Understanding Immigrant and Refugee Family Needs, Service Pathways, and Programs: A Literature Review

Peel Family Pathways Project: A collaborative project between the Peel Institute of Research and Training – Family Services of Peel and the University of Toronto Mississauga

Funded by: Tamarack Institute

Table of Contents

Abstract

Migration brings in a variety of new challenges, needs, and changes within the family system. These often lead to increased stress levels and reduced capacity for resilience within the family unit. Formal systems of support can accordingly be critical to address family needs and enhance resiliency. To understand the connection between mental health, needs, pathways, and services for newcomer families, this literature review focuses on five areas: (1) the family as the unit of analysis; (2) immigrant and refugee family needs; (3) pathways to and through services; (4) family theories; and (5) family programs. Scholarly and grey literature were collected through scholarly databases, government websites, and immigrant serving agency websites. Findings from this review demonstrate that immigrant and refugee families have needs that are complex, variable, and highly interconnected. Thus, comprehensive formal services across settlement, education, and health sectors are needed. However, extensive and thorough research into service pathways is lacking. Existing literature does show a variety of barriers that inhibit pathway continuity and coordination. Thus, there is a need to address pathway fragmentation and coordination to enhance family wellbeing outcomes. An extensive review of family theories highlights the importance of both a systems and strengths-based approach to working with newcomer families. Finally, this review indicates that several family-level programs have been found to be effective in improving family functioning, mental health, and overall well-being. This review will support the development of a Family Needs Framework and a Service Pathway to improve access and continuity of care to better meet the needs of immigrant and refugee families in the Region of Peel.

Introduction

Immigrant and refugee families migrating to Canada face immense changes and challenges that have the potential to significantly impact their functioning, structure, wellbeing of the family, and processes of resilience. Upon arrival in Canada, immigrants and refugees are expected to find housing, secure employment, become proficient in English, meet the needs of their families, and ultimately adapt and become self-sufficient (Veseley et al., 2017). These expectations occur in the context of coping with various pre-migration stressors, continuing uncertainties, disruption of cultural value systems, and loss of support networks. Further compounding these stressors and the settlement process are complex policies at the provincial and federal level that regulate the lives of newcomers, and at times cause harm (Veseley et al., 2017). The compounding nature of these migration and settlement stressors increase the risk of families and their individual members experiencing a range of mental health challenges, ranging from mild stress to clinical levels of depression, anxiety, and posttraumatic stress disorder (PTSD; Disney, 2021; Mawani et al., 2022; Stewart et al., 2010; Ziersch et al., 2017). In addition, stress and poor mental health impacts family functioning (Baghdarayan et al., 2021; Stewart et al., 2015), parent-child relationships (Bagdarayan et al., 2021; Shen et al., 2022), family mental health (Disney, 2021; Mawani et al., 2022; Stewart et al., 2010; Ziersch et al., 2017), parenting practices (Osman et al., 2016), and parents' sense of competence (Osman, 2017; Tulli et al., 2020).

However, addressing the mental health of newcomer families directly is often highly challenging given high levels of stigma and a lack of understanding of what 'mental health' means in the Western context (Salami et al., 2019). As a result, individuals and families from diverse ethnic backgrounds background do not enter mental health services through intended channels. Rather, they enter through other social service agencies, such as settlement agencies (United Way, 2014). Therefore, the mental health system would benefit from being viewed as much wider than the

standard understanding of mental health organizations. Thus, we aim to further explore the pre-migration and post-migration related needs of immigrants and refugees connected to mental health to understand how service providers may be able to enhance the process of meeting the needs of families and facilitating service pathways.

To understand the connection between mental health, needs, pathways, and services for newcomer families, this literature review focuses on five areas: (1) the strength of taking the family as the unit of analysis; (2) immigrant and refugee needs as they related to mental health; (3) pathways to and through services; (4) family theories; and (5) family programs. The aim is to identify knowledge and information needed to support improved access to services for families and to identify any barriers and challenges that impede access to and use of services. Recommendations for addressing needs, improving service pathways, and developing programs for families will be provided. The findings of this review, in combination with survey and focus group data collected from families and services providers, will be used to develop a Family Needs Framework and a Service Pathway. The goal is to improve knowledge on family needs and facilitate improved access to and movement through services in the Region of Peel.

Methodology

This literature review has been conducted by the Peel Family Pathways Project (PFPP), utilizing peer-reviewed articles and other scholarly sources, as well as grey literature, including theses and dissertations, government and organization reports, community newsletters, and news of issues affecting immigrants and refugees. Scholarly and grey literature was collected through keyword searches using the University of Toronto Libraries systems, the University of Guelph Libraries systems, and the Google Scholar web search engine, as well as the PsycINFO, and Sociological Abstracts databases. Keywords utilized in the search are listed below.

Keywords:

Needs: Immigrant, Refugee, Newcomer, Family, Family needs, Housing, Income, Employment, Social Support, Mental health, Mental health needs, Mental health care, Health, Health care, Barriers, Language, Children, Youth, Immigrant needs, Refugee needs, Needs, Impact of migration, Immigrant health, Refugee health, Family functioning, Social needs, Settlement needs

Pathways: Immigrant, Refugee, Newcomer, Pathways, Pathways to services, Service pathways, Referral pathways, Pathways to referral, Referral mechanisms, Needs assessment, Government services for newcomers, Continuity of care, Care coordination, Mental health care, Health care, Health, Mental health, Access to services, Community support, Settlement services, Resettlement Services

Family Theories: Family theory, Family theories, Family Systems Theory, Family resilience, Family stress, Family ecology, Immigrant, Refugee, Newcomer, Immigrant family, Refugee family

Family Programs: Immigrant, Refugee, Newcomer, Immigrant family, Refugee family, Family programs, Family-based program, Parenting programs, Family intervention, Family support, Mental health, Children, Family functioning, Canada, Health,

Inclusion criteria: (a) Scholarly or grey literature from reputable sources that focused on health, mental health, basic and/or social needs, service access and service pathways, barriers to meeting needs and accessing pathways, and/or family-based programs for immigrant and refugee families, as well as those that address family theories, (b) articles published in the last 10 years, with the exception of articles on family theories and in areas that have minimal specific research, (c) literature that is specific to immigrants and/or refugees.

Exclusion criteria: (a) research not published in English, (b) any literature published prior to 2012 (with the exception of family theories and a few key areas). The non-restrictive quality of these exclusion criteria is the result of the scarcity of research that exists on service pathways and family programming in the context of immigrant and refugee families.

Limitations

Limitations of this literature review include (a) lack of detail regarding specific pathways to and through services in Canada and the Region of Peel due to scarcity of data, (b) lack of discussion and analysis of family-based programs in Canada and the Region of Peel due to a lack of grey and scholarly literature on such programs, (c) relaxed inclusion criteria for service pathways and family programming literature due to scarcity of research, (d) cultural homogeneity in the ideologies underpinning family theories due to the majority of family theories being formulated in the Western cultural context, and (e) potential bias in papers selected due to language criteria.

Family as the Unit of Analysis

To improve the mental health and integration outcomes of immigrants and refugees, we contend that their needs should not be interpreted on an individual level but should be holistically examined in the context of the family unit. There are two reasons based on existing literature that support a family approach. First, systems theory enables the recognition that stressors have ripple effects across members of the family (Bowen, 1966, 1978; Walsh, 2016)**.** Second, family has been shown to be an important resource for immigrants and refugees in overcoming challenges associated with migration and mental health challenges (Sim et al., 2023).

The life of the client is intricately embedded in a family ecology where they are connected to, affect, and are affected by other family members and their living environments**.** This ecological perspective emphasizes the critical importance of examining attitudes, stress, behaviours, and needs in the social context in which the client is embedded, which, in this case, is the family and household. We recognize that the structure and functioning of the family, as well as the interactions between members, profoundly impacts stress and resiliency during settlement (Pederson & Revenson, 2005). As such, organizations providing services, counseling, and support to newcomers should not only attend to the needs, feelings, and experiences of the individual immigrant, but also seek to understand and attend, as much as possible and is appropriate, to the constellation of needs present in the family unit.

Immigrant and Refugee Family Needs

Refugees and immigrants (except those classified as "economic immigrants") are among the most vulnerable populations in terms of factors that negatively influence their mental health. Immigrant and refugee families potentially experience severe stress when migrating and resettling in the host country. Levels of stress, needs and requiring formal support often differ based on immigrant class (Nakhaie, 2018). For example, economic immigrants often arrive in the host country with more social and economic resources which help facilitate resettlement and reduce need complexity (Nakhaie, 2018). Refugees, on the other hand, often have more complex needs and less resources to meet those needs (Nakhaie, 2018), and thus, may be at a higher risk of mental health problems due to pre-migratory trauma in their home countries that results in depression, anxiety, and/or post-traumatic stress disorder (PTSD) for both parents and children.

Many immigrants and refugees are at risk of mental health challenges, due to stress levels that have increased, as a result of migration. Mental health is defined by the World Health Organization (WHO) as "a state of well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community" (2022). It is a key component of overall well-being and health. Mental health is crucial to the effective development of individuals, families, communities, and societies (WHO, 2022). It is determined by a complex interaction between individual, familial, social, and structural factors (WHO, 2022). Given this interactive nature of factors influencing mental health, it is necessary to address basic, social, economic, and family functioning needs that have been shown to be related to mental health.

Pre-Migration Needs: Trauma

Prior to migration, refugees are likely to have experienced some form of trauma, such as armed conflict, violence, poverty, and/or persecution (WHO, 2021). Individuals and families who are non-refugee immigrants may have also survived similar violent and traumatic conditions prior to migrating (Perreira & Ornelas, 2013; Sangalang et al., 2019). These experiences lead to reduced livelihood and sense of safety for individuals and families. In addition, during migration travel, refugees and other immigrants may be exposed to challenging and potentially life-threatening conditions such as violence and detention, as well as a lack of access to services to meet their basic needs (WHO, 2021). It is well established that these pre-migration and in-transit migration experiences and trauma increase the risk for reduced mental health and increased rates of serious mental disorders such as PTSD, depression and anxiety. Thus, conditions of past trauma, particularly as experienced by refugees, are likely to be considered upon arrival in the host country. However, what is less well-researched and understood, is how post-migration stressors influence mental health and may interact with pre-migration stressors and trauma (Sangalang et al., 2019). As such, the following sections focus pre-dominantly on post-migration stressors that are associated with mental health problems to develop a broader understanding of factors to consider when assessing the mental health of families.

Types of Post-Migration Needs that Influence Immigrant and Refugee Health and Mental Health

The post-migration factors that most consistently impact the mental health of immigrants and refugees include income, employment, housing, language, social support, social isolation, and discrimination (Hynie, 2018). The majority of these have been reported by service providers to be the most urgent needs of newcomers in the Region of Peel (Imbarlina-Ramos & Scantlebury, 2019). The need for access to services, creates additional needs for information, knowledge, awareness, and effective service coordination. These post-migration stressors and needs interact with pre-migration experiences, as well develop due to changes from pre- to post-migration to influence the mental health of families.

Employment

Immigrants and refugees face several challenges in obtaining employment in Canada. Some of the key challenges reported by both newcomers and service providers include: a lack of ability to obtain, and difficulty in obtaining Canadian work experience, difficulties in having foreign credentials recognized, perceived employer bias, lack of social and professional networks, overqualification and underemployment, lack of language proficiency, and cultural adaptation challenges (Employment and Social Development Canada, 2014).

These challenges often result in unemployment and underemployment, which impact immigrant and refugee families in concrete ways (i.e., impacts to income and housing) and nonconcrete ways (i.e., mental health effects). There is a connection between a lack of adequate employment and mental health. Specifically, negative employment status has been found to be associated with higher self-reported rates of poor/fair mental health (Mawani et al., 2022) and with increased levels of PTSD, anxiety disorders, and depressive disorders (Disney, 2021). The lack of adequate employment may also impact access to insurance for certain health and mental health care services.

Income

Income is closely linked to employment, as well as needs related to housing and food insecurity (Mental Health Commission of Canada, 2019). In Canada, Government Assisted Refugee (GAR) families qualify for up to one year of income support from the government through the Resettlement Assistance Program (RAP) if they can show that they cannot provide for the basic needs of life (Government of Canada, 2021). However, it is likely that the current income provided through the RAP is not sufficient to meet their needs given the current housing and economic situation in Canada.

Lack of adequate income can lead to poor health status amongst immigrants and refugees (DesMeules et al., 2010), due to the stress it causes and barriers to service access it may create. Financial strain has been found to impede access for children to mental health services (Tulli et al., 2020). Tulli et al. (2020) found that mothers were limited in their ability to afford counselling and reported a lack of sufficient income to afford their children's involvement in recreational activities that would promote positive well-being and mental health.

Housing

Housing is a primary urgent need that is key to successful resettlement and integration (Ziersch & Due, 2018). Primary issues related to housing are affordability, discrimination, challenges in securing housing, insecure tenure and mobility, overcrowding, and housing quality (Ziersch & Due, 2018). Affordability is particularly pertinent, given that housing affordability in Canada is currently deteriorating (Dahms et al., 2022). Another concern with housing is that immigrants may want to find housing in regions with others of a similar background or ethnicity, which can impact their options for housing.

