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FINAL OUTCOMES REPORT

FOR:

MENTAL HEALTH SERVICES FOR NEWCOMER YOUTH: EXPLORING NEEDS AND ENHANCING ACCESS

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EXECUTIVE SUMMARY

This report presents preliminary findings from the CHEO funded project entitled: Mental health services for newcomer youth: Exploring needs and enhancing access (MHSNY). MHSNY sought to understand the mental health needs and access barriers of youth and families from four newcomer communities in the Toronto area: Afghan, Colombian, Sudanese, and Tamil. The project utilized a mixed-method participatory research based approach, which involved focus groups and interviews with youth (14-18 years of age), who had arrived in Canada within the last five years from the above communities and parents, and service providers who work with these communities. A questionnaire, which included three psychometric instruments (the Rosenberg Self-Esteem Scale (RSE), selected scales from the Health Behaviour in School-Aged Children (HBSC) instrument and the Current Self-Esteem Scale (CSE)) and socio-demographic questions, was also administered to youth.

Specifically, the objectives of the project included:

1. To explore how newcomer youth from diverse cultural backgrounds understand and conceptualize mental health and mental illness;
2. To explore the mental health needs and help-seeking behaviours of newcomer youth;
3. To explore access and barriers to community-based mental health services;
4. To propose integrated policies and recommend proactive practices that improve access and reduce barriers for mental health services for newcomer youth in Ontario; and
5. To actively engage newcomer youth in the research process.

We held seven focus groups (2 Afghan, 2 Colombian, 1 Sudanese, 1 Tamil, and 1 service providers), 16 in-depth interviews (2 Afghan youth, 4 Sudanese youth, 4 Sudanese parents, 1 Colombian parent, and 5 service providers) and administered 56 questionnaires to youth.

In keeping with a community-based participatory research (CBPR) approach, we selected and recruited a Youth Advisory Committee (YAC) composed of seven male and female youth from the above communities. The YAC received training in CBPR, anti-racism and anti-oppression principles, the social determinants of mental health, and attended two forum theatre ¹ workshops. The YAC also pilot

¹ Forum theatre is a style of theatre that encourages and facilitates audience participation towards solving community issues and problems.
tested our questionnaire and provided feedback and context on preliminary qualitative and quantitative findings during our data collection.

Four Peer Researchers (PRs) were also interviewed and hired, based on their connections with youth members of the targeted communities, to assist the research team with participant recruitment.

A youth-led conference was also organized with the leadership and participation of the YAC members and PRs. This conference included innovative methods to engage the predominantly youth audience, such as a forum theatre workshop (based on a script written by YAC members and PRs), and a photovoice style presentation by YAC members and PRs. Another session on mental health and stigma also sought to break some of the myths around mental illness and challenge media stereotypes around these myths as well. The conference generated a great deal of attention on the part of service providers and youth – both newcomers and Canadians alike.

We have contextualized our preliminary findings within an ecosystemic framework, which considers the interrelatedness and interdependency between the individual (micro), family or community (meso), and societal (macro) levels. Preliminary findings from our data collection thus indicate that experiences within the school system, including linguistic factors, discrimination, cultural differences, teachers and other educators, etc. significantly impact youth mental health. At the societal level, community supports and employment opportunities also impact the mental health and wellbeing of youth and their families. The pre- and post-migration experiences and cultural and political contexts of youth also affect their subsequent mental health and wellbeing.

Based on the data analysis carried out thus far, we have also made preliminary conclusions and recommendations. In general, when conceptualizing mental health and mental illness, participants tended to have varied conceptions, which did not always overlap with western bio-medical psychiatric definitions of the same. Barriers to accessing mental health care were also based on the social determinants of mental health, which include the political, socio-cultural and economic conditions of people, and these must therefore be factored into the analysis and delivery of mental health care. Given that there are also a wide range of coping mechanisms and mental health promotion strategies described by respondents, mental health care needs to be delivered in non-traditional spaces and in innovative ways that engage youth more effectively, than at present. In particular, language and poverty, which form some of the biggest barriers against access to mental health care, need to be addressed in policy and program initiatives. These barriers exist at the individual, family/community and societal levels.
Based on the above, preliminary educational and practice recommendations have been made. Service providers as well as health and social service students need to be educated on the social determinants of mental health, health disparities, as well as on newcomer youth resiliencies. Newcomer families also need to be educated on the mental health system and how to access services, as well as on the importance of mental health to overall health and wellbeing. Culturally competent care needs to be implemented across the mental health care system, including support for inter-sectoral strategies that address the various dimensions of mental health and wellbeing. Finally, support should also be provided for multi-method, longitudinal and community-based research on newcomer communities and mental health.
# TABLE OF CONTENTS

**EXECUTIVE SUMMARY** .................................................. 2  
**GLOSSARY OF TERMS** ................................................. 6  
1. **PROJECT OVERVIEW** ............................................. 7  
   1.1 Context .......................................................... 7  
   1.2 Purpose and Objectives ....................................... 7  
2. **METHODOLOGY** .................................................. 8  
   2.1 Design and Theoretical Context .............................. 8  
   2.2 Project Modifications in Response to Ethics and Community Needs .............................. 10  
   2.3 Samples and Data Collection Process ........................ 11  
3. **RESULTS** .......................................................... 12  
   3.1 Process .......................................................... 12  
   3.2 Qualitative Data Collection and Results .................... 13  
   3.3 Ecosystemic Framework ....................................... 14  
   3.3.1 Individual Level ........................................... 15  
   3.3.2 Family and Community Level ............................. 18  
   3.3.3 Societal Level ............................................. 19  
3.4 Quantitative Data Collection and Results ...................... 21  
3.5 Working with Newcomers and Youth within the CBPR Approach ........................................... 27  
3.6. Engaging Youth and Capacity Building ....................... 29  
4. **PRELIMINARY CONCLUSIONS & RECOMMENDATIONS** ........ 30  
5. **KNOWLEDGE EXCHANGE PLAN** ................................ 32  
   5.1 Overview of Knowledge Exchange Activities ............... 32  
   5.2 Knowledge Dissemination .................................... 32  
   5.3 Future Plans .................................................. 34  
**FINAL ACCOUNTING SUMMARY REPORT** ............................. 35  
**BIBLIOGRAPHY** .................................................... 36  
**APPENDIX A: FOCUS GROUP & INTERVIEW GUIDES & QUESTIONNAIRE** ........ 38  
**APPENDIX B: LIST OF RESOURCES GIVEN TO PARTICIPANTS** ........ 55  
**APPENDIX C: YOUTH CONFERENCE REPORT (AGENDA, ADVERTISING POSTER, PROJECT INFORMATION FLYER, & SUMMARY OF WORKSHOPS & EVALUATIONS)** .................................................. 60  
**APPENDIX D: YAC/PR EVALUATION QUESTIONS** ............... 68  
**APPENDIX E: SELECTED EXAMPLES OF PROJECT DISSEMINATION** .... 70
## GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Access Alliance</td>
<td>Access Alliance Multicultural Health and Community Services</td>
</tr>
<tr>
<td>CBPR</td>
<td>Community-Based Participatory Research</td>
</tr>
<tr>
<td>Co-I</td>
<td>Co-Investigator</td>
</tr>
<tr>
<td>Co-PI</td>
<td>Co-Principal Investigator</td>
</tr>
<tr>
<td>FG</td>
<td>Focus Group</td>
</tr>
<tr>
<td>FoN, U of T</td>
<td>Faculty of Nursing, University of Toronto</td>
</tr>
<tr>
<td>MHP</td>
<td>Mental Health Promotion</td>
</tr>
<tr>
<td>MHSNY</td>
<td>Mental Health Services for Newcomer Youth</td>
</tr>
<tr>
<td>NYMH</td>
<td>Newcomer Youth Mental Health (this was the shorter name used for the project)</td>
</tr>
<tr>
<td>PI</td>
<td>Principal Investigator</td>
</tr>
<tr>
<td>PR</td>
<td>Peer Researcher</td>
</tr>
<tr>
<td>RA</td>
<td>Research Assistant</td>
</tr>
<tr>
<td>RC</td>
<td>Research Coordinator</td>
</tr>
<tr>
<td>SDoH</td>
<td>Social Determinants of Health</td>
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<tr>
<td>YAC</td>
<td>Youth Advisory Committee</td>
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1. PROJECT OVERVIEW

1.1 Context
Mental health services for newcomer youth: Exploring needs and enhancing access (MHSNY) was conceptualized to fill a gap in the current research and literature on newcomer youth and mental health.

According to 2006 Census data, Canada’s immigrant population has reached approximately six million, which represents almost 20% of Canada’s total population of 33 million (Statistics Canada, 2007). In Ontario, 25% (over three million) of the total population of approximately 12 million were born outside of Canada (Statistics Canada, 2006). Immigration accounts for about two-thirds of the population growth in Canada.

Between 2001 and 2006, over one million immigrants came to Canada. A significant majority (70%) of these immigrants settle in Toronto, Montréal, and Vancouver (Statistics Canada, 2007). Approximately half of the individuals who migrate to Canada are between the ages of 25 and 44 years. Just above 20% of those who have recently migrated are 15 years and younger (Citizenship and Immigration Canada, 2005).

1.2 Purpose and Objectives
Given the numbers of immigrants Canada receives every year from diverse national, cultural, and linguistic groups, services need to be appropriately conceptualized and delivered, to ensure easier settlement and integration for these groups. This is especially important, as the challenges associated with the immigrant and settlement experience could compound mental health issues amongst immigrants, and particularly for immigrant youth (Berry et al., 2006). Newcomer youth living in urban environments constitute a significant and important segment of the population, whose needs and access to resources at a particularly vulnerable time in their lives, must be examined. Yet little research exists on this portion of the population, particularly in reference to their mental health needs, mental health promotion strategies, and access barriers or challenges. The little research that does exist, however, points to the fact that newcomer youth may face multiple barriers and challenges in settling in Canada, including lack of access to vital services, which may negatively impact their mental health and well-being. This research project therefore involved the following specific objectives, to:

a. Explore how newcomer youth from diverse cultural backgrounds understand and conceptualize mental health and mental illness;

b. Explore the mental health needs and help-seeking behaviours of newcomer youth;
c. Explore access and barriers to community-based mental health services;
d. Propose integrated policies and recommend proactive practices that improve access and reduce barriers for mental health services for newcomer youth in Ontario; and
e. Actively engage newcomer youth in the research process.

