource Centre for Social Support and Integration, London, Ontario*

**Residential Counsellor** **November 2018 – April 2019**  
*WAYS Mental Health Support, London, Ontario*

**Youth Programs’ Facilitator** **May 2018 – August 2018**  
*Muslims Resource Centre for Social Support and Integration, London, Ontario*

**Psychology Intern** **January 2018 – April 2018**  
*Daya Counselling Centre, London, Ontario*

### **Presentations**

Saadeddin, L., Syeda, M., Crooks, C. (2020). Supporting Transition Resilience in Newcomer Groups (STRONG): Impact of Parental Involvement on Intervention Implementation. Poster Session presented at The National Center for School Mental Health: *The 2020 Annual Conference on Advancing School Mental Health - Equitable and Effective School Mental Health*

Saadeddin, L., Syeda, M., Crooks, C. (2020). Supporting Transition Resilience in Newcomer Groups (STRONG): Engaging Newcomer Parents in a Resilience-focused Youth Program. Poster Session presented at the AMENA-PSY: *Coming Together: Shaping and Nurturing a Stronger Future for AMENA-Psy Virtual Conference*