A lack of adequate housing is associated with both physical and mental health consequences. Physical health consequences include asthma, allergies, infectious diseases, and chronic conditions (Hadi & Labonte, 2010; WHO, 2018; Ziersch & Due, 2018). Physical health consequences often occur through the pathways of low quality, instability, and overcrowding (Ziersch & Due, 2018). Mental health impacts include high stress and anxiety, and a lack of social connectedness with neighbours (Ziersch & Due, 2018). Pathways to reduced mental health include poor housing conditions, insecure tenure, discrimination, lack of access, overcrowding, and lack of a sense of safety (Ziersch & Due, 2018).

Language

Language is a major need for immigrant and refugee families that affects their ability to access employment services, health care, and mental health services, and may hinder their ability to communicate with their children's schools. In Canada, a lack of language proficiency, insufficient translation services, and lack of understanding by health care providers and specialists have been major barriers to newcomers being able to access health and mental health care for themselves and their children, to securing appointments, to engaging effectively with providers, and in managing post-appointment care (Pandey et al., 2021). This can lead to delays in seeking treatment, more severe health outcomes, and emergency hospital visits and admissions.

There is a need for translation services to communicate with health care providers and to complete forms, but translators are not readily available (Stewart et al., 2015). Even if medical translators are available, their presence can create issues surrounding privacy and confidentiality, particularly regarding mental health (Pandey et al., 2021; Tulli et al., 2020). There is also concerns about the quality of translation services, with some interpreters struggling to explain instructions (Pandey et al., 2021). This can interfere with the management of illness, especially chronic conditions, and mental health concerns, which require continuous monitoring.

Due to a lack of language proficiency and a lack of quality translation services, many families rely on their children to be language brokers (Shen et al., 2022). This is often crucial for overcoming language barriers but can have the potential to negatively impact well-being of families. For parents, the reliance on children for communication, has shown to lead to some feelings of disempowerment (Baghdarayan et a., 2021), which may impact parent-child relationships and mental well-being. Research on the effects of language brokering on children's well-being remains mixed (Shen et al., 2022). Some research has shown it may be a positive experience for children,

while others have shown negative impacts. For example, Shen et al. (2022) found that frequent language brokering had a small negative association with family relationships and acculturation stress, as well as a negative association with children's well-being. They suggest that it may be beneficial for young language brokers to have the ability to engage in culturally appropriate interventions with both individual and family-based components to increase bicultural competencies.

Social Support

Social support is important for the maintenance of positive physical and mental health (Ozbay et al., 2007), as those who have regular connections to social networks report better health (Zhao et al., 2019). For immigrants and refugees, social support is an important resource for coping with migration and resettlement stress (Stewart et al., 2015). However, social support systems are often compromised, as families typically leave social networks back home, which can lead to isolation and negative physical and mental health outcomes (Stewart et al., 2010).

A lack of social support impairs access to information about services available to meet the needs of families (Stewart et al., 2010). When immigrant and refugee families connect with co-ethnics, largely through formal settings, their knowledge about services available and information about integrating into Canadian society, expands (Nakhaie, 2018).

Discrimination

Discrimination refers to biases and stereotypes held by individuals in the host country regarding immigrants and refugees that results in treating them poorly. Several studies have indicated that the mental health of newcomers is impacted by the extent to which they feel welcomed into the host country or experience hostility. In Canada, immigrants and refugees face discrimination due to racial/ethnic, religious, and language biases, alongside social and political discourses regarding immigrants from developing countries (Sangalang et al., 2019). A longitudinal study of young Somali immigrants in Canada and the United States found that while between 2013 and 2015, symptoms of PTSD and anxiety improved, and depression symptoms remained stable, there were marked increases in symptoms in all three areas from 2015 to 2019 (Ellis et al., 2022). In both countries, and across all disorders, experiences of perceived discrimination partially accounted for the changes in symptoms. In addition, Sangalang et al. (2019) found that amongst Asian and Latino immigrants in the United States, discrimination consistently predicted reduced mental health.

Parent-Child Relationships and Family Functioning

Migration, resettlement, and acculturation leads to changes in the family system and the roles within the family. These changes can lead to stress and conflict. Sangalang et al. (2019) found that family conflict was the most consistent predictor of negative mental health across all immigrant and refugee groups. Conflict often arises between parents and children due to children adapting faster to the host country and taking on more Western values (Baghdarayan et al., 2021). Parents and children may hold conflicting values regarding children's independence, which may impact parent-child dynamics. Conflict can also stem from parenting styles of the host country differing

from that of the home country. Parents often find that they must adjust parenting styles by integrating Western values into their parenting practices.

Changes also occur in relationships between parents, particularly regarding gender roles. Due to the financial strain many families face, women may need to work outside the home. However, women reported that men did not adjust their roles in the home to adapt to women's new role as workers, leading to women contending with dual workloads (Baghdarayan et al., 2021; Stewart et al., 2015). These changes in gender roles can lead to conflict in the marital relationship (Osman et al., 2016) and impact the functioning and dynamics of the family. Family conflict and dysfunction are related to declining mental health.

Thus, there is a need to address family functioning, conflict in the home, and integrating competing cultural values in the home. Parenting and family support groups and programs may be beneficial in this endeavour to reduce the risk for mental health problems for families and their individual members.

General Health Care and Health Information

Immigrants and refugees lack knowledge on the availability of services and how to navigate the Canadian health care system (Chowdhury et al., 2021). Immigrants lack information on general health care, mental health care and psychosocial support, maternal health and childcare, sexual and reproductive health, and oral and dental health care (Chowdhury et al., 2021). Lane and Vatanparast (2022) found that immigrants viewed participating in health care service orientation sessions to beneficial in addressing information needs. Service providers agree that there is a need to improve information dissemination to newcomers about the Canadian health care system to ensure that they are better prepared and understand how to access and make use of health care services (Lane & Vatanparast, 2022).

Psychosocial Support and Mental Health Care

There are several barriers to mental health care for immigrant and refugee families. These impact whether and when newcomers receive the mental health support that they need. These barriers that will need to be addressed include stigma of mental illness, lack of literacy around mental health, the primacy of resettlement stress, lack of awareness, and cultural relevancy barriers.

Stigma and Literacy of Mental Health

In immigrant and refugee populations, there is a high level of stigma attached to mental ill-health. Stigma has been related to viewing these challenges as a sign of weakness, and to fear of bringing shame to the family (Salami et al., 2019). This can result in some immigrants and refugees refraining from seeking help. Additionally, there is often a lack of literacy surrounding mental health in newcomer families, which may be attributed to cultural differences in defining it. In many cultures, terms that are commonly used in the West, such as depression and anxiety do not exist, and thus, immigrant clients typically viewed mental health/illness as a Western concept (Salami et al., 2019). Such a belief can impact the ability to recognize mental health problems in themselves and their families. However, psychoeducation for the individual or family is not often enough, as

the stigma of mental illness extends outside of the family system to the broader community for some who are part of tightly knit cultural communities (Ellis et al., 2020). Therefore, there may be a need to shifting how mental health and certain diagnoses are discussed and used with families, as well as to address the importance of mental health care at a community level.

Primary Focus on Resettlement Stressors

When immigrant and refugee families arrive in Canada, the focus is on resettlement; ensuring that families have adequate housing, secure employment, learn the English language, and create social networks (Ellis et al., 2020). Specific mental health needs may fall to the side, as they do not relate to direct and immediate needs. However, such a way of thinking does not acknowledge that resettlement stressors are significantly related to mental health problems. Yet, mental health services remain highly separated from the settlement sector and from resettlement stressors. Mental health services are defined more narrowly in terms of scope of treatment, which may lead to missing important areas of concern that can impede effective treatment (Ellis et al., 2020). A primary focus on resettlement stressors may also lead to ignoring mental health problems of children, which can greatly impact the family's functioning and settlement process. Thus, there is a need for mental health providers to engage more closely with resettlement processes to more effectively meet the needs of families.

Lack of Awareness

There is a need for improved awareness of and access to mental health services of newcomer families. In a review of the literature on mental health service access by immigrants in Canada, Thompson et al. (2015) found that many groups of immigrants were unaware of culturally appropriate services available for their use. Further, Tulli et al. (2020) found that immigrant mothers searching for mental health resources for their children experienced frustration in their lack of knowledge of where to find appropriate resources.

Cultural Relevancy Barriers

Language and cultural differences are major barriers to engaging in mental health services. There is a lack of mental health services available in the language of the newcomer family, which can impede getting appropriate help or relying on children to translate. Cultural barriers refer to the lack of accessible services that ensure cultural relevancy and humility when working with newcomer families and individuals. Diagnostic assessments and treatments are most often not culturally appropriate or relevant which can lead to misdiagnosis and ineffective treatment. Thus, there is a need for improve training to service providers in providing mental health support to immigrant and refugee families (Salami et al., 2019). Providers need to be are that newcomer families are likely to have differing ways of understanding behaviours and emotional reactions related to mental based on culture. This will involve increased cultural relevancy and appropriateness of mental health care, including improving assessment tests to minimize misdiagnosis and improve treatment (Thompson et al., 2015). There is also a major need to improve the referral system and coordination of care to reduce wait times and the fragmentation of care that currently exists (Salami et al., 2019).

Addressing Immigrant and Refugee Family Needs

Meeting the needs of the family is critical to the mental health of immigrants and refugees. While the overall goal is to address the mental health needs of families, to do so effectively will require addressing needs beyond stress, depression, anxiety, and/or PTSD. The needs of immigrant and refugee families are deeply interconnected and will require addressing the factors that influence the development and maintenance of mental health distress. This includes addressing needs related to housing, employment, income, language, social support, and family functioning. This will ultimately require well-coordinated systems of care.

Addressing family level mental health needs requires addressing the interconnected nature of the well-being of parents and children. Parental mental health and histories, and experiences of trauma, anxiety, depression, and stress related to migration can impact their ability to be responsive caregivers, and in turn, have detrimental effects on the well-being of and development of their children (Minhas et al., 2017). Children's behaviour and mental health can also impact parent's sense of wellbeing and competence in parenting. Due to the complexity of the challenges faced and the interconnected nature of parent and child well-being, family-level programs may be beneficial to addressing these needs.

Immigrant and Refugee Family Pathways to and Through Services

The success of immigrant and refugee families' settlement and eventual integration into life in Canada is impacted by their ability to effectively have their needs met. Due to the number and complexity of needs of families, it is vital to understand service use and the pathways to and through services. We need to understand what these pathways look like, how they are coordinated, what facilitates and hinders referrals to other services, how these services are integrated and coordinated, and how pathways and continuity of care can be improved. The literature explicitly assessing pathways to and through services is lacking. However, there is a variety of research from several immigrant receiving countries that examines initial entry, use of government-funded services, and barriers related to service pathways and continuity of care.

Initial Entry into Settlement Services

There is minimal information regarding initial entry into service pathways. In the single pathway mapping study found in the literature that was conducted in Toronto, Ontario, Parada et al. (2021) found that the primary way that newcomers connect with services and programs is through recommendations of family and friends. Other points of entry include settlement agencies, engagement of children and youth with settlement workers in schools (SWIS), information and orientation kiosks, and direct outreach by organizations (Parada et al., 2021). A report from Immigration, Refugee, and Citizenship Canada (IRCC) found that approximately 20% of clients of IRCC-funded programs accessed settlement agencies through support services, such as childcare, translation, education, and transportation services (IRCC, 2021a).

Initial entry into the health and mental health care system differs. The first point of contact for immigrants and refugees for these pathways is often emergency rooms in hospitals (Thompson et al., 2015). Primary healthcare teams and physicians are also common entry sources for assessments

of health needs and the management of referrals to meet health needs of newcomer families (Ogunsiji et al., 2017). However, it is highly challenging for newcomer families to find a primary care physician, which creates delays in health care service pathways.

Needs and Assets Assessments and Referral Services (NAARS)

Upon entry into settlement service agencies, the initial task is to assess the needs and assets of an individual or family to determine the services to which they need to be referred. This is done under the Needs and Assets Assessment and Referral Service (NAARS) program, provided by programs funded federally by Immigration, Refugee, and Citizenship Canada (IRCC) and/or those that are provincially funded. The NAARS program is essential for facilitating pathways through services to meet immigrant and refugee needs. Here, needs are assessed and short- and long-term settlement plans are developed accordingly. A 2021 outcomes report from IRCC reported that among those newcomers, for whom NAARS led to the identification of needs, 58% to 74% received referrals to IRCC-funded services and between 63% and 89% received referrals to broader community-based organizations (IRCC, 2021a).

For government assisted refugees (GARs) who are a part of the Resettlement Assistance Program (RAP), the NAARS program is provided within their first 4-6 weeks in Canada to address immediate and essential needs. For other immigrant classes, the NAARS program is offered only after they become aware of services, which can occur at variable times after arrival or not at all.

For those who have needs identified, the settlement worker collaborates with the family to determine the priority of needs. A referral plan is then developed based on the hierarchy of needs (IRCC, 2021b; Parada et al., 2021). For those with less complex needs, referrals may be sent out based on request of the newcomer family (Parada et al., 2021). While some needs may be able to be addressed on the spot, the majority will require internal or external referrals (Parada et al., 2021). When choosing to refer internally or externally, the settlement worker considers the capacity of the organization to meet the client's needs and the ability of the client to physically be able to access the organization (Parada et al., 2021) or can access virtual appointments.