The outcomes from this project were also intended to help inform Access Alliance Multicultural Health and Community Services’ (Access Alliance – the community partner) strategic goal of developing youth-focused mental health services. Further, the active involvement of youth in this project was intended to, “serve as a basis for understanding the benefits and challenges of involving youth to develop collaborative, client-centered mental health services and mental health promotion activities” (Original proposal, p. 3).

2. METHODOLOGY

2.1 Design and Theoretical Context
A mixed-method participatory research approach, including quantitative and qualitative measures was utilized, to allow for triangulation of data and thereby a more in-depth and accurate understanding of newcomer youths’ mental health needs. Data was gathered using focus groups, interviews, and questionnaires. Field logs, noting reflections during the project, were also kept by members of the research team. For the qualitative component, focus groups and interviews were conducted with newcomer youth (that is, those who had arrived within the last five years, between the ages of 14 and 18) from Afghan, Colombian, Sudanese, and Tamil communities, parents, and service providers working with these communities (Please see Appendix A for the focus group and interview guides). For the quantitative component, a questionnaire composed of three psychometric assessment scales was used, as well as socio-demographic questions, to obtain an understanding of youths’ self-esteem and self-rated health (Please see Appendix A for the questionnaire).

A mixed-methods community-based participatory research (CBPR) approach was used in this study. In order to engage youth directly in the research process (one of the objectives of this research project), a Youth Advisory Committee (YAC) was proposed. The role of the YAC was to include participation “in the research process, including advising on the relevance of the research questions, recruitment, analysis (for example, in qualitative analysis through member checks) and dissemination of findings” (Original proposal, p. 11). The YAC was to be composed of six to eight newcomer youth between the ages of 16 and 18, from the target communities, who would be committed to and interested in such a project.
CBPR indicates a range of methodologies, but at the heart of the approach lies a commitment to involving community members as active participants in one or more of the following aspects of the research: conceptualization, design, data collection, and/or analysis of community issues/problems requiring research. CBPR is also, “based on the premise that working with community members as co-researchers or research collaborators (as opposed to just research participants) is a way to make the research process and findings more accessible, accountable and relevant to people’s lives” (Israel et al., 2003). In more traditional approaches to research, where experts come in to conceptualize the research problem and the research project in its entirety, the results may not directly benefit the target community. Communities may further feel over-researched, without enjoying any benefits or results from the research. While CBPR attempts to avoid some of these pitfalls of traditional research, in order to make CBPR more effective, greater time is required to build research partnerships, collaborative models, and most importantly, trust.

Our model of the community academic partnership and CBPR included equitable collaboration at all stages of the project, including the project design, establishment of operational processes, such as the drafting of a memorandum of understanding between the community and academic partners, the writing and application of grants, the hiring of project staff and data collection, analysis, and dissemination during the project. Various capacity building components also formed an important part of the project, for both academic and non-academic stakeholders in this project. These are outlined in sections 3.6 and 5.1.

The practice of capacity building and empowerment is also echoed in the concept of Mental Health Promotion (MHP), which is defined as,

…the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. [MHP] uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections and personal dignity (Centre for Health Promotion, 1997).

MHP also resonates with the social determinants of health (SDoH), which are the socio-economic conditions that influence the health of individuals, communities and jurisdictions, and include not only physical but also mental health (Ornstein, 2006). It is estimated that 10-20% of Canadian youth are affected by a mental illness (Canadian Mental Health Association (CMHA), 2009). Research has also indicated that up to 30% of immigrant families have incomes that fall below the official poverty line, which may make them more vulnerable to mental health
problems (Beiser, 2005). Racialization\(^2\) and migrant status can also affect health, as shown by various studies investigating the health status of minority groups (AAMCHC, 2005; Choi, 2002; Glazier et al., 2000). Exploring the mental health of racialized newcomer youth is thus particularly important, given their higher levels of economic and social disadvantage, as compared to the general population (Ornstein, 2006).

### 2.2 Project Modifications in Response to Ethics and Community Needs

In the original project proposal, three of the four target groups identified were different. The original groups were: Ethiopian, El-Salvadorian, and Vietnamese. The groups were changed to: Sudanese, Colombian, and Tamil, to reflect the larger numbers of clients from these groups at Access Alliance. The Afghan group was the only one that remained from the original proposal \(^3\).

Another change was the age range for youth participants for the focus groups and interviews. It was originally 16-18 and later changed to 14-18. The key reason for expanding the age range was to increase the youth population from which recruitment could take place. The age range for the YAC remained between 16 and 18, to allow for greater commitment and participation, which is usually easier to obtain with older youth.

The Research Ethics Board at the University of Toronto had a concern with the CES-D (Centre for Epidemiological Studies Depression) scale (one of the three psychometric assessment scales used in the questionnaire), as reviewers pointed out that it is a diagnostic tool and there may be reporting obligations with it once youth fill out the questionnaire. This tool was therefore replaced by the Health Behaviour in School-aged Children (HBSC) survey, for which approval was granted and CHEO informed as well.

There were two changes in the personnel composition as well. Sonia Nerad was listed as the Co-Principal Investigator from Access Alliance in the original proposal. She subsequently moved from Access Alliance, and Dr. Yogendra Shakya, Co-Investigator from Access Alliance, became the Co-Principal Investigator. Also, instead of having two research assistants as stated in the proposal, there was a Research Coordinator (RC) and one Research Assistant (RA). The RC’s position was also made into a full time position, given the lack of a second RA.

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\(^2\) The term racialization refers to the way in which groups, who appear visibly different from a mainstream population, are discriminated against because of these differences. These groups experience race as a key factor in their lives (Galabuzi, 2001).

\(^3\) All project modifications were communicated to and received approval (where appropriate) from both CHEO and the Office of Research Ethics at the University of Toronto.
2.3 Samples and Data Collection Process

The proposed project sample was 100 for the qualitative component (focus groups and interviews with youth, parents, and service providers) and 100 for the quantitative component (questionnaire that only youth would fill out. Some of the youth were the same as those who came to the focus group and/or interview).

The actual data collection proved challenging for a number of reasons and we were not able to get the sample numbers proposed. Realizing this early on, we asked youth participants to fill the questionnaire as part of their involvement in the focus groups. They had the choice to not complete the questionnaire, but in fact all agreed to do so. It was much easier to have youth fill the questionnaire as part of their participation in the focus group (for which they also received an honorarium and public transportation tokens), than to get them back a second time or to recruit youth to just fill the questionnaire, for which no monetary compensation was offered.

The research team also kept field logs to record reflections and ideas during the research process. Research team members also held nine meetings as a whole team and maintained regular email and phone contact and individual face to face meetings as when necessary, to discuss project work and progress.

After ethics approval was granted from the Research Ethics Board at the University of Toronto (in December 2007), the RC began by doing extensive outreach with various ethno-specific community organizations, other settlement agencies, general non-profit organizations, health centres and relevant youth groups in the city. The RC and RA met with/contacted and made presentations to many of these agencies and groups, describing the project, with a view to recruiting interested youth for participation in the study. These included:

1) Tamil Eelam Society of Canada;
2) Afghan Women’s Organization;
3) York Weston Community Services Centre (Sudanese agency);
4) Planned Parenthood Toronto (we met with the Research Coordinator to hear about their lessons learned and best practices with their Toronto Teen Survey and specifically with their own Youth Advisory Committee);
5) Hispanic Development Council;
6) Canadian Tamil Youth Development Centre (CANTYD);
7) Settlement Workers with the SEPT program (Settlement and Education Partnerships in Toronto. The SEPT program is the Toronto version of the SWIS - Settlement Workers in Schools – Program) at the Toronto District School Board;
8) Thorncliffe Neighbourhood Office;
9) East Metro Youth Services;
10) New Outlook (Central Toronto Youth Services); and
11) Community Resource Connections of Toronto.

While most agencies and groups were very receptive to hearing about this project and felt that the research was very much needed, when it came to the youth, very few actually came forward to participate. Service providers promised to assist with outreach to their youth clients but on a few different occasions when focus groups were scheduled, no youth expressed interest in attending, and the sessions subsequently had to be cancelled. These agencies themselves faced challenges in assisting us with youth recruitment. When asked about possible reasons for the lack of youth engagement, ethno-specific service providers offered explanations around lack of English fluency, the stigma attached to mental health, or because youth might have been too overwhelmed with various schooling and settlement demands to attend focus groups.

Through continued efforts, a Youth Advisory Committee (YAC) was formed, composed of seven youth (2 Afghan females, 1 Afghan male, 1 Colombian female, 1 Colombian male, 1 Tamil female, 1 Tamil male). There was no Sudanese representation on the YAC. One Sudanese female attended the first YAC meeting, but subsequently left the group. This may have been in part because she was very new to the country (having only arrived a few months prior to attendance at this meeting), lived quite far away from the Access Alliance office (where meetings were held), spoke little English, and had no personal email or cell phone contact. To get in touch with this Sudanese female youth, the RC had to phone her father. Two other Sudanese youth were contacted (both male) over the phone, based on a community contact, but neither showed interest in joining the YAC.

3. RESULTS

3.1 Process
Given the difficulties with recruiting youth, Peer Researchers (PRs) were hired, one from each of the ethno-cultural communities. The PRs were interviewed by the RC and RA through an initial call advertised through Access Alliance networks, and selected, based on their ability to speak the languages of the target communities and knowledge of youth groups within those communities. The four PRs were then asked to specifically assist with youth recruitment for the project.