Referrals are made by settlement workers to a variety of services, including housing, financial aid, legal aid, employment support, education support, mental health, physical health, and recreational groups (Parada et al., 2021). Settlement workers making the referrals provide necessary information on the family to the referral service to ensure coordination, as well as provides the client has all necessary information to attend the appointment (Parada et al., 2021). One downside to the referral system, is that the referral agency does not follow-up to ensure the client receives a call or appointment from the referral receiving organization, which may impair pathway continuation (Parada et al., 2021). As newcomers move through these services, they may be provided with additional services, as needs change and progress over time. Further, newcomers may be looped back to the beginning stages as needs change and emerge (Parada et al., 2021).

There are some major limitations and challenges with the NAARS. Citizenship and Immigration Canada's (CIC), Immigration Contribution Agreement Reporting Environment (iCARE) system

found that only 23% of newcomers received NAARS in their initial year of arrival in Canada (IRCC, 2021a). Use of NAARS was highest during the newcomer's initial year of arrival, signifying relatively low use of these services, despite their effectiveness in service pathway facilitation. Secondly, the standard NAARS does not specifically address family needs as a unit (Dargy, 2018). Rather, the focus remains on the individual and assessment results are put in the Immigration Contribution Agreement Reporting Environment (iCARE) system within the individual's profile, which is not connected to other members of the family (Dargy, 2018). Further, client files care not created for children and youth under the aged of 18, as under the IRCC service agreement they are not considered 'unique clients' (Dargy, 2018). This lack of family assessment and connection between members are major limitations within the NAARS and does reflect that family needs are highly interconnected. Though, some agencies, such as COSTI, use an internal client needs assessment to collect family level information regarding needs (Dargy, 2018). Lastly, there are major challenges associated with external referrals, including the repetition of the intake process, slow response times, transportation barriers, language barriers, and technological challenges.

Despite these limitations, NAARS plays a critical role in the successful settlement and integration of immigrant and refugee families into their new communities by offering a thorough evaluation of needs and assets of the family and facilitating referrals to services to meet additional needs. NAARS can assist newcomer families in understanding and navigating the complex systems in Canada, which may lead to reductions in stress and anxiety of the family. However, the low use, lack of family unit assessment, and other barriers, prevent widespread success across families. Therefore, it will be important to address these challenges to improve the accessibility and responsive of service pathways.

Information and Orientation Services

Information and orientation services play a critical role in the successful resettlement of immigrant and refugee families in Canada. They provide newcomer families with information related to settlement at the national, regional, and/or local levels (IRCC, 2021a). Information is provided to help families understand the cultural, social, and political norms of the country, as well as on the Canadian health care system, school registration for children, housing, and language support. The purpose is to ensure newcomers are provided with realistic expectations regarding life in Canada, assisting them in navigating the Canadian system, and facilitating access to services (IRCC, 2021a) and have the necessary information to make informed decisions and navigate the settlement process. Knowledge is key to the settlement journey of the newcomer, as it is a primary access point into service pathways and can relieve levels of stress and anxiety for families, which can positively impact mental and physical health. A lack of timely provision of information on services to address family needs, can result in a pile-up of stress, which can impact family functioning and mental health.

General Health Care Service Entry and Pathway

The health care system in Canada can be challenging to access and navigate. This is complicated by the lack of access to a primary care physician, language barriers, lack of insurance, and waiting

periods. For many immigrant and refugee families, their first point of contact with the health care system is through hospital emergency rooms (Thompson et al., 2015). While this can be beneficial for initiating health care access and addressing immediate concerns, the long-term health related needs of the family will not be met due to lack of continuity and coordination of care.

To ensure improved access to and continuity of health service pathways, primary care is important. For the majority of Canadians, their first point of contact with the health care system is through primary care (Government of Canada, 2016). Primary care services are also the services through which patient care is coordinated, as they ensure continuity of care and ease of movement through the system when more specialized services are required (Government of Canada, 2016). However, many immigrant and refugee families struggle to find a family physician, especially one with whom they can communicate effectively, due to language barriers.

While it is challenging to gain initial access to primary care, some newcomer families do accomplish it, which facilitates health-related service pathways. However, the needs of families are much more complex than solely being related to health. There are other social, and economic challenges that can directly or indirectly impact the wellbeing of families. Unfortunately, existing services that aim to meet newcomer family needs tend to operate in silos, leading to a fragmented and inefficient system of health and social services. It may be important for health care providers to form connections with non-related health services (i.e., social services) to improve service pathways.

Mental Health Care Entry and Pathway

Pathways to and through mental health services for immigrant and refugee families are greatly impacted by social and demographic factors, as well as clinical factors (Tarricone et al., 2021). Mental health/illness stigma and a lack of culturally relevant services are major barriers to initiating these pathways (Hynie et al., 2022). Initiation into mental health service pathways often occurs through settlement workers, case managers, primary care providers (Hynie et al., 2022), and family and friends (Tarricone et al., 2011).

There is a lack of usage of mental health services by immigrants and refugees. For example, Wylie et al. (2020) found that most mental health professionals reported on 1% to 3% of their clients being of migrant status. Providers with vast experience working with immigrants reported a higher usage rate of 25% (Wylie et al., 2020). The same providers reported negative care coordination resulting from a lack of clarity around the responsibilities of providers and available resources when it comes to referrals, as well as a tendency from various departments and sectors to work in silos (Wylie et al., 2020). Also impacting care coordination is that mental health care providers do not always effectively leverage immigrant and refugee community connections that could facilitate support and continuity of care (Wylie et al., 2020)

To enhance mental health care pathway initiation and continuation, effective care coordination between health care providers, settlement workers, other community care providers, and immigrant and refugee clients is essential. Additionally, providers must receive appropriate

training to assess the needs and capacities of newcomer families, and to assess the availability of appropriate services to ensure that their mental health needs are effectively addressed.

Barriers to Successful Pathways

There are several barriers to successful pathways. First, there is a lack of awareness that federally an/or provincially funded services for newcomers exist, evidenced by 70% of non-clients reporting that they were unaware of these services (IRCC, 2021). Secondly, while NAARS has been indicated to increase the success of newcomers receiving referrals when needs were identified, the uptake of NAARS is low. That is, only 23% of newcomers were found to by the IRCC to have used the service in their first year of arrival, with usage only declining as time in Canada increases (IRCC, 2021).

Thirdly, the standard version of the NAARS does not specifically address needs at the level of the family unit (Dargy, 2018). Rather, the focus remains on the individual and assessment results are documented in databases within the individual's profile, which is not connected to the family (Dargy, 2018). Further, client files are not created for children and youth under the age of 18, as under the IRCC service agreement, they are not considered 'unique clients' (Dargy, 2018). This lack of family assessment and connection between members does not reflect the highly interconnected nature of needs of family members. However, some agencies make use of an internal client needs assessment to collect family level information regarding needs (Dargy, 2018).

Fourthly, within the current referral system, there is not follow-up to ensure that the client receives a call or appointment from the referral receiving organization, which may impair pathway continuity (Parada et al., 2021). Additionally, there are pathway challenges related to repetition of the intake process, slow response times and transportation, language, and technological barriers. Fifthly, barriers to pathway continuation and continuity of care include transportation barriers (Brandenberger et al., 2019), lack of childcare (Mukhtar et al., 2016), and language barriers (Shannon et al., 2016). Transportation barriers and lack of childcare prevent immigrant and refugee newcomers from attending referral appointments. Language barriers prevent newcomers from understanding the next steps required to facilitate service use. Another barrier, also related to continuity of care, is the tendency for health care, mental health care and social service sectors to work in silos. This is detrimental to meeting newcomer family needs given how interconnected the needs of housing, employment, income, and social support are with health and mental health. Thus, services working in isolation have an impact on which needs are met and how effectively those needs are satisfied.

Finally, there are some systemic barriers related to services existing within a neoliberal context. Neoliberal policies have led to reduced funding and strict funding criteria for immigrant serving agencies (Mukhtar et al., 2016). Additionally, neoliberal policies have also imposed restrictive mandates on service provision (Mukhtar et al., 2016). Service providers reported that many programs offered by their organizations were more closely aligned with funder requirements than the needs of newcomers due to funding requirements (Mukhtar et al., 2016). Agencies are unable

to be effective and responsive to the changing needs of families. Also, in some cases, increased competition between agencies (Mukhtar et al., 2016).

Improving Pathways to and Through Services

Based on the review of the service pathway literature the following recommendations are suggested: (1) increase the awareness of newcomers that services exist; (2) increase the use of family level assessment of needs in the NAARS; (3) enhance coordination between health care, providers, settlement workers, mental health clinicians, other community care providers, and immigrant and refugee clients; (4) ensure that providers receive more training in mental health, cultural humility, and trauma-informed approaches; (5) increase use of a social determinants of health framework (Richard et al., 2019; Wylie et al., 2020) and (5) advocate for policy changes that impact service pathways.

Family Theories

Family theories were reviewed to determine which would be most appropriate for the development of the Family Needs Framework and proposed Service Pathway. Further, family theories guide the development of programming for families. The following sections expand upon prominent family theories, including Bowen's Family Systems Theory, Bronfenbrenner's Ecological Theory, Attachment Theory, Family Stress Theory, and Family Resilience. These theories have largely been developed based on the Western nuclear family and tend to lack a specific consideration to family differences across cultures. However, specific considerations of these theories to immigrant and refugees are discussed.

Bowen's Family Systems Theory

Family Systems Theory was developed by Bowen to examine family dynamics and functioning to be able to provide recommendations to improve relationality. Within Family Systems Theory, the family is defined as an "emotional unit" or "system" in which each family member has a role, and each member influences and is influenced by one another at the individual, dyadic, systemic, and intergenerational levels (Bowen, 1978; Papero, 1990). Bowen viewed the family as a system because "a change in one part of the system is followed by a compensatory change in other parts of the system" (Bowen, 1966, p.351). The theory consists of eight concepts: differentiation of self, triangles, nuclear family emotional processes, family projection process, multigeneration transmission process, sibling position, emotional cutoff, and emotional process in society.

Bowen argued that there are two main factors that relate to family functioning: (1) chronic anxiety and (2) differentiation of self (DoS) (Kerr & Bowen, 1988). Chronic anxiety develops from the struggle to maintain a sense of self while remaining connected to the family. DoS, a central concept to Family Systems Theory, refers to the ability of an individual to remain autonomous and maintain a coherent sense of self, while continuing to remain connected to significant others (Kerr & Bowen, 1988). DoS determines how roles, rules, and boundaries are developed and established within the family, how triangulations and alliances are formed and transmitted, and more importantly, how functional and dysfunctional family systems come to be defined (Erdem & Safi, 2018). There exists a great deal of evidence that high levels of DoS are associated with better mental health,

well-being, and relationship satisfaction and quality (Erdem & Safi, 2018). However, it is important to note that most of the studies have been conducted in the West with non-immigrant populations. Thus, the findings are not necessarily applicable to non-Western contexts and immigrant and/or refugee families, as what is deemed functional may vary according to different cultural values and beliefs.

Erdem and Safi (2018) note that studies done outside of the United States demonstrate results that are mixed or in opposition to what is stated by Family Systems Theory. For example, Kim et al. (2014) investigated the association between Family Systems Theory concepts (DoS, I-position, fusion, emotional reactivity, and emotional cutoff) and family functioning (family adaptability and cohesion) in South Korea and found mixed results. In alignment with Family Systems Theory, Kim et al. (2014) found that high DoS was associated with increased family functioning, improved family satisfaction, and more positive communication. However, contrary to what is proposed by Family Systems Theory, they found that fusion with others also predicted balanced levels of family cohesion. Such findings suggest that high fusion and high DoS can exist within the same cultural context and can promote better family functioning. These findings point to cultural differences in what is defined as a functional family.

A Proposed Approach to Improve the Cultural Relevancy of Family Systems Theory

Erdem & Safi (2018) hypothesized that there may be culture-specific ways to define DoS, particularly when it comes to fusion with others. They propose the integration of Kağıtçıbası's Family Change Theory (FCT) and Carter and McGoldrick's multicultural perspective with Family Systems Theory. Erdem & Safi (2018) "argue that DoS evolves differently in family models of independence, interdependence, and psychological interdependence as a function of different self-construals. All those potential models are situated within individualism-collectivism dimensions of culture" (p. 478-479). Thus, understanding the family's orientation to individualism and/or collectivism becomes integral for addressing family functioning.

Many immigrants and refugees come from cultures that value collectivism. Where a family falls on the individualism-collectivism continuum influences how the family functions, shapes what defines dysfunction, and leads to differences in differentiation levels amongst family members. For example, many family theorists believe that the enmeshed mother/disengaged father syndrome is common in dysfunctional families (Rothbaum, 2002). However, this belief is grounded in Western thought. In Asian families, the overinvolved mother-child relationship is common and less likely to be viewed as dysfunctional. Rothbaum et al. (2002) demonstrates that culture may change what is perceived as sensitive and responsive caregiving and what are signs of functionality and dysfunction in a family. Thus, there needs to be a dimension that considers cultural differences in family functioning with needs assessments and program provision.