During this time, we also had six meetings with our YAC over a period of 8 months (April 2008-November 2008). The PRs did well with recruitment of youth and we were able to organize focus groups and interviews through them. The PRs then joined the YAC and we had further meetings, to work towards
organizing the youth-led conference that was held on June 20th, 2009. Then we held another 13 meetings between February and June of 2009. Closer to the date of the conference, we were meeting once a week with our YAC members and PRs. Each meeting lasted two-three hours, depending on work that needed to be accomplished for the upcoming youth conference.

During the first few meetings of the YAC, the RC and RA helped facilitate training sessions for the YAC on such topics as CBPR; the social determinants of mental health; and anti-racism and anti-oppression. The YAC then provided feedback on the focus group guide, based on which we made minor changes to the wording and order of questions (please see Appendix A for the original and revised versions of the FG and Interview guides). The YAC also pilot tested the questionnaire for us. They provided feedback on words that were confusing and the question order.

Once the PRs joined these meetings starting in February, the RC and RA presented preliminary findings based on data gathered until then, and YAC members and PRs provided feedback and context on these findings, confirming many of them. The concepts and ideas that arose from these sessions also became the preliminary focus for the youth-led conference. YAC members and PRs were asked to use the findings that resonated with them, to develop ideas for workshops or presentations for the youth conference. An Access Alliance Community Researcher was also asked to present on a photovoice project that she had coordinated. The YAC members and PRs were particularly interested in this idea for their own conference.

Over the course of the next few months, the YAC and PRs refined their ideas for the youth-led, youth-focused conference, scaling back some of their more ambitious plans (such as the production of a short film in about two months)!

3.2 Qualitative Data Collection and Results
The following data was collected during the course of this project:

7 focus groups (2 Afghan, 2 Colombian, 1 Sudanese, 1 Tamil, 1 service providers)
16 Interviews (2 Afghan youth, 4 Sudanese youth, 4 Sudanese parents, 1 Colombian parent, 5 service providers)

56 questionnaires were administered, but only 52 were valid and used for the study.
Table 1: Participant Demographics

<table>
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<th>Focus Group</th>
<th>Interview</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghan</td>
<td>2 FGs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>1 (youth)</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
<td>1 (youth)</td>
<td>7</td>
</tr>
<tr>
<td>Colombian</td>
<td>2 FGs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>9</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
<td>1 (mother)</td>
<td>9</td>
</tr>
<tr>
<td>Sudanese</td>
<td>1 FG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>7 (3 youth, 4 mothers)</td>
<td>9</td>
</tr>
<tr>
<td>Tamil</td>
<td>1 FG</td>
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<td>2</td>
</tr>
<tr>
<td>Female</td>
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<td>Service Providers</td>
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</tr>
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<td>Male</td>
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</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td><strong>TOTAL qualitative sample</strong></td>
<td></td>
<td></td>
<td><strong>59</strong>*</td>
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* While the total is 63, four respondents from the focus groups were the same as in the interviews. Thus the actual number of respondents is 59.

Challenges in terms of recruiting youth from these communities have been previously discussed. However, an added barrier to recruitment particularly in terms of the Tamil community presented itself during 2009 (approximately April to July), given the escalation of the political conflict in Sri Lanka. Many members of the Tamil Sri Lankan community were involved in protests in Toronto and there was a general feeling of anxiety given that they had not heard from family members still living in Sri Lanka. Given this, and based on the concerns of the Tamil PR, we decided it would not be prudent to continue attempting to recruit Tamil youth. As such, our Tamil recruitment essentially came to a standstill. Later in July when the political conflict seemed to have dissipated somewhat, there was not enough time left to organize FGs and interviews at that point. As a result, the numbers of Tamil participants are lower in this study.

3.3 Ecosystemic Framework

We have framed our preliminary findings within an Ecosystemic framework. This is “‘a way of thinking and organizing knowledge that emphasizes the interrelatedness and interdependency’ between individuals and social systems (e.g., families, groups, organizations, communities, societies)” (Queralt in Waller, 2001: 290). Our findings are therefore divided into individual (micro) level,
family/community (meso) level, and societal (macro) levels of analysis. However, these are all interlinked and some themes exist at more than one level, such as individual role changes, which affect the whole family. For the sake of clarity of presentation, we have divided them, and repeated the theme where necessary to illustrate its relevance to another level.

3.3.1 Individual Level
- Linguistic barriers:
  Throughout our FGs and interviews, youth, parents and service providers noted challenges resulting from having low English fluency (within the Toronto context). Youth indicated that lack of fluency in English, as well as differences in accents, and culturally-specific expressions caused mild stress at best, but difficulty with classes, making friends and all round settlement, at worst. On a more positive note, youth acknowledged that it was much easier for them to learn English and generally adapt to Canadian culture than for their parents or sometimes even their older siblings. By contrast, for parents, older youth and seniors, learning to speak a new language was extremely difficult. It affected their ability to find employment, as well as to integrate.

- Role of ESL and other teachers:
  Many of the youth discussed having had at least one positive experience with an English as a Second Language (ESL) teacher, or other subject teacher at school. The support and encouragement of one or more teachers at school provided a type of long lasting protective function for many youth, helping to make them resilient to subsequent challenges or setbacks at school or outside of school. It wasn’t necessarily anything in particular that a teacher may have done, except to lend an ear, to be encouraging and non-judgmental, that allowed the youth to approach other aspects of schooling with more confidence.

On the other hand, teachers who presumed that simply because some of the newcomer youth did not speak English fluently and/or spoke it with a different accent, and were therefore also incapable of performing as well as Canadian students, revealed various stereotypical notions about newcomers. Some youth who had been here for a few years felt that they were being streamed towards a college education or were placed in the general as opposed to the advanced classes at school. Others also shared some discriminatory comments they had heard from teachers, and which had negative impacts on them.

- Academic grade placement:
  Connected to the above point was the fact that some youth were placed in grades below the age-appropriate level. While this may have been necessary, it appeared to negatively impact their confidence and ability to integrate and socialize at school.
• Bullying at schools:
Youth discussed bullying at schools as well. For many of the newcomers this bullying took the form of making fun of their lack of English fluency, or different accents. For others it was based on intra or inter-ethnic rivalries. For instance people from the same national origins might argue based on differences in their religious sect, ethnicity, region of home country, etc. Some of the youth also pointed out that boys are expected and even encouraged to respond with physical violence when bullied, to stand up for themselves. Girls on the other hand are more easily permitted to simply walk away when being verbally bullied.

• Changing self-identifications:
Some youth who had been here for a few years reflected upon their sense of self when they first arrived, bearing the name of “refugee”. They talked about the negative connotations associated with being labelled a “refugee” for example, but also how over time they no longer saw themselves as a refugee, but as an immigrant or even a hyphenated Canadian. An informal social hierarchy also seemed to exist between youth who had lived here longer and who saw themselves as “Canadian” (as reported by our youth participants, though none themselves identified only as Canadian), versus those who had been here only a few years and still very much identified with their country of origin, ethnic, and/or religious identities. Those who had been here longer seemed to look down upon those who were newly arrived, as reported by our participants.

• Changes in family roles:
Most of the youth felt tremendous pressure to grow up very quickly after they arrived in Canada. While increasing responsibility is undoubtedly a part of the adolescent development phase, the rate and degree at which youth in this study experienced this, led to significant strain and pressure in their lives. For instance, due to the language barriers faced by their parents, many youth had to become translators, assisting their parents for job applications, in accessing various settlement services, at doctor’s appointments, etc. Having to take on this role, exposed them to adult concerns that were beyond their years, and which brought added stress in their lives.

• Parental employment/economic insecurity and youth mental health:
Many youth highlighted how their parents, despite high levels of education and successful careers in their home countries, faced tremendous labour market challenges and were able to only get “survival jobs” here. In some cases, youth participants noted that their parents were working a few different survival jobs to keep food on the table and roof over the heads of their families. This appeared to have significantly negative mental health impacts on the youth. Many of them were acutely aware of the pain and frustration that was a constant part of their
parents’ lives and the youth felt tremendous pressure to get through school quickly and to find a good job so that they could assist their families financially. In this context, having even one bad grade on a report card would often be devastating for youth, given what they knew they had to aim for in the context of family poverty.

- Cultural knowledge/acculturation:
Many youth described initial challenges they faced in understanding the cultural context in Canada. Cultural knowledge spanned such practices as classroom behaviour (such as being used to standing up when responding to a teacher), to the cultural cues and unsaid rules around dating and inter-gender interactions. While most youth learned these cues fairly quickly, given that it is important to their integration at school, some did not learn fast enough. In one extreme case, a service provider described a youth who was suspended from school because of his inappropriate behaviour towards another (female) student.

In other instances, youth felt caught between two cultures. For instance, some youth and school settlement workers pointed out that in many cultures, making direct and sustained eye contact with adults is considered rude. In Canada quite the opposite is true, to the extent that when someone does not make eye contact while communicating, it is considered not only impolite, but also might be construed as suspicious behaviour.

- Politics of home countries:
While for the most part youth did not discuss their home country political situations, some did point out that differences of religion, ethnicity, region, etc. can become flashpoints for inter and intra-group conflicts in Canada as well. More often though, youth were only too eager to leave behind the political baggage of their parents and befriend anyone here. This did not mean that their connections to and sympathies with political actors in their home countries were necessarily diminished here in Canada. The most salient example of this was the Tamil protests that took place in Toronto and which effectively brought our Tamil recruitment to a standstill.

- Youth resilience:
It must be pointed out that throughout the focus groups and interviews, while youth did not necessarily think of themselves as resilient, strong or courageous, they certainly displayed these qualities in amplitude. Despite having gone through some horrific experiences as young children (including seeing the atrocities of war first-hand), they showed enthusiasm and hope for their futures in Canada and/or back in their home countries once older. Many of them had educational and career aspirations that were geared towards helping the situation in their home countries in one form or another. Across the board, they
also felt very happy to be in Canada and felt that the country had much to offer them.