Bronfenbrenner's Ecology Theory

Bronfenbrenner (1986) saw the family as the main context for human development. Brofenbrenner' Ecology Theory focuses on the interrelationship between the family and other ecological systems, which influence child development (Bronfenbrenner, 1986). Brofenbrenner's

(1986) ecological theory consists of five subsystems – microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The innermost level, the microsystem, consists of relationships between individuals and their families. The family itself is a microsystem. The mesosystem is a network of microsystems. The exosystem includes social settings that indirectly affect an individual, such as neighbourhoods (Paat, 2013). The macrosystem is the overarching set of social values, cultural beliefs, political ideologies, customs, and laws that the microsystem, mesosystem, and exosystem are embedded within (Bronfenbrenner, 1977). Lastly, the chronosystem is the historical time period and addresses how life transitions impact the family (Bronfenbrenner, 1986).

Applying Bronfenbrenner's Family Ecology Theory to Immigrants

Similar to other families, immigrant and refugee families are 'open and dynamic systems' that are vulnerable to changes (Cox & Paly, 2003; Portes & Zhou, 1993). However, they face different challenges and changes related to migration, which place increased pressure to adapt to the mainstream society in the host country. Drawing on the literature of family functioning as a need and an article by Paat (2013), we can understand how Bronfenbrenner's ecological theory highlights the critical role that ecological systems play in the development and acculturation of immigrant children and youth.

Microsystem: Healthy family interactions are critical for regulation of children's behaviour (Paat, 2013). However, migration can lead to conflict in family interactions, impacting children's behaviour and mental health, as well as overall family functioning. When immigrant families experience greater levels of cohesiveness, there is improved family functioning and greater positive psychological adjustment (Cox & Paley, 2003). This points to the need to address conflict and acculturation divides to improve mental health and functioning in the family.

Mesosystem: Strong ties between newcomer families and other social institutions can aid in family functioning and acculturation (Paat, 2013). Language is a major challenge to enabling such social participation for the family (Paat, 2013). As seen, newcomer families face social isolation, lack of connection to social services, and language barriers.

Exosystem: Children of immigrants adapt better when there is public support for cultural diversity in their neighbourhoods and communities (Paat, 2013). Given the diversity of Peel, the region may be a beneficial environment for immigrant families to adapt to the host country.

Macrosystem: The macrosystem impacts the immigrant family's adjustment to the host country, as it defines and directs the larger society (Paat, 2013). Immigrant families are "socially disadvantaged as newcomers due to unfamiliarity with the dominant cultural practices and norms" (Paat, 2013). Immigrant children are often living between two cultures: the culture of their parents and/or their country of origin and mainstream society. Children of immigrant parents are often less connected to their parents' country of origin and culture and tend to adapt to Western mainstream culture at faster rates than their parents. This can lead to feeling torn between the two cultures. It can also lead to a cultural divide between parents and children, which can lead to conflict, which will lead to a disruption in the family system.

Chronosystem: Immigrant families not only have to contend with typical life transitions, such as puberty, starting school, and getting married, but they must also contend with the non-normative life transition of migration. This transition leads to major upheavals in the family system and requires a multitude of resources within the different systems to adapt.

Attachment Theory

Attachment theory has been viewed as one of the most foundational theories for conceptualizing healthy families and parent-child relationships for the purpose of developing interventions and programs for families (Rothbaum et al., 2000). Attachment theory, in the most traditional sense, has predominantly developed out of the work of John Bowlby and Mary Ainsworth. Bowlby (1969/1982) described attachment as a relationship between an infant/child and their caregiver that sets the foundation for further healthy development. For Ainsworth (1963), attachment is a 'secure base from which to explore.' Attachment forms as children seek comfort and safety from their caregiver, and the success of attachment depends on the response acquired. Ainsworth (1967) also developed the idea that the central components of attachment theory were culturally universal.

There is a growing acceptance that what constitutes healthy, sensitive, responsive caregiving and healthy attachment, varies by culture. When cultural definitions of attachment, sensitivity, and responsiveness are not understood, therapists and other providers may inappropriately identify family members as insensitive and attachment relationships as dysfunctional (Mirecki & Chou, 2013). Thus, family-based programming, must be developed in a way that enables the integration of culture-based family approaches.

For immigrant and refugee parents, how they respond to their children is complicated by having to navigate different and often competing cultural values between their home culture and the host country. Parents must not only be sensitive to the needs of their children, but also be responsive to the context in which they are parenting (Claussen & Crittenden, 2000). This is due to some parenting styles, deemed appropriate in the home country, being viewed as insensitive within the new culture (Mirecki & Chou, 2013). Thus, parents are faced with the challenge of having to adapt their responses to their children to align more closely with the new culture. It may be beneficial for parents to learn ways to integrate Western values into their parenting practices to develop more effective cross-cultural relationships (Mirecki & Chou, 2013).

Family Stress Theory

Family Stress Theory was first developed in 1949 by Reuben Hill. Hill (1958) developed the ABCX model, which outlines a pattern for the development of a crisis:

> A (the stressor event) interacts with B (the resources of the family to meet the demands of the stressor) interacts with C (the meaning the family places on the event) to produce X (the crisis).

The ABCX model has been further developed into the Double ABCX Model. This model takes Hill's ABCX model as its foundation and adds post-crisis variables to describe: (1) the accumulation of stressors that influence adaptation; (b) the acquisition of family resources over time; (c) the changes in meaning of stressor events; (d) the coping strategies used; and e) the outcomes of the family's efforts (McCubbin & Patterson, 1983). The Double ABCX Model addresses coping capabilities to manage the initial stressor, as well as new coping strategies that need to be used following a crisis to enable adaptation (Danespour, 2017).

Applying the Theory to Immigrant Families

Stressors (aA factor)

A stressor is defined "as a life event or transition impacting upon the family unit which produces, or has the potential of producing, change in the family system" (McCubbin & Patterson, 1983, p.8). Families seldom deal with a single stressor at a time, but rather, face a pile-up of stressors. A pile-up of stressors can overwhelm family functioning, particularly when coping resources are lacking, which can heighten vulnerability and risk of additional problems (Patterson, 2002). For immigrant and refugee families, migration is a major life transition which leads to a host of additional stressors related to resettlement. Due to the number of needs associated with migration and settlement, families are likely to face a pile-up of stressors and may lack resources to effectively cope, further impacting family functioning and well-being.

Resistance Resources (bB factor)

Resources are the tools that families employ to prevent a crisis from occurring, as well as in response to a crisis or pile-up of stressors. Coping with a crisis often demands that the family expand their resources to cope more effectively and prevent breakdown (McCubbin & Patterson, 1983). Social support is one of the most important resources to help a family cope with stress. Families who have sources of social support are more resistant to crises and are better able to recover and restore equilibrium in the family system following a crisis (McCubbin & Patterson, 1983). However, immigrant families often lack social support upon arrival. As a result, they are more likely to reach a crisis point as their stressors and needs expand.

Meaning of the Event (cC factor)

This refers to the subjective meaning formulated by the family regarding the seriousness of the stressor. The meaning of the event will vary based on the family's culture, their values, and the family's prior experience with coping with change and managing crises (McCubbin & Patterson, 1983).

Family Crisis (xX factor)

A "crisis is characterized by the family's inability to restore stability and by the continuous pressure to make changes in the family structure and patterns of interaction" (McCubbin & Patterson, 1983, p.10). A crisis occurs when the demands placed on a family that exceed their capabilities persist for a significant period (Patterson, 2002). A crisis is often a turning point for a family, leading to a significant change in the family structure, to their interaction patterns, or both (Patterson, 2002). The Double ABCX model of stress theory considers what the family does in

response to a crisis to restore balance. Here, the family will engage in processes of adaptation that will either lead to a restoration of balance, which is called regenerative power if the outcome is good (family bonadaptation), or lead to poor adaptation, which is called vulnerability (McCubbin & Patterson, 1983). For immigrant and refugee families, the process of migration and related settlement stressors, combined with a lack of social and economic resources, may increase the risk of experiencing a family crisis. Therefore, access to services for the family becomes imperative for preventing and/or resolving crises and helping the family adapt.

Family Resilience

Resilience is the capacity to adjust and adapt in the face of adversity. The concept of resilience has come to the forefront in the field of mental health (Walsh, 2016). Over the past decade, there has been an increasing focus on expanding the understanding of human resilience beyond the individual level to view resilience as involving the interaction of multilevel systemic processes (Walsh, 2016). This increasingly relational view of resilience assumes that relationships are central to adaptation and coping. One such relational view of is the concept of family resilience. Family resilience refers to the ability of the family system to endure and overcome adversity (Walsh, 2003). Beyond solely coping with or surviving the challenge, resilience involves positive adaptation, where there is individual and relational growth and transformation (Walsh 2016). Currently, there does not exist a cohesive theory of family resilience. While there remains debate about how to conceptualize family resilience, most research views it as a process consisting of three elements: (1) a condition of risk, which initiates the resilience process; (2) protective factors, which facilitate the resilience process; and (3) good outcomes (Patterson, 2002a). Understanding the concept of family resilience as a process has its roots in General Systems Theory, Family Systems Theory, Family Stress and Coping Theory, and Family Therapy.

Taking family resilience as a process, Walsh (2012, 2016) developed a family resilience framework, that combines systems theories, as well as ecological and developmental perspectives. Expanding upon the large body of systems research on family functioning, this framework attends to how families effectively deal with challenge events and conditions (Walsh, 2016). In this framework family resilience is inherently contextual, as the strengths and challenges of families are assessed and addressed in relations to the family's challenging situation and other systemic factors at the micro, meso, and macro levels. Here, the basic premise within this systems view is that major stressors and crises impact family functioning across the system, causing ripple effects for all members and relationships (Walsh, 2012; 2016). This systems orientation enables the consideration of how resilience occurs within and amongst family relationships. While some families may have experienced more severe trauma or be more vulnerable, a family resilience perspective contends that there is always potential for growth.

The eco-systemic perspective of Walsh's family resilience framework recognizes that family resilience involves the complex interactions of multiple risk and protective factors over time, that involve and are influenced by individual, interpersonal, community, socioeconomic, and cultural factors (Masten & Monn, 2015). Thus, when working with a family, social, economic, political,

and environmental influences must be considered as families do not exist external to broader forces. The family cannot be viewed in isolation from other forces beyond the micro-level.

The developmental perspective of family resilience refers to two forms of development. First, it considers the developmental stage of the family unit and how that impacts distress and resilience. That is, various challenges interact with other issues that arise depending on individual and developmental stages and are greatly influenced by past experiences with challenges within the multigenerational network (Walsh, 2016). Secondly, it refers to how most forms of stress are not short-term, but a complex set of conditions that change adapt over time (Walsh, 2016). Therefore, families have to draw on various strengths and supports in the process of adaptation.

Walsh's (2012; 2016) family resilience framework helps to understand how what is deemed functional in an immigrant or refugee family varies based on their culture, values, relational resources, and the challenges they face. Further, it recognizes that processes of optimal functioning and well-being of immigrant and refugee families vary as they face new challenges and adapt to life in the host country. Walsh's (2012; 2016) framework focuses on the strengths of a family that are constructed in response to crises, promoting a strengths-based rather than deficit-based approach, which is beneficial when working with marginalized communities.

An Additional Theoretical Perspective

Given that this research addresses the settlement process for families and takes a systems approach to understanding needs and adaptation, we also review Arlene Bierman's (2009) *Gender, Migration, and the Determinants of Health* framework. Bierman's framework brings together elements of theory from four areas of inquiry: (1) social determinants of health; (2) gender equity; (3) racial and ethnic disparities in health; and (4) the migration experience (Bierman et al., 2009). While this framework was developed with a focus on immigrant women, we contend it remains applicable to the family given that the family can be a highly gendered context where roles are often heavily based according to one's gender. Further, as the literature of family relationships in the context of migration demonstrates, shifting gender roles can create conflict and stress in families, which have the potential to impact mental health. Therefore, a framework that recognizes that gender differences arise surrounding health will be particularly relevant to enhancing the understanding of needs and impacts of stress across the family unit. It can help to understand how migration and associated needs differentially impact women/mothers/partners compared to men/fathers/partners given that the migration experience is fundamentally different for women from that of men (Bierman et al., 2009)

The framework takes a systems approach in two ways. First, the framework considers both pre-migration and post-migration factors and forces, enabling the ability to understand and address changes that occur during migration. Secondly, the framework considers factors and forces at the macro-level (geopolitical environment, national factors such as the economy and immigration policy), meso-level (i.e., community-level factors such as social networks, discrimination, and neighbourhood characteristics), and micro-level (i.e., income, employment, housing, values of family; Bierman et al., 2009). These levels of factors are considered as to what they were pre-

migration to what they are post-migration to understand how they have changed, either positively or negatively. Similar to Bronfenbrenner's Ecological Theory, the family or individual can be viewed as embedded within a series of concentric circles. The health and wellbeing (e.g., mental health, functional status, other illness) of the family or individual members is the product of the determinants of health that are related to each of the levels (Bierman et al., 2009).