A limitation with a study such as this where participation is voluntary, is that youth who are already very motivated and fairly well integrated tend to come to the focus groups and interviews. These are youth who no doubt will do very well and succeed in their goals. However, those who are “falling through the cracks” don’t usually come to participate in such research projects. Service provider and parent interviews were therefore extremely valuable for providing us a glimpse of those who had somehow not done well in any of the institutional spaces here, whether school or settlement services. Thus we were able to capture the stories of some of these youth who for various reasons had not been as resilient in the face of great hardship and were either very vulnerable to mental health concerns or actually had mental illness.

3.3.2 Family and Community Level

- Parental under or unemployment:
Parents’ inability to find suitable or any employment upon arrival to Canada was a significant source of stress for the whole family. This was also one of the most common and most difficult aspects of settlement that youth, parents, and service providers told us about. It also caused tremendous mental stress for families.

- Changes in family roles:
As in the previous section, family role changes affected everyone, not simply the youth. For parents as well, having to give a certain amount of responsibility and power to their young children was uncomfortable and undermined their traditional role as parents. This left many parents feeling even more vulnerable and powerless in the post-migration context, which impacted the family as a whole.

- Family separations and family break-ups:
In many instances, youth described the process of migration to us as one involving long periods of separation for family members, sometimes leading to family break-ups in the longer term. In some of the Colombian cases, many families lived in the US for a few years or months prior to coming to Canada, and often only one parent would come with the children, so that the other parent could continue to stay in the US or in Colombia, continuing to earn some money for the family until the migrating parent found a job in the new country - whether at first the US or later in Canada.

In the case of some of our Sudanese youth, they went first to Saudi Arabia and then came to Canada. In some of the cases the fathers attempted to find work here but when they were unable, they returned to Saudi Arabia or to Sudan to
work and send money to their families here. These separations were sometimes long lasting ones and proved to be a tremendous strain on all family members. Fathers or mothers who were left in home countries did not see their children grow up and were not able to be part of their development. Children felt the loss of this parent deeply, especially in cases where they had been particularly close to the parent.

Living in single parent homes also led in some cases to youth falling into substance abuse as coping methods, and in a few extreme cases, to being in conflict with the law and at risk of deportation. In the few extreme cases, where we heard that youth had “fallen into bad company”, it was always a male, rather than a female.

- Familial resilience:
  Despite the family separations, the hardships, pressures, and challenges, some families seem to have become even closer as a result. One youth remarked that at first the outside pressures led her to fight with her sister, but that after a while, they both came to understand one another and now felt much closer.

3.3.3 Societal Level

- Educational and bridging programs:
  Some of our participants’ parents had benefitted from various educational and bridging programs offered by colleges and universities. Others had found job programs to be very helpful. Many used the professional networks within their communities to find employment. These positive experiences mitigated against some of the other settlement challenges, to assist in overall wellbeing.

- Lack of community:
  One aspect that youth reported finding strange was that there was a real lack of community in their everyday lives. For instance, some of the Colombian participants described celebrating certain festivals with the whole street, where neighbours regularly came out and mixed with one another. For many of them, their first Christmas here was a lonely experience. A service provider described the experience of some of his Sudanese clients, saying that back home when they had a problem they would call a neighbour, but here they are encouraged to call 911.

Indeed some of the youth whose families had attended classes prior to migration to learn about Canadian culture, recounted learning such things as how to dial 911 in these classes.
• Religious institutions provide informal settlement support:
For many of our youth, going to a mosque, church or temple was not so much about religiosity, but about being able to connect with members of the community, to find out about potential work, community events, etc. Religious institutions seem to become informal sites of settlement and integration on the one hand, and community celebration on the other. Many youth also joined youth groups that were organized through churches or mosques, as a way to meet other youth and to make friends. Members of the community who had been in Canada for a longer period of time would provide guidance and support to the newly arrived.

• Discrimination:
While youth did not always use the word discrimination, many of the experiences they described were discriminatory or racist at times. Discrimination, prejudice, and racism were not only meted out to youth by other youth, but sometimes also by teachers and other authority figures they came in contact with, within the broader society.

Some of the Muslim female youth we interviewed and who wore the hijab, felt that they were sometimes discriminated against because of their clothing. Others felt that they were discriminated against for being “too Black”. Service providers who worked with these communities also recounted instances of discrimination, prejudice, and racism.

Some of our Afghan and Tamil youth in particular also talked about being called terrorists. For Afghans this was connected to 9/11 and for Tamils, some were disparagingly referred to as being Tamil Tigers, in reference to the militant group in Sri Lanka.

• Youth centres and peer leader programs:
Youth discussed programs such as those organized by schools, community centres and libraries as being very useful for them. Peer to peer programs where youth who are familiar with the school system mentor new students, were also found to be very useful by many of our respondents.

• Stigma around seeking help for mental health problems:
There is great stigma around discussion of mental health, and therefore also around seeking help when needed. This stigma is further exacerbated by the fear that accompanies certain institutions such as the police force, child services, etc. as well. Many have left countries where police forces are not to be trusted (for various reasons). There is also fear on the part of many parents that their children will somehow be taken away from them if they reveal any problem to a social service worker, especially one outside of their culture.
• Good programs and services exist:
Various good programs exist, through which youth and parents have benefitted. However, information about these programs and services is often obtained accidentally, which does not ensure general and broad accessibility. Further, many of these programs and services require a great deal of initiative, in which language fluency also plays an important part. Thus those who benefit from these programs would likely have been doing fairly well anyway. It is the harder to reach populations, which still it seems, are not reached.

3.4 Quantitative Data Collection and Results

Questionnaire Results: Demographics

In total, 56 respondents completed the questionnaire. The statistics below represent the descriptive aspects of the questionnaire data collected from 52 respondents. Four of the questionnaires were eliminated due to English language limitations and age limitations. Please note that this is a preliminary report, only reflecting on the descriptive statistics. In future reporting, significance testing and other analyses will be presented.

The above pie graph depicts the number of respondents who completed the questionnaire grouped by ethnicity. Recruitment for data collection was challenging due to various issues (please refer to section 2.3 for details).
Also, there was an approximately evenly distributed response rate between both male and female respondents.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>25</td>
<td>48.1</td>
</tr>
<tr>
<td>Male</td>
<td>27</td>
<td>51.9</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Self-Esteem: Global and Current**

*Rosenberg Self-Esteem Scale (RSE) & Current Self-Esteem Scale (CSE)*

**Rosenberg Self-Esteem Scale**

![Histogram of Rosenberg Self-Esteem Scale](image)

- Mean: 1.49
- Std. Deviation: 1.50
- Minimum: 0
- Maximum: 5

N=49, missing responses = 3

The data collected from the Rosenberg Self-Esteem Scale were converted to a six-item conversion scale. The ten-question instrument was divided into six separate scales and the responses were evaluated based on this converted scale (Rosenberg, 1965). The above graph depicts the frequency of responses from all respondents. The value of 0 represents very high self-esteem whereas 6 represents very low self-esteem. Within this group, no members scored a value of six. Seventeen respondents scored zero (very high self-esteem) and three respondents scored five. Forty-nine respondents completed this scale. Therefore, the group had an overall high level of global self-esteem. Three respondents did not complete the Rosenberg Self-Esteem scale.
The graphs below depict the scores separated by gender and by ethnic group.

**Current Self-Esteem Visual Analogue Scale Results**

The Current Self-Esteem scale (CSE) is an instrument developed by Dr. Khanlou, one of the principal investigators of the project. The CSE contains a visual analogue scale (VAS) and three open-ended questions to determine a respondent’s self-esteem promoting influences, self-esteem challenging influences, and self-esteem promotion strategies. This report will discuss the results from the VAS. Future reports will incorporate the results of the rest of the instrument. Respondents were asked to complete a visual analogue scale, rating how they felt about themselves over the course of the past week. A rating of ten indicated a very high current self-esteem whereas a rating of one indicated a very low level of self-esteem at the time of completing the questionnaire. The CSE was used in previous studies with youth of various ethnic backgrounds (Khanlou et al., 2008; Khanlou, 2004; Khanlou et al, 2002). The graph below demonstrates the breakdown of responses from all respondents. Forty-nine responses were used in calculating the results of this scale. Three respondents did not complete this instrument. Nine respondents (17.3%) reported a very high level current level of self-esteem. Fifteen respondents reported their current self-esteem levels at that time as level of eight (28.8%) on the visual analogue scale.

**Ethnicity and CSE VAS Results**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghan</td>
<td>7.56 (2.13)</td>
</tr>
<tr>
<td>Colombian</td>
<td>7.77 (1.80)</td>
</tr>
<tr>
<td>Sudanese</td>
<td>8.75 (1.26)</td>
</tr>
<tr>
<td>Tamil</td>
<td>9.00 (0.82)</td>
</tr>
<tr>
<td>Total</td>
<td>7.96 (1.81)</td>
</tr>
</tbody>
</table>
The CU-SE average score was 7.96 (SD=1.81) for the entire group of respondents. All groups rated themselves in the high CU-SE group on average. The highest CU-SE score was the Tamil group (9.0, SD=0.82) and the lowest CU-SE score was from the Afghan group (7.56, SD=2.13).

**Gender and CSE VAS Results**

Twenty-four female respondents completed the CSE VAS instrument (N=24, missing =1). Female respondents reported a larger variance in CSE VAS scores (2-10 on the CSE VAS). Three responded with the highest CU-SE (CSE score of 10). Eighteen responded with high CU-SE (CSE score between 7-10). Three responded with medium CU-SE (CSE score between 5-6) and three responded with low CU-SE (CSE score 4 and below).

Twenty-five males responded to the CSE VAS scale (N=25, missing=2). Male respondents reported a narrower variance in CSE VAS scores (6-10). Six responded with the highest CU-SE (CSE score of 10). Twenty-two responded with high CU-SE scores (CSE scores between 7-10). Three responded with medium CU-SE scores (CSE scores between 5-6). No males responded with low CU-SE scores.