Family- and Parent-Based Programming for Immigrant and Refugee Families

Family-based programs are those programs and services which attend to the needs of parents and/or children with the aim of improving the well-being of the family unit. The literature demonstrates that family-based programming can be effective for promoting positive behaviours, improved family functioning, enhanced mental health, as well as reducing the risk of negative outcomes in the family unit. Abi Zeid Daou et al., 2022; El-Khani et al., 2021; Huisken et al., 2021; Young et al., 2021; Betancourt et al., 2020; Annan et al., 2017; Wu & Lee, 2015). However, most of the studies demonstrating these positive outcomes come from outside of the Canadian context. Across Canada, a variety of services and programs aimed at addressing the needs of family as a unit exist. However, there is a scarcity of research available assessing the efficacy of these programs on family stress, mental health, family functioning, and other social needs. Therefore, the following sections first discuss some family-based programs and services in Canada to explore what these programs look like. Subsequently, literature from the global context, assessing the outcomes of family-based and parenting programs from the global context are examined to understand what has been effective and areas for improvement. Programs from the global context that are available for families fall within the categories of (1) mental health and (2) physical health.

Canadian Family Programming

In Winnipeg, Manitoba, a primary organization providing services for the newcomer family unit is Mosaic – Newcomer Family Resource Network. They are a rights-based organization that provide newcomer parents and primary caregivers with access to English language classes and parenting programs (Mosaic, n.d.). An important component of these programs is that quality childcare is provided while parents engage in them to address this barrier that many caregiver (primarily women) face in accessing services. Parenting programs focus on child and parent attachment and including parenting skills programs, literacy programs for children, and home visiting programs (Mosaic, n.d.). Another organization in Winnipeg offering family services for newcomers is Family Dynamics. They provide holistic case management services for families, particularly refugee families, with more complex needs related to basic needs, health and mental health, social issues, education and employment, and family relationships (Family Dynamics, n.d.). A great service of this program is that needs assessment incorporate a family level needs assessment, recognizing that families are highly interconnected systems.

In Calgary, Alberta, the Calgary Immigrant Women's Association (CIWA) provides women, girls and their families with access to the Family Resource Network (FRN). The FRN is an accessible and inclusive family-focused, community-based centre that provides families with youth and

children aged 0 to 18 years with a wide range of prevention and intervention services aimed at supporting the family wellbeing (CIWA, n.d.). They offer cross cultural parenting programs, which assist immigrant parents with coping with parenting challenges related to being immersed into a new country and culture. They also offer home visitation programs, rapid counselling, and youth programs (CIWA, n.d.).

In Ontario, Catholic Crosscultural Services (CSS), offers the Family in Settlement Together programs which is available to newcomer families with young children and families with children with special needs. This program offers wrap-around settlement services, which includes a family unit needs assessment, the development of a family settlement plan based on the needs identified, ongoing case management, information sessions, groups activities for families, and parent support groups.

In British Columbia (B.C.), one organization providing family-based services to immigrants and refugees is Pacific Immigrant Resources Society (PIRS). They provide a variety of family programs, including language programs, play-based, trauma-informed, early learning programs, family literacy programs, and others (PIRS, n.d.). Another organization providing family programing is MOSAIC B.C. They offer a variety of child, youth, and family support programs for different immigrant and refugee groups, related to parenting of different age groups, parent-child relationships, navigating the school system, and youth programs (MOSAIC B.C., n.d.). Additionally, in B.C., the organization S.U.C.C.E.S.S. promotes the wellbeing of families through a wide range of programs that focus on strengthening family relationships, fostering personal growth and resiliency, and building social connections (S.U.C.C.E.S.S., n.d.).

In a recent project, Benipal et al. (2022) conducted interviews with refugee caregivers and service providers to gather information on what elements they would like to see included in a parenting program for newcomers. This is the first step in a community-based participatory research (CBPR) project to develop a parenting program in Canada. The main topics that participants identified as being beneficial to incorporate into the program were: features of child development, information on navigating the Canadian health care system, self advocacy, caregiving practices in the new culture, balancing self-identity and acculturation, and addressing the mental health needs of caregivers (Benipal et al., 2022). Participants indicated key barriers to accessing the program would be language barriers, the inability to advocate for their rights, overlapping responsibilities that compete with time for the program, and lack of awareness about the program. Such barriers would have to be addressed to ensure the success of a parenting program for refugees. A primary facilitator for the program would be to ensure it is culturally relevant and based in anti-racist and anti-oppressive frameworks (Benipal et al., 2022).

Some of these key elements identified in Benipal et al.'s (2022) study are evident in family-based and parenting programs already operating across Canada. Specifically, multiple programs address child development, provide information on the Canadian system, assist in developing parenting skills and practices in the Canadian context, and addressing mental health needs. Further, these programs are specific to the immigrant and refugee populations, indicating that these programs have likely be adapted to meet the cultural needs of these communities. Further research into these

programs will be helpful for understanding how they are working, their impact of family wellbeing and how they be adapted into other communities across Canada.

Mental Health and Related Family Programming

Mental health programs include those that provide psychoeducation on mental health and those that address factors associated with mental health, such as family functioning, children's behaviour, and/or parenting skills. It was found that while many programs did not specifically address mental health through the content and skills provided to families, outcomes of many programs consisted of mental health changes as an indicator of success. Family-based programs can be divided into two categories: (1) multi-family programming and (2) parenting programs.

Multi-Family Programming

The Refugee Family Strengthening Program (RFS) has demonstrated efficacy amongst refugee families in the United States (U.S.). RFS is designed to improve communication and problem-solving skills, develop financial independence, and to improve the marriages, parenting, and family relationships of refugees (Young et al., 2021). It includes three, 8-hour modules. The first two modules teach skills from the Relationship Enhancement (RE) program and focus on topics related to adjusting to life in the U.S. (Young et al., 2021). The third module combines RE skills with information on managing financial needs (Young et al., 2021). RFS is delivered by trained facilitators. Through a randomized control trial with two treatment groups and a control, Young et al. (2021) found that RFS resulted in significant improvements in communication and relationship skills, conflict management skills, and economic stability amongst those in the RFS interventions groups compared to those in the control (Young et al., 2021). These results remained statistically significant at three-month follow-up.

A similar program, called Family Strengthening Intervention for Refugees (FSI-R) has also been found to be effective. FSI-R is a home-visiting intervention "for refugees by refugees", that employs ecological systems theory (DiClemente-Bosco et al., 2022). It was created with a strengths-based orientation, positing that understanding the family narrative and family strengths and resiliency that had helped the family navigate challenges in the past, can serve as resources to support family functioning in the present (DiClemente-Bosco et al., 2022; Fournfelker et al., 2020). FSI-R includes developing a family narrative, psychoeducation on mental health, promotion of resiliency, teaching skills related to positive parenting, educating parents on the education system in the U.S., education on and skills development for stress management, and communication skills (Betancourt et al., 2020; Fournfelker et al., 2020). It involves a series of separate and joint meetings with parents and children to discuss challenges faced, identify family strengths, and to develop positive coping strategies (Fournfelker et al., 2020). Unlike most interventions, FSI-R is delivered by facilitators belonging to the same community as the family.

Using a community-based participatory research approach, Betancourt et al. (2020) examined the feasibility, acceptability, and initial efficacy of FSI-R in a sample of 40 Somali Bantu and 40 Bhutanese families. Families were randomly assigned to receive FSI-R or care as usual. Results demonstrated the program to be highly feasible and widely accepted by the community (Betancourt et al., 2020). For both groups, results showed a reduction in traumatic stress reactions in children

in the FSI-R group compared to the control. Caregiver reported lowered depressive symptoms in children amongst those in the FSI-R compared to the control group (Betancourt et al., 2020). Bhutanese children in the FSI-R group reported reduced family arguing, and parents reported reduced conduct problems in children compared to Bhutanese children in the control group (Betancourt et al., 2020). Qualitative results, based on exit interviews with 36 families who completed FSI-R, revealed that the largest contributor to acceptability and feasibility was the flexibility of scheduling sessions, as they occurred within the home, the facilitator being a member of the community, improved family communication, and increased time spent together as a family (DiClemente-Bosco et al., 2022). Although these findings are preliminary, they provide evidence that FSI-R is feasible and acceptable, as well as that FSI-R has the potential to promote positive mental health and improve family relationships and functioning.

Another family-based intervention found to be effective for refugees is an interactive, culturally tailored, family-based storybook intervention, which incorporates elements of cognitive behavioural therapy (Abi Zeid Daou et al., 2022). In a preliminary, mixed methods study, six Syrian refugee mothers and their children read stories, in which children were asked to point out the emotions of the protagonist and provide a potential solution for the conflict in the story (Abi Zeid Daou et al., 2022). Quantitative results indicated a reduction in anxiety symptoms of children. Thematic analysis of journals (written in by mothers and children following each reading session) revealed that the intervention was effective in enhancing children's overall well-being, agency, and family connectedness, and that families found the stories to be highly culturally relevant (Abi Zeid Daou et al., 2022). This provides preliminary evidence that a cognitive behaviour-informed storybook intervention can enhance refugee well-being and reduce anxiety among children. However, due to the small sample size, and cultural specificity, generalizability is limited.

Further evidence for culturally tailored family programming comes from a brief, community-based intervention for Asian immigrant families in the U.S. Over four weeks, a sample of 12 parent-child dyads participated in psychoeducational workshops focused on the mental health challenges faced by Asian American families and effective parent-child communication (Wu & Lee, 2015). The workshops focused on identifying symptoms of anxiety and how to discuss anxiety with children, assertiveness and social skills training for children, and improving parent-child relationships (Wu & Lee, 2015). Both qualitative and quantitative results demonstrated the efficacy of this workshop as a short-term intervention. Qualitative results indicated communication skills learned led to improvement in parent-child relationships (Wu & Lee, 2015). Children reported increased use of adaptive emotion regulation skills, as well as enhanced understanding of assertive communication (Wu & Lee, 2015). Parents highlighted that it was important for them to address intergenerational cultural gaps with their children (Wu & Lee, 2015). Quantitative results showed higher levels of satisfaction amongst the domains of personal well-being, quality of family relationships, and academic or occupational functioning for both parents and children (Wu & Lee, 2015). However, the pre- and post-intervention differences in these measures were not statistically significant.

Evidence for family interventions also comes from outside of North America. The Happy Families Program was developed and implemented among Burmese migrant and displaced families living

in 20 communities in Thailand. The program consists of 12 weekly sessions in which children learn social skills and caregivers learn parenting skills in separate groups for the first hour and come back together in the second hour of the session to practice skills through structured and unstructured play and receive feedback from facilitators (Annan et al., 2017; Puffer et al., 2017). Topics of focus for children include emotion recognition, coping with anger, problem solving, effects of alcohol and drugs, and communication skills (Annan et al., 2017). Parenting sessions focus on child development, rewarding good behaviour, setting goals, communication skills, effects of drugs and alcohol on families, setting boundaries, and problem solving (Annan et al., 2017). To test the efficacy of the program, 513 caregivers and 479 children, aged 7 to 15 years, were randomly assigned to a treatment group or waitlist control group (Annan et al., 2017; Puffer et al., 2017). Examining the effects of the program on children's mental health, Annan et al. (2017) found that children in the treatment group demonstrated significant reductions in attention problems and externalizing behaviours, as well as improved prosocial behaviours compared to the control group. However, no reductions in internalizing behaviour of children were found (Annan et al., 2017). Examining the effects of the program on parenting and family functioning, Puffer et al. (2017) found that compared to controls, families in the intervention group demonstrated improvement in the quality of parent-child interactions, improvement in family functioning and family cohesion, and decreased negative interactions. Children reported improved communication and caregivers reported decreased hard discipline (Puffer et al., 2017). Thus, the Happy Families Program can be seen as effective in improving the mental health and family functioning of migrant and displaced families.

Parenting Programs

Parenting programs are those which target parents, aiming to provide immigrant and refugee parents with skills and support in adjusting to parenting in a new country. The programs also aim to improve the mental health of parents, and indirectly improve the behaviour and well-being of children.

The *Nobody's Perfect* parenting program is used by a few immigrant serving organizations across Canada in meeting the family and parenting needs of newcomer families. *Nobody's Perfect* is a community-based parenting education and support program that was developed by the Public Health Agency of Canada in the 1980s. It was specifically developed for parents with children aged 0 to 5 who are young, single, social, culturally or geographically isolated, with low income and limited education (Skrypnek & Charchun, 2009). The goals of the program are to increase parents understanding of their children's health, to effect positive change in parents regarding their children's health and behaviours, to improve parenting competence and coping skills, and to increase support among parents (Skrypnek & Charchun, 2009). It is a group-based program provided over six to eights weeks and led by a trained facilitator.

The most recent evaluation of the program is from 2009. However, findings from an evaluation comparing an intervention group to a waitlist control provided strong support for the program. First, parents reported an increase in their use of positive discipline strategies and a decrease in negative practices. These practices were maintained or continued to improve over time. Parents

became more active in their response to unwanted behaviours of their children. Parents also reported increases in positive interactions between parents and children, however, these improvements were not sustained at six months follow up. Further, the program increased parents' abilities to cope with typical stressors, their problem-solving capabilities and perceptions of social support. Focus group interviews indicated strong positive support for the program, with parents reporting multiple positive changes, such as a decreased sense of isolation, increased knowledge about their children's needs, effective discipline, and community resources (Skrypnek & Charchun, 2009). However, there is no indication if any members of the sample were immigrants. So, while the findings provide strong support for the program, further evaluation amongst immigrant and refugee families is needed.

The Ladnaan program has been implemented and extensively studied amongst Somali immigrants in Sweden. This program is a culturally sensitive intervention consisting of two components: (1) information on Swedish society, including information on child welfare services, parenting styles, and children's rights, and (2) the Connect parenting program, which is a standardized program based on Attachment Theory (Osman et al., 2021, 2019, 2017a, 2017b; Osman, 2017). Ladnaan is a 12-week, group-based program, where the first two weeks focus on providing parents with societal information, and the remaining 10 weeks comprise of the Connect program. The Connect program focuses on strengthening parent-child relationships through the enhancement of parents' abilities to reflect on how they respond to their children's behaviour, and by helping parents build trusting and secure relationships with their children (Osman et al., 2021, 2019, 2017a, 2017b; Osman, 2017). Culturally relevant role plays, examples, and exercises are used to present information and teach skills (Osman et al., 2019). Ladnaan was delivered by trained group leaders of Somali background and was conducted in the parents' native language.

Three studies assessing the effectiveness and relevance of the Ladnaan program have been conducted. The first study used a randomized control trial to assess changes in parent mental health and parenting competency, as well as changes in children's behaviour (Osman et al., 2017a, 2017b; Osman 2017). Results for children's behaviour showed that there was significant improvement in children's behavioural problems at two months post-intervention for those in the Ladnaan group, compared to the control group (Osman et al., 2017b; Osman, 2017). The largest effect sizes were found for aggressive behaviour, social problems, and externalizing behaviour (Osman et al., 2017b; Osman, 2017). Parents in the intervention group showed a significant improvement in mental health outcomes, compared to parents in the control group (Osman et al., 2017b; Osman, 2017). Dropout rates were low and participation rates were high, indicating the effectiveness of the program (Osman et al., 2017b).

In another study examining Ladnaan, Osman et al. (2019, 2017) interviewed 50 participants two months post-intervention. Parents reported that they gained confidence in their parenting role and became more aware of, and available for, the needs and behaviours of their children (Osman et al., 2019). Parents reported that learning more about social services and the social environment of the new country increased their confidence and decreased their fears and misconceptions about social services (Osman et al., 2019). Parents emphasized that their increased confidence in parenting resulted in reduced stress and tension between them and their children. Further, parents discussed

having learned how to respond to their children in less authoritarian ways, how to handle conflict, how to listen actively, how to be more present, and about attachment patterns across developmental stages (Osman et al., 2019).

In the third study, the long-term impact of Ladnaan on the mental health of parents and children was assessed (Osman et al., 2021). Results of the longitudinal cohort study indicated that the positive changes in the mental health of parents and children were maintained at three years post-intervention (Osman et al., 2021). This is one of the few studies assessing the long-term impact of a family program for immigrants. Although, this program was specifically modified for Somali immigrants, these short-term and long-term results demonstrate the efficacy of a culturally tailored parenting program for immigrant parents and their children.

An additional parenting program that has been assessed is the Enhancing Family Connection program (Ballard et al., 2017). This program is an adapted version of the manualized, evidence-based intervention, GenerationPMTO, which aims to assist parents in managing children's misbehaviour. Enhancing Family Connections was adapted for Karen refugees resettled from Burma to address cultural background, exposure to trauma, and strain associated with resettlement, alongside parenting practices and emotion regulation (Ballard et al., 2017). The goal of the intervention is to disrupt the intergenerational transmission of maladaptive coping mechanisms that can negatively impact parent-child relationships and well-being (Ballard et al., 2017). The program consists of 10 group sessions led by outside trained providers and interpreters. Following the intervention, caregivers reported changes in their teaching, directions, emotion regulation, discipline, and child compliance (Ballard et al., 2017). Interestingly, in contrast to other parenting programs, immediately upon completion of the program, caregivers reported higher levels of distress, which, the authors posited, may be due to increased awareness of family struggles (Ballard et al., 2017). Children, on the other hand, reported decreases in mental health symptoms.

Another parenting program shown to be effective is CAPAS-Youth, which is a culturally adapted version of the GenerationPMTO intervention (Parra-Cordona et al., 2022). This parenting intervention was adapted to explicitly address stressors related to immigration, discrimination, and challenges associated with biculturalism (Parra-Cordona et al., 2022). The program consists of 9 weekly, two-hour group sessions and is disseminated through the use of role play. Parents use role play to enact familial and cultural conflicts, as well as real time stressors. As role plays are enacted, parents are taught skills to address cultural challenges with their adolescent children, cope with discrimination, and promote family biculturalism (Parra-Cordona et al., 2022). Mindfulness skills are also taught to assist parents in regulating distressing emotions. A randomized control trial showed that mothers in the intervention group showed improvement in four of the core parenting practices, and also reported significant improvements in the internalizing and externalizing behaviours of youth in comparison to the control group (Parra-Cordona et al., 2022). While the results of this study are promising, only mothers were included, limiting understanding of the program on the whole family system.

A scoping review of the literature on parenting programs for immigrant families found that the main objectives of such programs were to support, strengthen, and enhance parenting or to reduce/prevent behavioural problems in children (Hamari et al., 2022). Interventions were also focused on improving family communication and strengthening the parent-child relationship (Hamari et al., 2022). Overall, results from reviewed studies indicate improvements for children in psychological functioning, social and problem-solving skills, mental health, and English-language skills, as well as improvements in behavioural problems, externalizing and internalizing problems, attention problems, stress reactions and depression (Hamari et al., 2022). Improvements for parents were found in parenting skills and practices, well-being, resilience, parenting self-efficacy and confidence, mental health, sense of competence in parenting, coping strategies, parental warmth, and knowledge of alternative forms of discipline (Hamari et al., 2022). For parents, reductions were found in negative discipline, harsh punishment, loneliness and isolation, and parenting stress (Hamari et al., 2022). At the family level, improvements were found in family communication and relationships, parent-child relationship quality, problem-solving communication, family functioning, and social skills, as well as reductions in family arguing and immigration related stress (Hamari et al., 2022).

Physical Health Programs

Programs were categorized as addressing physical health if they were aimed at educating parents/families on and/or facilitating the involvement of families in healthy eating, physical activity, dental health, or anything related to physical or medical health. There is a lack of literature that evaluates family-based physical health programs.

First, Alrashdi et al. (2021) conducted a randomized clinical trial to examine the dental knowledge and behaviours associated with oral health of refugee families. The intervention consisted of two, 1-hour sessions educating families on five oral health topics that had been culturally adapted. Results revealed that this short-term, culture-informed, oral health education intervention alone was not sufficient to improve the oral health knowledge and behaviour of refugee families.

An additional physical health intervention is the Healthy Together (HT) program. HT is an interactive, group-based, family education program that aims to bring families together to improve healthy eating and increase physical activity (Huisken et al., 2021). Although HT has not been developed specifically for immigrant and refugee families, the program was designed to be adaptable to needs of diverse families. The program was implemented in 10 community-based organizations across Canada that offer services to immigrants and refugees. Survey results indicated that HT was acceptable to immigrant and refugee caregivers and led to positive changes in healthy eating and physical activity amongst families (Huisken et al., 2021).

In British Columbia, Canada, the Food Skills for Families program has demonstrated efficacy in improving the food literacy and healthy food intake of families. This program is a hands-on, 6-week, food literacy program for newcomer, low-income families, seniors, Indigenous peoples, and those of Punjabi descent, that teaches participants how to make health meals, snacks, and beverage choices for their families (BC Centre for Disease Control, 2019). Since the initiation of the

program in 2008, over 1,800 programs have been delivered in more than 150 communities in the province (BC CDC, 2022). Following the end of the program, participants reported that they were applying new skills at home, felt more informed about food choices, and felt encourage to eat healthy. In addition, 88% of participants stated that they would eat for fruit and vegetables, 77% felt more connected to their community, and 93% felt more confident in cooking healthy meals (BC CDC, 2022).

Lastly, Wieland et al. (2018) conducted a randomized control trial on a family-based nutrition and physical activity intervention amongst Hispanic, Somali, and Sudanese immigrant communities. While the intervention led to improved dietary habits amongst adults, there were not significant changes found in the adolescent sample (Wieland et al., 2018). Taking these three studies together, there is mixed evidence for the efficacy of family-based, physical health interventions for immigrants and refugees. More research into such programs is needed to determine effectiveness.

The Need for Culturally Relevant Programming

Programs for immigrant and refugee families must be culturally targeted to ensure cultural relevancy and sensitivity, and to ensure the specific needs of the target population can be effectively met. Hamari et al (2022) found that programs for immigrant and refugee families/parents frequently required cultural tailoring to improve religious, linguistic, and cultural suitability. Cultural tailoring was found to lead to increased attention of participants in programming, to be associated with increased acceptance of intervention strategies, increased rates of intervention adherence, and to lead to reduced dropout rates (Hamari et al., 2022). For example, Osman et al. (2019) found that delivering the Ladnaan program with cultural sensitivity and in the language of the target population, led to increased participation of parents.

Hamari et al. (2022) suggest that cultural tailoring should be viewed as a bi-directional process, incorporating cultural tailoring from both the immigrants' cultural background, as well as including information regarding the host country's culture. The Ladnaan program in Sweden for Somali immigrants demonstrates such an approach, as the program combined information from the host country and the Connect parenting program, which included culturally tailored examples, was conducted in the language of the participants, and was facilitated by a trained member of the community (Osman et al., 2021; Osman et al., 2019).

To ensure programs are appropriately culturally tailored, there is a need to involve ethno-specific community organizations, community members, and other stakeholders in the adaptation process. Many of the programs that have been successfully culturally tailored involved an adaptation process. During this process, the researchers first conducted interviews and focus groups with relevant stakeholders to learn more about the needs of the community and the culture of the community to be served. They uncovered local definitions and indicators of family, parent, and child well-being, in order to understand specific risk and protective factors of families in the community (Annan et al., 2017; Ballard et al., 2017; Betancourt et al., 2020; DiClemente-Bosco et al., 2022; Fournfelker et al., 2020; Osman, 2017; Osman et al., 2017a, 2017b, 2019, 2021; Parra-Cordona et al., 2022; Pejic et al., 2016; Puffer et al., 2017).

Recommendations

Based on the literature review, the following recommendations are made for improving the ability to meet family needs, to increase access to and continuation of service pathways, and development of family-based programs: (1) improve how, what, and where information is provided to immigrant and refugee families; (2) ensure that the family needs framework represents the complexity, variability and interconnectedness of newcomer family needs; (3) add to the NAARS an explicit section for assessing the needs of the family unit; (4) coordinate family level settlement needs by linking family members' file in iCARE (Dargy, 2018); (5) improve the education and training of service providers to enhance their cultural competency and to improve knowledge on health and mental health conditions amongst immigrants; (6) create more programs and/or increase access to programs that address employment, housing, income, language, and family health; (7) develop and implement programs that are culturally sensitive and relevant; (8) advocate for improved policy around determining access to support; (9) develop and implement family-based and parenting programs in Canada and the Region of Peel; (10) engage more research efforts to assess existing family programming in Canada to understand what is working and what needs improvement; and (11) form partnerships between settlement agencies, community organizations, and the health care and mental health care sectors to enhance coordination. These recommendations are complex and requires the collaboration of a wide range of stakeholders, including multiple organizations, policy makers, health care providers, and newcomers to ensure their effectiveness. All stakeholders have crucial roles to play and must work together to ensure successful outcomes.

Conclusions

Migration and resettlement are challenging processes for the majority of immigrant and refugee families. The purpose of this review was to understand the needs of immigrant and refugee families during the process of migration, service pathways, and family-based and parenting programs that exist in Canada and globally. The review focused on the family as a unit, rather than the individual, recognizing that within the family, needs are highly interconnected and must be addressed in tandem for the most success. Four key areas of the literature were examined to gain a deeper understanding of family needs, service use and pathways, and programming.

First, we examined some of the most urgent needs of immigrant and refugee families in the Region of Peel that relate to mental health and well-being. These included housing, employment, income, social support, language barriers, family functioning, general health care and mental health care. It was found that these needs are intricately interconnected, as they affect and are affected by other needs of the family. Thus, addressing the mental health of immigrant and refugee families will entail addressing underlying needs that impact stress.

Given the quantity, complexity, and interconnected nature of family needs, services providing support to these needs are integral. Thus, the second focus of the review was to examine access to and pathways to and through services, as well as major pathway barriers. There is a lack of research examining the effectiveness of service pathways for newcomer families. However, a variety of other research addressing pathway components does exist. In Canada, there are many settlement agencies funded by the federal and/or provincial governments that offer programs and services

intended to help meet the resettlement needs of newcomer families. However, despite their existence, there are low levels of awareness of services. This greatly impacts service pathways and indicates the need to improve information services to enhance awareness and initiate pathways.

The primary way that newcomers become aware of and initially enter services is through family and friends. However, many newcomer families do not have these connections. Federal programs and services delivered by community-based settlement and resettlement organization, such as NAARS are key to facilitating pathways, as they enable newcomers to learn more about their needs and services available to support them. However, standard NAARS do not assess family unit needs. Some Canadian immigrant serving organizations are adapting the NAARS to include a family level assessment. There is also a lack of usage of NAARS by immigrants. Finally, there are several barriers impact pathways, including lack of awareness by families of services, fragmented care, lack of funding, and program restrictions.