Please refer to the graphs below dividing the CSE VAS scores based on both gender and ethnicity.

**Current Self-Esteem Ratings Divided by Gender and Ethnicity**
Health Behaviour in School-Aged Children (HBSC)

Subjective Levels of Life Satisfaction

Forty-six participants responded to the Subjective Life Satisfaction scale. Six respondents did not complete this component of the questionnaire. This scale is a Cantril ladder that asks the respondents to rate their life satisfaction at the time of filling out the questionnaire. The value of ten indicates the best possible life a respondent can have and zero indicates the worst possible life, subjectively (Gabhainn, 2004). The mean score for the subjective life satisfaction was 6.87 (SD = 1.61). The range of responses was between three and nine. Male respondents scored higher than female respondents (M = 6.92, SD = 1.44; M = 6.82, SD = 1.82, resp.). Sudanese Respondents had the highest subjective level of life satisfaction (8.25, SD = 0.96). Tamil respondents reported the lowest level of life satisfaction compared to the rest of the groups (6.43, SD = 1.99). In the Afghan and Colombian groups, the females scored lower than the males (6.33 vs. 7.00, 6.78 vs. 6.92, resp.). However, in the Sudanese and Tamil groups, the females scored higher than the males (9.00 vs 7.50, 6.60 vs. 6.00, resp.).

Mean Subjective Level of Life Satisfaction Based on Ethnic Group and Gender

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Gender</th>
<th>Mean Response (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghan</td>
<td>female</td>
<td>6.33 (2.42)</td>
</tr>
<tr>
<td></td>
<td>male</td>
<td>7.00 (1.51)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6.71 (1.90)</td>
</tr>
<tr>
<td>Colombian</td>
<td>female</td>
<td>6.78 (0.97)</td>
</tr>
<tr>
<td></td>
<td>male</td>
<td>6.92 (1.56)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6.86 (1.32)</td>
</tr>
<tr>
<td>Sudanese</td>
<td>female</td>
<td>9.00 (0.00)</td>
</tr>
<tr>
<td></td>
<td>male</td>
<td>7.50 (0.70)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>8.25 (0.96)</td>
</tr>
<tr>
<td>Tamil</td>
<td>female</td>
<td>6.60 (2.30)</td>
</tr>
<tr>
<td></td>
<td>male</td>
<td>6.00 (1.41)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6.43 (1.99)</td>
</tr>
<tr>
<td>Total</td>
<td>female</td>
<td>6.82 (1.82)</td>
</tr>
<tr>
<td></td>
<td>male</td>
<td>6.92 (1.44)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6.87 (1.61)</td>
</tr>
</tbody>
</table>
Self-Rated Health Results

Forty-nine respondents completed the self-rated health question. Three respondents did not complete this question. On average, the respondents rated their health as good (M = 3.39, SD = 0.53). No respondents reported a poor self-rated level of health. Twenty respondents (38.5%) reported an excellent level of health, 28 respondents (53.8%) reported a good level of health, and one respondent (1.9%) reported a fair level of health.

<table>
<thead>
<tr>
<th>Self-Rated Health</th>
<th>Frequency</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>fair</td>
<td>1</td>
<td>1.9</td>
</tr>
<tr>
<td>good</td>
<td>28</td>
<td>53.8</td>
</tr>
<tr>
<td>excellent</td>
<td>20</td>
<td>38.5</td>
</tr>
<tr>
<td>Missing</td>
<td>3</td>
<td>5.8</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>

On average, there were differences in self-rated health between the ethnic groups. Colombian respondents reported the highest level of self-rated health (3.50, SD = 0.51). Sudanese respondents reported the lowest levels of self-rated levels of health (3.25, SD = 0.50). Male respondents reported higher levels of self-rated health compared to female respondents (M = 3.54, SD = 0.50 vs. M = 3.22, SD = 0.52, resp.). Female respondents scored consistently lower than male respondents for their self-rated health. Please see table below for details.
**Self Rated Health Scores Based on Gender and Ethnicity**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Gender</th>
<th>Mean Self-Rated Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghan</td>
<td>female</td>
<td>3.14 (0.69)</td>
</tr>
<tr>
<td></td>
<td>male</td>
<td>3.40 (0.52)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3.29 (0.59)</td>
</tr>
<tr>
<td>Colombian</td>
<td>female</td>
<td>3.25 (0.46)</td>
</tr>
<tr>
<td></td>
<td>male</td>
<td>3.67 (0.49)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3.50 (0.51)</td>
</tr>
<tr>
<td>Sudanese</td>
<td>female</td>
<td>3.00 (0.00)</td>
</tr>
<tr>
<td></td>
<td>male</td>
<td>3.50 (0.71)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3.25 (0.50)</td>
</tr>
<tr>
<td>Tamil</td>
<td>female</td>
<td>3.33 (0.52)</td>
</tr>
<tr>
<td></td>
<td>male</td>
<td>3.50 (0.71)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3.38 (0.52)</td>
</tr>
<tr>
<td>Total</td>
<td>female</td>
<td>3.22 (0.52)</td>
</tr>
<tr>
<td></td>
<td>male</td>
<td>3.54 (0.51)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>3.39 (0.53)</td>
</tr>
</tbody>
</table>

**3.5 Working with Newcomers and Youth within the CBPR Approach**

Newcomer youth, who in the case of this project were those who had arrived within the last five years, are usually much too busy with their settlement, integration and basic survival especially within the first year post migration, to be interested in participating in a research project! Coupled with the great stigma that mental health or more accurately mental illness carries in many communities, youth enthusiasm to participate in this project was minimal and extremely difficult to mobilize. As one of our PRs pointed out, in his language, even the utterance of the term mental illness was thought by some to bring bad luck.

Another significant factor was the language barrier. Especially for those who had only arrived a few months ago to Canada, their English fluency was often not enough to allow for participation. Even after being in ESL classes for a few years, terms that were specific to this research project, such as mental health promotion, self-esteem, psychiatrist, counselor, settlement services, etc. tended to cause some confusion at first for youth in our focus groups and as they answered our questionnaire. Provisions had been made for interpreters at the focus groups,
during interviews, and for translating the questionnaire into the languages that our participants would be speaking. However, costs as well as the time constraints made this difficult and we ended up recruiting those who had some fluency in English. In other cases, our PRs volunteered to do some translating for us, or in cases where younger youth (14 and 15 year olds were involved), PRs would escort them to the FG or interview and take them back home, but were not allowed to participate in the interview or FG. PRs were told that they could not act as interpreters for us. As research team members we noticed that this created some confusion and discomfort for both the PRs and participants, but we attempted to explain that this was necessary to maintain the confidentiality of participants and that the PRs were only assisting us with recruitment.

Given all these issues, even when youth sometimes expressed initial interest in participating, they later did not show up for the focus group or interview, or otherwise cancelled before we were able to collect data. We also “lost” four of our original seven YAC members, and two PRs. In a few cases, this was due to personal issues and commitments and the person explained this to us. In other cases, the YAC member or PR simply stopped attending meetings without any explanation.

Some community agencies that we initially approached to seek assistance with recruitment also seemed to express a certain amount of research fatigue. They felt that they had participated themselves, or had encouraged community members to participate in numerous other focus groups and other research projects, without seeing any direct benefits to their community. In some instances, ethics practices were not well aligned with the cultural norms and practices within which our participants were more comfortable. For example, the fact that we were not legally obliged to seek parental consent for youth to participate in focus groups, interviews, and answer our questionnaire, made some parents (especially of the younger youth) uncomfortable. We certainly sought informed consent from participants themselves, but did not have to send consent forms home for parents to sign. In one instance where this would not have allowed us to get any youth participants, the school settlement worker through which we recruited some Afghan participants, explained the project in Farsi to the parents of the youth she knew. Once parents had heard the explanation in their own language and from someone they knew and trusted, they allowed their children to attend our focus group. Two of those students also came back for an interview. Without our Farsi-speaking cultural mediator, we would likely not have had access to these youth. Examples such as these highlighted the different ways in which childhood, children, and the age of majority is conceived in legality and in different cultural contexts.
Linguistic and cultural differences can also lead to lack of trust at times, and this is one of the key reasons we decided to hire PRs, who were members of the communities we were recruiting from. Not only did the PRs enter community spaces and events that we as the research team could not even have hoped to be a part of, but they also created trust, and helped build some community networks and connections for Access Alliances’ future work with those communities as well.

Another example of mistrust, based on language was the discomfort that one mother felt upon reading our consent form which states that suspected cases of child abuse have to be reported by us, and that is the one time we would break confidentiality. She thought that the interviewer was there to “check up on her and her family”, a concern she had expressed to the PR who had escorted the RC to the respondent’s home where the interview was being conducted.

Finally there were differences in the concepts of mental health, mental illness, and the different ways in which some would describe ailments as somatic symptoms, whereas others would name them as mental symptoms. Youth and parents seemed fairly comfortable discussing the social determinants of mental health, but far less comfortable when the discussion moved to mental health in general, and specifically to mental illness.

3.6. Engaging Youth and Capacity Building
A survey was designed by Access Alliances’ Data and Evaluation Coordinator, and put on Survey Monkey (please see Appendix D for the evaluation survey questions). Five out of the six YAC/PRs have completed the survey online. Based on preliminary analysis of the results so far, YAC members and PRs decided to participate in this project for reasons of: interest; wanting to contribute to their communities; to gain more knowledge and experience; and because they had personally been impacted by mental illness in their family. The YAC members and PRs also said that they enjoyed the training very much, finding the forum theatre workshops and meetings to be particular highlights of their experience. The PRs found recruiting youth to be particularly challenging, and one stated that “people were suspicious and unwilling to participate (no matter how convenient you made it)”. Overall, YAC members and PRs gained a great deal of knowledge and experience, and were very happy to have participated in this project.

Aside from the youth conference, there was considerable work done in terms of capacity building for youth (YAC members and PRs) involved in this project. Many of them were able to find further employment, in large part because of their role in this project. The RC provided references for a number of the YAC and PRs for employment purposes. Youth were also able to form networks
within their own communities and for professional purposes, through their involvement in this project.