Clearly, there is a need to facilitate improved pathways to and through services. This will involve providing information to families about services and how to access them early on in their arrival, increasing use of NAARS, and improving continuity and coordination of care through integrated, intersectoral care. However, the ability to improve service pathways may be impacted by limited funding, funding requirements, neoliberal ideologies, and siloed care. Thus, effectively creating and improving service pathways will also require systemic and structural changes surrounding policies, funding, and dominant ideologies.

Thirdly, following the analysis of pathways, the focus of the review shifted to specific family theories and programs. Family theories were examined since they are key to understanding family dynamics and functioning and are helpful in the development of effective programs and services for families. However, the majority of family theories are based on the Western, nuclear family, which may not align with the experience of immigrant and refugee families, limiting their ability to lead to effective programming. Theories on family stress and resilience may be the most applicable, given that they focus predominantly on experiences of stress, crisis, resources, subjective meaning, and adaptation relative to the individual family of focus.

Lastly, family-based and parent-based programming were analyzed to determine the types of programs that have been used and their efficacy in addressing well-being and functioning of immigrant and refugee families. Family-based programs exist across Canada, however, there is a lack of research published on the outcomes of these programs, which impedes the understanding of their effective. Literature from the global context has assessed some outcomes, and therefore a variety of these programs were reviewed. Most programs in the literature focus on mental health and related issues, including family functioning and children's behaviour. The programs examined are highly clinical, which may limit ability to be applied in community context, although, some programs were implemented in communities and were effective. These programs were also found to be highly ethno-specific, which may limit their usefulness and/or require significant adaptations for settlement agencies that serve a broader range of cultures. Further, while mental health is addressed, these programs do not extend into additional underlying factors that affect family

mental health, such as housing, income, employment, and language. Thus, it is recommended that further programs engage with these needs. Additionally, most of the programs focus on refugee populations. When compared to other immigrant families, refugee families may be at heightened risk of mental health issues and family dysfunction, due to the nature of migration.

Some key components of programming arose. First, the majority of the programs were effective in improving mental health, family functioning, and overall well-being of parents and children. Second, many of these programs were culturally adapted in collaboration with the community to ensure cultural relevancy. Program users found cultural relevancy to be key to their engagement. Ensuring cultural relevancy of program for immigrant and refugee families is key for program success.

The findings of this literature review have implications for settlement agencies, broader community-based organizations, funding agencies and other relevant stakeholders involved in supporting immigrant and refugee families resettling in Canada. This review can help facilitate a better understanding of family-level needs and how mental health is impacted by basic needs. These basic needs will need to be addressed before or simultaneously with the addressing of mental health problems. Further, this review indicates that a comprehensive assessment of current gaps is service pathways for families is critical to being able to improve family support and accessibility to services. This review provides guidance on program development and implementation for immigrant and refugee families. It can also inform policy to enable the creation of more effective service pathway and program development. Lastly, this review serves as a valuable resource for health care providers and funding agencies involve in supporting newcomer families and can assist in guiding decision-making around the provision of mental health services.

References

Abi Zeid Daou, K.R., Abi Zeid Daou, L.R., & Cousineau-Perusse, M. (2022). Storytelling as a tool: A family-based intervention for newly resettled Syrian refugee children. *International Journal of Social Welfare*, *31*(1), 56-65. https://doi.org/10.1111/ijsw.12476

Alrashdi, H.A., Cervantes, Mendez, M.J., & Farokhi, M. (2021) education intervention with respect to the oral health knowledge, attitude, and behaviors of refugee families: A randomized clinical trial of effectiveness. *Journal of Public Health Dentistry*, *81*(2), 90-99. https://doi.org/10.1111/jphd.12415.

Annan, J., Sim, A., Puffer, E.S., Salhi, C., & Betancourt, T.S. (2017). improving mental health outcomes of Burmese migrant and displaced children in Thailand: A community-based randomized controlled trial of parenting and family skills intervention. *Prev Sci*, *18*, 793-803. https://doi.org/10.1007/s11121-016-0728-2

Baghdasaryan, Z., Lampa, E., & Osman, F. (2021). '*Let us understand each other and work together in the child's interest'* – Exploring the narratives of newly arrived refugee parents in

Sweden. *International Journal of Intercultural Relations, 81*, 226-235. https://doi.org/10.1016/j.ijintrel.2021.02.004

Ballard, J., Wieling, E., & Forgatchm M. (2017). Feasibility of implementation of a parenting intervention with Karen refugees resettled from Burma. *Journal of Marital and Family Therapy, 44*(2), 220-234. https://doi.org/10.1111/jmft.12286

BC Centre for Disease Control (CDC). (2022). *Food skills for families: Evaluation report 2021-2022.* http://www.bccdc.ca/Our-Services-Site/Documents/Food%20Skills%20for%20Families/Evaluation%20Reports/BCCDC_2021-2022_Evaluation_Report_FINAL.pdf

Benipal, P.K., Ho, B., Kaukab, T., Rashid, M., Bowry, A., Yousafzai, A.K., & Singh Minhas, R. (2022). For the parent, by the parent: Creating a program to empower parents of refugee background in Canada using novel participatory approaches. *Children*, 9, 1816. https://doi.org/10.3390/childre9121816

Bierman, A.S., Ahmad, F., & Mawani, F.N. (2009). Gender, migration, and health. In V. Agnew (ed.), *Racialized migrant women in Canada: Essays on health, violence and equity.* (pp. 98-136). University of Toronto Press.

Bowen, M. (1966). The use of family theory in clinical practice. *Comprehensive Psychiatry, 7*(5), 345-374. https://journals-scholarsportal-info.myaccess.library.utoronto.ca/pdf/0010440x/v07i0005/345_tuofticp.xml

Bowen, M. (1978). *Family therapy in clinical practice.* New York, NY: Aronson.

Brandenberger, J., Tylleskar, T., Sontag, K., Peterhans, B., & Ritz, N. (2019). A systematic literature review of reported challenges in health care delivery to migrants and refugees in high-income countries – the 3C model. *BMC Public Health, 19*, 755 – 765. https://doi.org/10.1186/s12889-019-7049-x

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology, 22*(6), 723-742. https://doi.org/0012-1649/86/$00.75.

Calgary Immigrant Women's Association (CIWA). (n.d.). *Family resource network – immigrant/newcomer.* https://ciwa-online.com/newcomer-services/family-resource-network/

Catholic Crosscultural Services (CCS). (n.d.). *Family in settlement together.* https://www.cathcrosscultural.org/family-in-settlement-together/

Chowdhury, N., Naeem, I., Ferdous, M., Chowdhury, M., Goopy, S., Rumana, N., & Turin, T.C. (2021). Unmet healthcare needs among migrant populations in Canada: Exploring the research

landscape through a systematic integrative review. *Journal of Immigrant and Minority Health, 23*, 353-372. http://doi.org/10/1007/s10903-020-01086-3.

Cox, M.J., & Paley, B. (2003). Understanding families as systems. *America Psychological Society, 12*(5), 193-196.

Dahms, K., King, D., & Duchame, A. (2022, August 16). *Housing affordability: The worst deterioration in 41 years in Q2 2022.* National Bank of Canada. https://www.nbc.ca/content/dam/bnc/en/rates-and-analysis/economic-analysis/housing-affordability.pdf

Daneshpour, M. (2017). Examining family stress: Theory and research. *Quarterly of Clinical Psychology Studies, 7*(28), 1-7.

Dargy, T. (2018, June). *Serving immigrant families: Using knowledge translation to inform a family approach in the settlement sector.* (Working paper no. 2018/1).

DiClemente-Bosco, K., Neville, S.E., Berent, J.M., Farrar, J., Mishra, T., Abdi, A., Beardslee, W.R., Creswell, J.W., & Betancourt, T.S. (2022). Understanding mechanisms of change in a family-based preventative mental health intervention for refugees by refugees in New England. *Transcultural Psychiatry, 104.* https:/doi.org/10.1177/13634615221111627.

Disney, L. (2021). The impact of employment on immigrant mental health: results from a national survey. *Social Work, 66*(2), 93-100. https://doi.org/10.1093/sw/swab005

Ellis, B.H., Abdi, S.M., & Winer, J.P. (2020). *Mental health practice with immigrant and refugee youth: A socioecological framework.* American Psychological Association.

Ellis, B.H., Sideridis, G., Davis, S.H., Cardeli, E., Abdi, S.M., & Lincoln, A.K. (2022). Discrimination and mental health of Somali immigrants in North America: a longitudinal study from 2013 to 2019. *Social Psychiatry and Psychiatric Epidemiology, 57*, 1049-1059. https://doi.org/10.1007.s00127-022-02235-9

Employment and Social Development Canada. (2014, December). *Panel on Employment challenges of new Canadians: Summary of the panel's online consultation.* Government of Canada. https://www.canada.ca/content/dam/esdc-edsc/documents/programs/foreign-credential-recognition/consultations/emp-challenges/Summary_of_the_Panel's_Online_Consultation_WP-199_EN.pdf

Erdem, G., & Safi, O.A. (2018). The cultural lens approach to bowen family systems theory: Contributions to family change theory. *Journal of Family Theory & Review, 10*, 469-483. https://doi.org/10.1111/jft.1225.

Family Dynamics. (n.d.). *Family supports for newcomers program.* https://familydynamics.ca/services/family-supports-for-newcomers/

Fournfelker, R.L., Mishra, T., Gautam, B., Berent, J.M., Abdi, A., & Betancourt, T.S. (2020). Engaging refugee families in a family-strengthening intervention to promote child mental health and family functioning. In Ventevogel, P. (eds). *Child, Adolescent, and Family Refugee Mental Health.* Pp. 257-269. https://doi.org/10.1007/978-3-030-45278-0_16.

Government of Canada. (2016, August 22). *Canada's health care system.* https://www.canada.ca/en/health-canada/services/canada-health-care-system.html

Hadi, A., & Labonte, R. (2011). *Housing and the health of immigrants in Canada: A narrative review*. (Working papers volume 2, number 5). E/Exchange. Housing_and_Health_of_Recent_Immigrants.pdf

Hamari, L., Konttila, J., Merikukka, M., Tuomikoski, A.M., Kouvonen, P., & Kurki, M. (2022). Parent support programmes for families who are immigrants: A scoping review. *Journal of Immigrant and Minority Health, 24*, 506-525. https://doi.org/10.1007/s10903-021-01181-z

Hill, R. (1958). Generic features of families under stress. *Social Casework, 49*, 139-150.

Huisken, A., Bottorff, J.L., & Nesmith, C. (2021). Evaluating the feasibility and acceptability of the healthy together program for immigrant and refugee families in Canada. *International Journal of Migration, Health, and Social Care, 17*(4), 487-499. https://doi.org/10.1108/ijmhsc-12-2019-0101.

Hynie, M. (2018). The social determinants of refugee mental health in the post-migration context. *The Canadian Journal of Psychiatry*, *63*(5), 297-303. https://doi.org/10.1177/0706743717746666

Imbarlina-Ramos, R., & Scantlebury, T. (2019, March). Report on Peel Newcomers. Peel Newcomer Strategy Group. pnsg_2019-report-on-peel-newcomers_v1-6_interactive.pdf (peelnewcomer.org)

Immigration, Refugees, and Citizenship Canada. (2021a). Settlement outcomes highlights report: Summary findings from IRCC's first settlement outcomes report 2021. https://www.canada.ca/content/dam/ircc/documents/pdf/english/corporate/publications-manuals/settlement-outcomes-highlights-report-2021.pdf

Immigration, Refugee and Citizenship Canada (IRCC). (2021b, July 19). *Resettlement assistance program and case management services for government-assisted refugees and other vulnerable newcomers: Funding guidelines*. Government of Canada. https://www.canada.ca/en/immigration-refugees-citizenship/corporate/partners-service-providers/funding/rap-gov-assisted-vulnerable-newcomers-funding-guidelines.html

Lane, G., & Vatanparast, H. (2022). Adjusting the Canadian healthcare system to meet newcomer needs. *International Journal of Environmental Research and Public Health, 19*, 3752. https://doi.org/10.3390/ijerph19073752

Kerr, M.E., & Bowen, M. (1988). *Family evaluation.* New York, NY: Norton.

Kim, H., Prouty, A.M., Smith, D., B., Ko, M.J., Wetchler, J.L., & Oh, J.E. (2014). Differentiation of self and its relationship with family functioning in South Koreans. *American Journal for Family Therapy, 42*, 257-265. https://doi.org/10/1080/01926187.2013.838928

Masten, A., & Monn, A.R. (2015). Child and family resilience: A call for integrating science, practice, and training. *Family Relations*, *64*(1), 5-21.

Mawani, F.N., O'Campo, P., & Smith, P. (2022). Opportunity costs: Underemployment and mental health inequities between immigrant and Canadian-born labour force participants: A cross-sectional study. *Journal of International Migration and Integration, 23,* 1443-1470.

McCubbin, H.I., & Patterson, J.M. (1983). The family stress process: The Double ABCX Model of adjustment and adaptation. *Marriage & Family Review, 6*(1-2), p. 7-37. Doi: https://doi-org.myaccess.library.utoronto.ca/10.1300/J002v06n01_02

Mirecki, R.M., & Chou, J.L. (2013). A multicultural application of attachment theory with immigrant families: Contextual and developmental adaptations. *Contemporary Family Therapy, 35*, 508-515. https://doi.org/10.1007/s10591-012-9210-x.