Both the RC and RA are also doctoral students, in Sociology and Nursing, respectively. Both were given a number of opportunities to present as part of a team or as first presenters at various academic conferences (please see list under 5.2 Knowledge Dissemination) during this project. Both also attended workshops and conferences, where they distributed information about this project, provided input on research with newcomer youth and mental health, and gained further information and knowledge that was relevant for this project and for their own research as doctoral students. Both the RC and RA also gained first-hand experience in qualitative and quantitative research methods, community-based research, and the social determinants of mental health. Examples of conferences and workshops attended by the RC and/or RA include:


Hong Fook. Diversity and Equity in Mental Health/Addiction Conference. May 28, 2009, Toronto.


CHEO Made in Ontario: A showcase of leading practices in child and youth mental health. May 9, 2008, Mississauga.

4. PRELIMINARY CONCLUSIONS & RECOMMENDATIONS

In this section we present our preliminary conclusions and preliminary recommendations based on our initial analyses of data. These will be further elaborated and refined as we continue the analyses and synthesis of data.

1. Western bio-medical models of mental health that are often still steeped in a separation of mind and body or of the individual from his/her community often do not resonate with the conceptualizations of mental health by members of diverse communities. It is therefore very important to understand the cultural context and strive for cultural competency when delivering mental health
services to diverse communities, whose needs cannot be boxed into pre-constructed categories.

2. The social determinants of mental health are extremely important, and must be factored into the analysis of mental health issues, and in particular, as they exist for immigrant and refugee communities. For example, while each of us may carry biophysiological vulnerabilities, critical stressors such as war, rape, and torture or other forms of extreme violence (that many refugee communities have faced) can also trigger serious mental health concerns. Thus, the context within which a person is embedded, whether their personal histories or their socio-political and national origins must also be a part of mental health care.

3. Services for newcomer youth need to be delivered in flexible and youth friendly ways. For instance, while many very good programs exist, some youth may not fit easily into these, given their unique histories and varied needs. Cross-sectoral collaboration between agencies, government departments, and funders is required in order to create services that reflect the needs of newcomer youth. While one-stop shops may be the most cost-effective way to deliver services, they may not be the best method for meeting individual needs. Non-traditional locations for dissemination (such as malls or certain ethnic stores or neighbourhoods) and non-health related programs (such as a sports camp) also need to be considered to do outreach to youth.

4. Linguistic barriers and poverty are some of the biggest challenges facing newcomer youth and their families when it comes to accessing community-based mental health and other health services. There is also a lack of actual services in suburban areas, where an increasing amount of newcomers are now settling, given the high rental and ownership costs in downtown Toronto. Getting to downtown locations from the suburban areas becomes virtually impossible for newcomers as a result of lack of transportation or difficulty getting to or cost of public transportation.

Based on the preliminary data analysis, the following preliminary recommendations are made:

1. Educate service providers and health and social service students in the social determinants of mental health, health disparity, and newcomer youth resilience (Education recommendation).

2. Implement culturally competent care across the mental health system from community based health organizations to tertiary mental health settings (Practice recommendation).
3. Educate newcomer communities including families and individuals regarding the mental health system in Ontario and how to access services (Community education recommendation).

4. Educate newcomer communities including families and youth on the importance of mental health as a part of overall health and wellbeing, in order to contribute to anti-stigma initiatives (Youth education recommendation).

5. Advocate for intersectoral strategies that address the various dimensions of mental health and wellbeing, such as individual resiliencies, resettlement challenges, employment, language, etc. (Policy/systems recommendation).

6. Provide support for multi-method, longitudinal and community-based research on newcomer communities and mental health (Research recommendation).

5. KNOWLEDGE EXCHANGE PLAN

5.1 Overview of Knowledge Exchange Activities
Collaborative research partnerships and sharing of resources between academic and community partners took place during the project. Both PIs shared information and resources about conferences, workshops, and seminars, etc. that were relevant to the project and appropriate for future research collaboration, such as various calls for proposals. The RC also benefitted from information shared through the Access Alliance staff listserv and through staff members themselves for other projects, initiatives, and organizations that could be used as relevant contextual material or as potential sources of participant recruitment for this project.

The RC also had a number of meetings with service providers, giving informal feedback on challenges and opportunities associated with working with newcomer youth, the process of doing CBPR, ethics considerations, etc. for groups looking to embark on their own research projects with youth. The RC met with or had email or phone communications with staff members from: the Centre for Addiction and Mental Health (CAMH), various settlement service agencies in Toronto and from a staff member at the City of Toronto, who was researching best practices for youth mental health initiatives. The youth-led conference, which was advertised on various health and settlement listservs, garnered a great deal of interest and attention by various service providers. The report from the conference will be made available on Access Alliance’s website and a link sent to these groups.

5.2 Knowledge Dissemination
Knowledge dissemination and diverse venues has been taking place for many months. To date, we have presented preliminary project findings at the following nine conferences, with members of the research team:


5.3 Future Plans
Research team members will be making a presentation at the upcoming annual convention of the American Psychological Association in Toronto. August 6-9, 2009. The presentation is entitled, “Promoting newcomer youth mental health through CBPR”.

Dr. Khanlou (PI) and Ms. Gonsalves (RC) are co-authoring a book chapter for an upcoming book on, “Intersectionality-type health research in Canada”. This collection is edited by Dr. Olena Hankivsky, who is an Associate Professor at the Public Policy Program & Co-Director of the Institute for Critical Studies in Gender and Health at Simon Fraser University. The chapter, “An intersectional understanding of youth cultural identities and psychosocial integration: Why it matters to mental health promotion in immigrant receiving pluralistic societies” (draft title) will draw, in part, on the preliminary findings from this study.

Further dissemination will also continue at various academic peer reviewed, lay/public, and service provider and policy venues.
Please note, that the Grants Research Accountant has been in the midst of an office move and is presently on vacation. As this final accounting report needs to be prepared through the Research Services Accounting Department (and the Grants Research Accountant) at the University of Toronto, it will follow this report later.

Please contact Ms. Marjorie Bhola-Swami (Grants Research Accountant) at:
Email: m.bhola.swami@utoronto.ca
Phone: 416.978.1870
BIBLIOGRAPHY


APPENDICES

APPENDIX A: FOCUS GROUP & INTERVIEW GUIDES & QUESTIONNAIRE

Original Focus Group and Interview Guide

1. PERCEPTIONS AND EXPERIENCES OF MENTAL HEALTH

   a. Perspectives on mental health
      i. When you hear the word “mental health” what does it mean to you?
      ii. Do you feel that the way you and your community understand mental health is different from how others understand mental health? If so, how is it different?
      iii. To what extent do you feel that adults understand the issues that youth are facing?

   b. Determinants of mental health
      i. What does “self-esteem” mean to you?
      ii. What are some of the things that affect your self-esteem?
      iii. What things make people (youth) feel sad and down?
      iv. What things make people (youth) feel happy and good about themselves?

   c. Role of Community
      i. What role do family and friends play in making people feel good and healthy?
      ii. What role do community and culture play in happiness and health?
      iii. How do people in your community respond to people who are feeling down or having mental health issues (how ever participants define mental health)? How do you feel about this?

2. MENTAL HEALTH IMPACT OF IMMIGRATION AND SETTLEMENT

   a. Mental health implications of immigration
      i. How does leaving one’s home country and settling in a new country (Canada) impact on youth?
      ii. What can be done to make it easier for youth to settle in Canada?
3. ACCESS AND BARRIERS TO MENTAL HEALTH SERVICES
   i. Do you know about services that youth can use when they
      are feeling sad, stressed or down?
   ii. What are some challenges that youth face in using these
      services?
   iii. In what ways can these services be improved?
   iv. In what ways can these services be made more accessible to
      youth and more youth friendly?

Based on feedback we received from our YAC, we revised the focus group guide so that
the questions might flow more easily, by asking about the first few months of settlement
rather than starting with mental health questions right away, as in the original guide.

Focus Group and Interview Guide Revised

1. Tell us a little bit about your first few months in Canada? What was it
   like?
   a. School (teachers, bullying, ESL, social customs at school)
   b. Family (dynamic between members, younger siblings, playing
      translator for parents?)
   c. Community (community support, religious institutions?)
   d. Language
   e. Culture (figuring out the Canadian culture)
   f. Social services (going to get services – to government offices,
      settlement agencies)
   g. Health (getting health cards, doctors’ offices, appointments)
   h. Climate
   i. Food

2. What are some of the impacts of all this on your health in general, on your
   mental health specifically?
   a. Probe about conceptions of mental health individually, within
      community and understanding from community and adults
   b. Self-esteem - what does this mean to you, what are things that
      affect your self-esteem, what things make youth feel happy and
      what things make youth feel unhappy? What do you do to make
      yourself feel happy when things are getting you down?

3. Role of the community
   a. What role do family and friends play in making people feel good
      and healthy?
   b. What role do community and culture play in happiness and health?
c. How do people in your community respond to people who are feeling down or having mental health issues (how ever participants define mental health?) How do you feel about this?

4. Given the impacts of settlement in Canada on your mental health, what can be done to make it easier for youth to settle here in Canada?

5. Access and barriers to mental health services
   a. Do you know about services that youth can use when they are feeling sad, stressed or down?
   b. What are some challenges that youth face in using these services?
   c. In what ways can these services be improved?
   d. In what ways can these services be made more accessible to youth and more youth friendly?

Once we had found preliminary themes emerging from focus group and interview transcripts, we also began asking specific questions on these themes in subsequent focus groups and interviews. These themes included:

1. Bullying in schools (not just by “Canadians” but also from other ethnic minority groups or from groups from the same country but from a different region).

2. Discrimination (stereotypical ideas about Afghans as terrorists, or comments from teachers, for example).

3. Language (barriers to communication with other students/teachers and ESL stigma).

4. Multiple migration (going through many countries before finally arriving in Canada, often involving long periods of family separation).