MOSAIC B.C. (n.d.). *Children, youth and family support.* https://mosaicbc.org/our-services/children-youth-and-family-support/

Mosaic – Newcomer Family Resource Network (n.d.). *Family literacy and parenting programs.* https://www.mosaicnet.ca/family/

Mukhtar, M., Dean, J., Wilson, K., Ghassemi, E., & Wilson, D.H. (2016). "But many of these problems are about funds…": The challenges immigrant settlement agencies (ISAs) encounter in a suburban setting in Ontario, Canada. *International Migration & Integration, 17*, 389-408. https://doi.org/10.1007/s12134-015-0421-5

Nakhaie, M.R. (2018). Service needs of immigrants and refugees. *International Migration & Integration, 19,* 143-160. https://doi.org/10.1007/s12134-017-0534-0

Ng, E., & Zhang, H. (2020, August 19). *The mental health of immigrants and refugees: Canadian evidence from a nationally linked database.* (Report no. 82-003-X). Statistics Canada.

Retrieved from https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2020008/article/00001-eng.pdf?st=jgykBhl3

Ogunsiji, O., Ng Chok, H., Mashingaidze, G., & Wilkes, L. (2017). "I am still passionate despite the challenges": Nurses navigating the care for refugees. *Journal of Clinical Nursing, 27*, 3335-3344. https://doi.org/10.1111/jocn.13863

Osman, F., Vixner, L., Flacking, R., Klingberg-Allvin, M., Schön, U-K., & Salari, R. (2021). Impact of a culturally tailored parenting programme on the mental health of Somali parents and children living in Sweden: A longitudinal cohort study. *BMJ Open, 11*(8), e045067-e045067. https://doi.org/10.1136/bmjopen-2020-045067

Osman, F., Flacking, R., Allvin, M.K., & Schon, U.K. (2019). Qualitative study showed that a culturally tailored parenting programme improved the confidence and skills of Somali immigrants. *Acta Paediatrica, 108*, 1482-1490. https://doi.org/10.1111/apa.14788

Osman, F. Salari, R., Klingberg-Allvin, M., Schon, U-K., & Flacking, R. (2017a). Effects of a culturally tailoered parenting programme in Somali-born parents' mental health and sense of competence in parenting: A randomised controlled trial. *BMJ Open, 7*, e017600. https://doi.org/10.1136/bmjopen-2017-017600.

Osman, F., Flacking, R., Schon, U-K., & Kilingberg-Allvin, M. (2017b). A support program for Somali-born parents on children's behavioural problems. *Pediatrics, 139*(3), e20162764. https://doi.org/10.1542/peds.2016-2764.

Osman, F., Klingberg-Allvin, M., Flacking, R., & Schon, U-K. (2016). Parenting in transition – Somali-born parents' experiences of and needs for parenting support programmes. *BMC International Health and Human Rights, 16*(7). https://doi.org10.1186/s12914-016-0082-2.

Ozbay, F., Johnson, D.C., Dimoulas, E., Mogran, C.A., Charney, D., & Southwick, S. (2007). Social support and resilience to stress. *Psychiatry, 4*(5), 35-40.

Paat, Y.F. (2013). Working with immigrant children and their families: An application of Bronfenbrenner's ecological systems theory. *Journal of Huma Behavior in the Social Environment, 23*(8), 954-966. https:doi.org/10.1080/10911359.2013.800007.

Pacific Immigrant Resources Society (PIRS). (n.d.). *Children & Family Programs*. https://pirs.bc.ca/programs-services/childrens-programs/

Pandey, M., Maina, R.G., Amoyaw, J., Li, Y., Kamrul, R., Michaels, C.R., & Maroof, R. (2021). Impacts of English language proficiency on healthcare access, use and outcomes among immigrants: A qualitative study. *BMC Health Services Research, 21¸* 741. https://doi.org/10.1186/s12913-021-06750-4

Papero, D.V. (1990). *Bowen family systems theory*. Needham Heights, MA: Allyn and Bacon.

Parada, H., Limon Bravo, F., Loewen, R., & El-Lahib, Y. (2021). Exploring the practices of refugee settlement practitioners in Toronto: an institutional ethnography. *Journal of Immigrant & Refugee Studies, 19*(4), 422-435. https://doi.org/10.1080/15562948.2020.1824053

Parra-Cordona, R., Fuentes-Balderrama, J., Vanderziel, A., Lopez-Zeron, G., Domenech Rodriguez, M.M., DeGarmo, D.S., & Anthony, J.C. (2022). A culturally adapted parenting intervention for Mexican-origin immigrant families with adolescents: Integrating science, culture, and a focus on immigration-related adversity. *Prevention Science, 23,* 271-282. https://doi.org.10.1007/s11121-021-01317-5

Patterson, J.M. (2002a). Integrating family resilience and family stress theory. *Journal of Marriage and Family, 64*(2), 349-360. https://doi.org/10.1111/j.1741-3737.2002.00349.x

Patterson, J.M. (2002b). Understanding family resilience. *Journal of Clinical Psyhcology, 58*(3), 233-246. https://doi.org/10.1002/jclp.10019.

Pedersen, S., & Revenson, T.A. (2005). Parental illness, family functioning, and adolescent well-being: A family ecology framework to guide research. *Journal of Family Psychology, 19*(3), 404-419. https://doi.org/10.1037/0893-3200.19.3.404

Perreira, K.M., & Ornelas, I. (2013). Painful passages: traumatic experiences and post-traumatic stress among immigrant Latino adolescents and their primary caregivers. *International Migration Review, 47*(4), 976-1005.

Puffer, E.S., Annan, J., Sim, A.L., Salhi, C., & Betancourt, T.S. (2017) the impact of a family skills training intervention among Burmese migrant families in Thailand: A randomized controlled trial. *PLOS One, 12*(3), e0172611. https://doi.org/10.1341/journal.pone.0172611

Richard, L., Richardson, G., Jaye, C., & Stokes, T. (2019). Providing care to refugees through mainstream general practice in the southern health region of New Zealand: a qualitative study of primary healthcare professionals' perspectives. *BMJ Open, 9*, e034323. https://doi.org/10.1136/bmjopen-2019-034323

Rothbaum, F., Rosen, K., Ujiie, T., & Uchida, N. (2002). Family systems theory, attachment theory and culture. *Family Process, 41*(3), 328-350.

Salami, B., Salma, J., & Hegadoren, K. (2019). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *International Journal of Mental Health Nursing, 28*, 152-161. https://doi.org/10.1111/inm.12512.

Sangalang, C.C., Becerra, D., Mitchell, F.M., Lechuga-Pena, S., Lopez, K., & Kim, I. (2019). Trauma, post-migration stress and mental health: A comparative analysis of refugees and immigrants in the United States. *Journal of Immigrant and Minority Health, 21,* 909-919. https://doi.org/10.1007/s10903-018-0826-2

Shen, Y., Seo, E., Jiles, A.I., Zheng, Y., & Wang, Y. (2022). Language brokering and immigrant-origin youth's well-being: A meta-analytic review. *America Psychologist.* https://dx.doi/10.1037/amp0001035

Sim, A., Puffer, E., Ahmad, A., Hammad, L., & Georgiades, K. (2023). Resettlement, mental health, and coping: a mixed methods survey with recently resettled refugee parents in Canada. *BMC Public Health, 23,* 386. https://doi.org/10.1186/s12889-023-15300-y

Skrypnek, B.J., & Charchun, J. (2009, July). *An evaluation of the Nobody's Perfect parenting program.* Public Health Agency of Canada.

Stewart, M., Dennis, C.L., Kariwo, M., Kushner, K.E., Letourneau, N., Makumbe, K., Makwarimba, E., & Shizha, E. (2015). Challenges faced by refugee new parents from Africa in Canada. *Journal of Immigrant Minority Health, 17,* 1146-1156. https://doi.org/10.1007/s10903-014-0062-3.

Stewart, M.J., Makwarimba, E., Beiser, M., Neufeld, A., Simich, L., & Spitzer, D. (2010). Social support and health: Immigrants' and refugees' perspectives. *Diversity in Health and Care, 7,* 91-103.

S.U.C.C.E.S.S. (n.d.). *Multicultural early years & parenting support programs.* https://successbc.ca/earlyyears/?filter=family

Tarricone, I., Stivanello, E., Ferrari, S., Colombini, N., Bolla, M., Giubbarelli, C., Costantini, C., Cazzamalli, S., Mimmi, S., Tedesco, D., Manchetti, M., Rigatelli, M., Maso, E., Balestrieri, M., Vender, S., & Beradi, D. (2011). Migrant pathways to community mental health centres in Italy. *International Journal of Social Psychiatry, 58*(5), 505-511. https://doi.org/10.1177/0020764011409523

Thompson, M.S., Chaze, F., George, U., & Guruge, S. (2015). Improving immigrant populations' access to mental health services in Canada: A review of barriers and recommendations. *Journal of Immigrant Minority Health, 17,* 1895-1905. https://doi.org/10.1007/s10903-015-0175-3

Tulli, M., Salami, S., Begashaw, L., Mehrali, S., Yohani, S., & Hegadoren, K. (2020). Immigrant mothers' perspective of barriers and facilitators in accessing mental health care for their children. *Journal of Transcultural Nursing, 31*(6), 598-605. https://doi.org/10.1177/1043659620902812

Vesely, C.K., Letiecq, B., & Goodman, R.D. (2017). Immigrant family resilience in context: Using a community-based approach to build a new conceptual model. *Journal of Family Theory & Review, 9*, 93-110. https://doi.org/10.1111/jtfr.12177

Walsh, F. (2003). Family resilience: A framework for clinical practice. *Family Process, 42*(1), 1-18.

Walsh, F. (2012). Family resilience: Strengths forged through adversity. In *Normal Family Processes, fourth edition: Growing Diversity and Complexity.* (pp.399-427). The Guildford Press. https://web-s-ebscohost-com.subzero.lib.uoguelph.ca/ehost/ebookviewer/ebook/bmxlYmtfXzQxNTc2Ml9fQU41?sid=8ec8587f-414d-4a80-b4b5-282246a5b802@redis&vid=0&format=EB&lpid=lp_399&rid=0

Walsh, F. (2012). Family resilience: A developmental systems framework. *European Journal of Developmental Psychology, 13*(3), 313-324. https://doi.org/10.1080/17405629.2016.1154035.

Walsh, F. (2016). Applying a family resilience framework in training, practice, and research: Mastering the art of the possible. *Family Process, 55*(4), 616-632. https://doi.org/10.1111/famp.12260

Wieland, Hanza, M. M. M., Weis, J. A., Meiers, S. J., Patten, C. A., Clark, M. M., Sloan, J. A., Novotny, P. J., Njeru, J. W., Abbenyi, A., Levine, J. A., Goodson, M., Capetillo, G. D. P., Osman, A., Hared, A., Nigon, J. A., & Sia, I. G. (2018). Healthy Immigrant Families: Randomized Controlled Trial of a Family-Based Nutrition and Physical Activity Intervention. American Journal of Health Promotion, 32(2), 473–484. https://doi.org/10.1177/0890117117733342

World Health Organization (WHO). (2022, June 17). Mental health: strengthening our response. ahttps://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

World Health Organization (WHO). (2021, August 31). *Mental health and forced displacement.* https://www.who.int/news-room/fact-sheets/detail/mental-health-and-forced-displacement

World Health Organization (WHO). (2018, November 26). *Housing impacts health: New WHO guidelines on housing and health.* https://www.who.int/news/item/26-11-2018-housing-impacts-health-new-who-guidelines-on-housing-and-health

Wu, T.Y.& Lee, J. (2015). A pilot program to promote mental health among Asian-America immigrant children and their parents: A participatory approach. *International Journal of Child, Youth and Family Studies, 6*(4.1), 730-745.

Wylie, L., Corrado, A. M., Edwards, N., Benlamri, M., & Murcia Monroy, D. E. (2020). Reframing resilience: Strengthening continuity of patient care to improve the mental health of

immigrants and refugees. *International Journal of Mental Health Nursing, 29,* 69-79. https://doi.org/10.111/inm.12650

Young, S.J., Rockhill, S., Hernandez, A., & DeMaria, R. (2021). Evaluation of the impact of a health relationship program among U.S. refugees. *Family Relations, 70*(5), 1643-1656. https://doi.org/10.1111.fare.12563

Zhao, J., Xue, L., & Gilkinson, T. (2010). Health status and social capital of recent immigrants to Canada. In *Health Policy Research Bulletin,* (pp. 41 – 44). file:///C:/Users/Sarah/Downloads/Migration_and_Health_2010_pdf.pdf

Ziersch, A., & Due, C. (2018). A mixed methods systematic review of studies examining the relationship between housing and health for people from refugee and asylum seeking backgrounds. *Social Science & Medicine, 213,* 199-219. https://doi.org/10.1016/j.socscimed.2018.07.045.

Ziersch, A., Walsh, M., Due, C., & Duivesteyn, E. (2017). Exploring the relationship between housing and health for refugees and asylum seekers in South Australia: A qualitative study. *International Journal of Environmental Research and Public Health, 14*, 1036.