5. Community support by those who’ve been here longer or through religious institutions – mosques and churches.

6. Negotiating new family roles (having to mediate cultural and linguistic things for parents or older siblings).

7. Parental unemployment or underemployment (impacts of this on family and in particular youth who feel the burden therefore of having to achieve a great deal, given what their parents have sacrificed).
8. **Cultural differences** (especially in terms of how much independence youth get here).

**Interview Guide for Service Providers**

1. What services/support does your agency provide to newcomer youth?

2. In particular, can you describe the work that you do with newcomer youth?

3. What are some of the key issues you’ve seen for the newcomer youth you work with, in terms of their integration and settlement and their mental health?
   a. Linguistic barriers?
   b. Adjusting to School? Making friends? Bullying?
   c. Adjusting to new culture?
   d. Navigating/accessing services?
   e. Isolation?
   f. Discrimination?
   g. Changes in inter-generational/family relationships?
   h. Family Separation?
   i. Parental situation?

4. What are some of the positive and negative coping strategies that you’ve seen youth use to address the issues/stresses/challenges they face?

5. What is the role of the community in general in terms of settlement and mental health? Are there particular supports that the community can/has provided for these youth?

6. What are the unmet needs and gaps in services for youth from your community or other newcomer communities? (Probe for mental health service needs).

7. What are some of the challenges of providing services/support to newcomer youth? What are some opportunities that are worth building on? (Probe particularly for mental health and mental health promotion services).

8. What is the process for accessing services/treatment for youth and their families when they are facing acute mental distress/illness (e.g. suicidality/depression/psychosis)? Do they first seek help from their
family doctors or go to ERs? Do youth and their families know how to access the mental health system in an acute situation?

9. In your opinion, what changes/improvements are needed to address challenges and stresses that newcomer youth face?
   a. At the service provider level
   b. At the policy/systemic level
Newcomer Youth
Health Project
Questionnaire

Please do not write your name!!

2008
Dear Participant,

Hello! Thank you for taking the time to fill this questionnaire.

Responses from participants like you will help us to understand some things that are important for newcomer youth and their health. All information you provide on this questionnaire is confidential. Do not write your name. Please try to respond to the questions in the order that they appear. It takes about 20-25 minutes to complete the questionnaire. We hope you find it interesting.

Thank you again for your participation.
The following table indicates your feelings about yourself. After reading each statement, please indicate the extent to which you agree or disagree with it by circling the appropriate number. 1 means you strongly agree with the statement. 2 means you agree with it. 3 means you disagree with it. 4 means you strongly disagree with it.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>On the whole, I am satisfied with myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel I do not have much to be proud of.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I am able to do things as well as most other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I wish I could have more respect for myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel that I have a number of good qualities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>At times I think I am no good at all.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel that I’m a person of worth, at least on an equal plane with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>All in all, I am inclined to feel that I am a failure.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I take a positive attitude toward myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I certainly feel useless at times.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I can talk to my family about things that are important to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I can talk to my friends about things that are important to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Here is a picture of a ladder.
The top of the ladder ‘10’ is the best possible life for you and the bottom ‘0’ is the worst possible life for you.

In general, where on the ladder do you feel you stand at the moment?

Mark the box next to the number that best describes where you stand.

10 Best possible life
9
8
7
6
5
4
3
2
1
0 Worst possible

Would you say your health is...?

Excellent
Good
Fair
Poor
In the last 6 months, how often have you had the following...?
(Please mark one box for each line)

<table>
<thead>
<tr>
<th></th>
<th>About every day</th>
<th>More than once a week</th>
<th>About every week</th>
<th>About every month</th>
<th>Rarely or never</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Head ache</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Stomach ache</td>
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<td></td>
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</tr>
<tr>
<td>c. Back ache</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>d. Feeling low (depressed)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Irritability or bad temper</td>
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<td></td>
</tr>
<tr>
<td>f. Feeling nervous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Difficulties getting to sleep</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Feeling dizzy</td>
<td></td>
<td></td>
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</tbody>
</table>

(Please mark one box for each line)
How easy is it for you to talk to the following persons about things that really bother you? *(Please mark one box for each line)*

<table>
<thead>
<tr>
<th></th>
<th>Very easy</th>
<th>Easy</th>
<th>Difficult</th>
<th>Very Difficult</th>
<th>Don’t have or see this person</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Father</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>b. Stepfather (or mother’s boyfriend)</td>
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</tr>
<tr>
<td>c. Mother</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Stepmother (or father’s girlfriend)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Older brother(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Older sister(s)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>g. Best friend</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Friends of the same sex</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>i. Friends of the opposite sex</td>
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<td></td>
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</tbody>
</table>

(22)  
(23)  
(24)  
(25)  
(26)  
(27)  
(28)  
(29)  
(30)  
(31)
Do you feel confident in yourself?

- Never
- Rarely
- Sometimes
- Often
- Always

Do you ever feel helpless?

- No
- Yes, sometimes
- Yes, quite often
- Yes, very often

Do you ever feel lonely?

- No
- Yes, sometimes
- Yes, quite often
- Yes, very often

How often do you feel left out of things?

- Never
- Rarely
- Sometimes
- Often
- Always
**Please show how much you agree or disagree with the following statements**  
*Please mark one box for each line*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. My parents understand me.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>b. I have trouble making decisions.</td>
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<td></td>
</tr>
<tr>
<td>c. I have a happy home life.</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>d. I am often sorry for the things I do.</td>
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<tr>
<td>e. I often wish I were someone else.</td>
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<tr>
<td>f. My parents expect too much of me.</td>
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</tr>
<tr>
<td>g. My parents trust me.</td>
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<td></td>
</tr>
<tr>
<td>h. I would change how I look if I could.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. I have a lot of arguments with my parents.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>j. I am usually tired when I go to school in the morning.</td>
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<tr>
<td>k. There are times I would like to leave home.</td>
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<td></td>
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</tr>
<tr>
<td>l. I often have a hard time saying “no”.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>m. What my parents think of me is important.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n. My parents expect too much of me at school.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
On the following scale, please circle the number that shows how you have felt about yourself over the course of the past week. The bigger the number, the more positive you have felt about yourself. 1 means you didn't feel good about yourself. 10 means you felt great about yourself.

1 2 3 4 5 6 7 8 9 10
Didn't feel good about myself

Felt great about myself

What things made you feel GOOD about yourself?

What things made you feel NOT GOOD about yourself?

What things can you DO TO FEEL GOOD about yourself?
DEMOGRAPHIC INFORMATION

How old are you? _____________________________________________ (54)

What grade (for school) or year (for College or University) are you in?
__________________________________________ (55)

How do you identify your gender? (e.g. male, female, transgendered)?
__________________________________________ (56)

Where do you live? (Major intersection) ______________________ (57)

Where were you born? ______________________ (58)

How long have you been living in Canada? ______________________ (59)

With whom did you come to Canada? ______________________ (60)

In which country were you living before coming to Canada?
__________________________________________ (61)

Do you have any brothers or sisters and if so, how many?
__________________________________________ (62)

Where was your mother born? ______________________ (63)

What level of education does your mother have
(primary/secondary/university/college/trade school)?
__________________________________________ (64)

Did your mother work in your home country? ______________________ (65)

What type of work did your mother do in your home country?
Does your mother work now in Canada?

What type of work does your mother do now in Canada?

What is the ethnic background of your mother?

Where was your father born?

What level of education does your father have?

Did your father work in your home country?

What type of work did your father do in your home country?

Does your father work now in Canada?

What work does your father now do in Canada?

What is the ethnic background of your father?

With whom do you live?

What language(s) do you speak at home?
Please share any other thoughts you may have below:

This is the end of the survey. Thank-you very much for answering our questionnaire!
APPENDIX B: LIST OF RESOURCES GIVEN TO PARTICIPANTS

COUNSELING:

CANADIAN CENTRE FOR VICTIMS OF TERRORISM
.................................................. 416.363.1066
They have two office locations in the GTA. They provide counseling and
other services for survivors of torture. Online: www.ccvt.org

CENTRAL TORONTO YOUTH SERVICES..... 416.924.2100
This is a community-based youth centre which provides a range of mental
health services for youth in Toronto. Online: www.ctys.org

DISTRESS CENTRES OF TORONTO..... 416.408.HELP(4357)
This is a 24-hour help-line you can call when you’re distressed, depressed
or in crisis. They have interpreter services in 151 languages.

HEYY (Hearing Every Youth through Youth)
.................................................. 416.423.HEYY(4399)
This is a confidential listening service for youth, operated by youth. Open
Mon-Fri 6-9 pm. Online: www.hey.net

KIDS HELP PHONE......................... 1.800.668.6868
Provides 24-hour confidential counseling for children and youth.
Online: www.kidshelpphone.ca

YOO MAGAZINE...............................
An interactive health magazine where you can ask questions online.
Online: www.yoomagazine.net

SETTLEMENT AND HEALTH:

ACCESS ALLIANCE MULTICULTURAL HEALTH AND COMMUNITY SERVICES
............................ 416.324.8677
Provides health and settlement services for immigrants and refugees.
Online: www.accessalliance.ca

ANNE JOHNSTON HEALTH STATION........ 416486.8666
Provides a wide range of health and other services for youth and others.
Online: www.ajhs.ca/ajhs.htm
PLANNED PARENTHOOD……………………416.961.0113
    A community health centre which provides accessible and inclusive health services with a youth-friendly focus.
    Online: www.ppt.on.ca

SCADDING COURT COMMUNITY CENTRE….416.392.03
    A multi-service agency that provides services to the community.
    Online: www.scaddingcourt.org

SETTLEMENT AND EDUCATION PARTNERSHIP IN TORONTO
(SEPT)…………………………VARIOUS LOCATIONS
    SEPT workers are located in schools and libraries. They assist with various settlement needs. Ask at your school.

SEXUAL HEALTH CLINICS……………………………………
    These clinics provide free and confidential services for men and women.
    A list can be found on the City of Toronto website.
    Online: http://www.toronto.ca/health/sexualhealth/sh_clinics.htm

SHERBOURNE HEALTH CENTRE………416.324.4180
    A community health centre which provides various health and counseling services and supports. Online: www.sherbourne.on.ca

SOY (SUPPORTING OUR YOUTH) Program of Sherbourne Health Centre…………………………
    Online: www.soytoronto.org

TELEHEALTH ONTARIO………………….1.866.797.0000
    This is a free, confidential telephone service which provides health advice or general health information from a Registered Nurse.

THORNCLIFFE NEIGHBOURHOOD OFFICE..416.421.3054
    This is a multi-service agency providing services to residents of Thorncliffe Park and the surrounding communities.
    Online: www.thorncliffe.org

MENTAL HEALTH:

ACROSS BOUNDARIES…………………………..416.787.3007
    An ethno-racial community mental health centre which provides supports and services to refugees and immigrants who are experiencing mental health problems. Online: www.acrossboundaries.ca
CENTRE FOR ADDICTION AND MENTAL HEALTH (CAMH)
........................................416.535.8501 x 6878
   An addiction and mental health teaching hospital in Toronto.
   Online: www.camh.net

COMMUNITY RESOURCE CONNECTIONS OF TORONTO (CRCT)
..................................................416.482.4103
   Assists people with severe mental health problems.
   Online: www.crct.org

ETHNO-SPECIFIC COMMUNITY BASED AGENCIES:

AFGHAN WOMEN’S ORGANIZATION........416.588.3585
   Works specifically with Afghan women and children in the GTA.
   Online: www.afghanwomen.org

CANADIAN TAMIL YOUTH DEVELOPMENT CENTRE
..................................................416.431.4100
   Works to empower Tamil youth.
   Online: www.cantyd.org

HISPANIC DEVELOPMENT COUNCIL........416.516.0851
   Works towards healthy and sustainable development of the community
   with a focus on social, economic and environmental equity. Online:
   www.hispaniccouncil.net

TAMIL EELAM SOCIETY OF CANADA........416.757.6043
   Serves Tamil and other newcomers in the settlement process.
   Online: www.tesoc.org

YORK WESTON COMMUNITY SERVICES CENTRE
..................................................416.240.7726
   Sudanese Settlement and Community Services Organization of Canada.
   Online: www.ssocanada.org

SETTLEMENT SERVICES WITH YOUTH PROGRAMS:

BLACK CREEK COMMUNITY HEALTH CENTRE
..................................................416.249.8000
   Provides community health services for people living within the service
   area. Online: www.bcchc.com
CENTRE FOR SPANISH SPEAKING PEOPLES...416.533.8545
Provides services for newcomers from 22 Spanish speaking countries.
Also has a youth program. Online: http://www.csspcghh.org/index.html

COSTI IMMIGRANT SERVICES..............416.658.1600
Online: www.costi.org

CULTURELINK...............................416.588.6288
Newcomer Youth Centre and general settlement services for newcomers.
Online: www.culturelink.net

DAVENPORT-PERTH NEIGHBOURHOOD CENTRE
..................................................416.656.8025
This is a multi-service agency located in the west end of Toronto.
Online: http://www.dpnc.ca/mainframeset.htm

EAST SCARBOROUGH STOREFRONT.......416.208.9889
Provides various settlement services for newcomers in East Scarborough.
Online: www.thestorefront.org

OCASI YOUTH NETWORK.....................
Online: on Facebook

REXDALE WOMEN’S CENTRE..............416.745.0062
Provides services for those with high-needs in Etobicoke. Online:
www.rexdalewomen.org

RIVERDALE IMMIGRANT WOMEN’S CENTRE
..................................................416.465.6021
Youth Empowerment Action (YEA). Online: www.riwc.ca

EMPLOYMENT:

MICROSKILLS DEVELOPMENT CENTRE......416.247.7181
This is a community-based multicultural organization that assists people
who are unemployed, especially women, youth, racial minorities and
immigrants. Online: www.microskills.ca

YOUTH EMPLOYMENT SERVICES (YES).....416.504.5516
Provides assistance for youth with employment, resumes and cover
letters. Online: www.yes.on.ca
PUBLICATIONS:

CANADIAN NEWCOMER MAGAZINE..................
   Online: www.cnmag.ca

SETTLEMENT.ORG........................................
   Web page with useful information and resource listings on issues
   pertinent to youth in Toronto.
   Online: http://www.settlement.org/site/CTH/youth.asp

YOUNG PEOPLE’S PRESS.............Online: www.ypp.net
APPENDIX C: YOUTH CONFERENCE REPORT (AGENDA, ADVERTISING POSTER, PROJECT INFORMATION FLYER, & SUMMARY OF WORKSHOPS & EVALUATIONS)

Conference Agenda:

When: June 20th 2009, 10:30 am - 4:30 pm
Where: 155 College Street, Toronto (Near Queen’s Park Subway), LSB Faculty of Nursing, University of Toronto, First floor

10:30 am – Registration and light breakfast

11 am – Welcome and introduction

11:10 am – Keynote talks by Martha Ocampo, Across Boundaries and by Axelle Janczur, Executive Director, Access Alliance Multicultural Health and Community Services

12 noon – Screening of “Behind the Mask” DVD by Across Boundaries

1 pm – LUNCH

1:30 pm – Poster presentations by members of Youth Advisory Committee and Peer Researchers

2 – 2:10 pm – BREAK

2:10 pm – Session on mental health and stigma

3 – 3:15 pm – BREAK

3:15 pm – Interactive workshop on newcomer youth mental health, settlement and integration issues using forum theatre techniques

4: 15 pm – Wrap up, thank you and evaluation form
Youth Conference!

- MEET OTHER YOUTH!
- LEARN ABOUT NEWCOMER YOUTH EXPERIENCES OF SETTLEMENT AND MENTAL HEALTH!
- PARTICIPATE IN WORKSHOPS AND GET INFORMATION ABOUT SERVICES IN YOUR COMMUNITIES!

IT’S FREE!!

Who? We are focusing only on YOUTH from their mid teens to early 20s
When? June 20th 2009 from 10:30am – 4:30pm
Where? 155 College Street, Toronto (Near Queen’s Park Subway), LSB
Faculty of Nursing, University of Toronto

Register Now – Space is limited!
Email: tahira.gonsalves@utoronto.ca by June 15 to be a part of it!

This one-day youth-led conference will showcase the work of the Youth Advisory Committee and Peer Researchers, using some of the findings from the Newcomer Youth Mental Health Project.
The goals of this conference are: to bring newcomer youth together to raise awareness about mental health and settlement related issues and, to connect youth to information and services that can help to overcome stigma and barriers associated with mental health.

The Newcomer Youth Mental Health project is an innovative Community-academic research partnership, funded by the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO.
Newcomer Youth Mental Health Project at a Glance

What is it?:

The Newcomer Youth Mental Health Project is an innovative community-academic research partnership, funded by the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (2007-2009). Principal Investigators for this project are: Dr. Nazilla Khanlou (OWHC Chair in Women’s Mental Health Research at York University and Adjunct Professor, University of Toronto) and Dr. Yogendra Shakya (Director, Research and Evaluation at Access Alliance Multicultural Health and Community Services). Dr. Carles Muntaner is Co-Investigator (Centre for Addiction and Mental Health and the University of Toronto).

In this research project we have focused on newcomer youth (those who arrived in Canada within the last 5 years, and are between the ages of 14-18) from Afghan, Colombian, Sudanese, and Tamil communities. We have looked at how youth understand and conceptualize mental health, and what their diverse mental health needs, help-seeking behaviours, and promotion strategies are, with a view to making program and policy recommendations that reduce barriers and improve access for mental health services for newcomer youth.

Method:

We have used a mixed-method participatory research approach, which included qualitative and quantitative methods: focus groups, interviews, and a questionnaire comprised of three psychometric assessment scales.

Data Collection:

We first selected and set up a Youth Advisory Committee (YAC) with youth from the different communities (above) and then provided training workshops on various project-related topics. We then consulted the YAC on the focus group and interview guides and pilot tested the questionnaire with them. We also hired 4 Peer Researchers who assisted with recruitment for focus groups and interviews.

We have conducted 7 focus groups and 16 in-depth interviews with youth and parents (from these communities), and service providers who serve these communities. We have also administered a total of 56 questionnaires to youth. We also held a youth-led conference with our YAC and Peer Researchers and have been disseminating preliminary findings at different venues.
For project information, please contact the Project Coordinator: Tahira Gonsalves at: 416.946.7409, tahira.gonsalves@utoronto.ca

Biographies of NYMH Research Team and Keynote Speakers at Conference:

KEYNOTE SPEAKERS

**Axelle Janczur:** Axelle has been working in the non-profit sector in Toronto for over twenty-five years. As a senior manager in a number of agencies serving immigrants and refugees, she has long been an advocate for access to services for groups facing individual or systemic barriers. In recent years, as the executive director of Access Alliance Multicultural Health and Community Services, she has been actively involved in addressing issues such as primary health care reform, cultural competence in health care, access and equity, determinants of health, and local planning for local issues.

Axelle has also been a member of numerous boards of directors – including provincial associations as well as local service agencies. Currently working towards a continuing education certificate in risk management at U of T, Axelle has her Masters in Political Science as well as a Masters in Business Administration.

**Martha Ocampo:** Martha is a founding member of Across Boundaries: An Ethnoracial Mental Health Centre. She was the previous Co-director of Across Boundaries, responsible for programs and services, including the development of Y-Connect, a youth program in the Jane/Finch neighborhood in partnership with the Griffin Centre. She is currently the manager of education and resource. She also works closely with caregivers and domestic workers. She provides advocacy and leadership training to members of the Caregiver Connections, an organization which has been formed to do advocacy for the rights of marginalized women and newcomers. Martha is the chair of the Board of the Carlos Bulosan Theatre, a member of the Board of the North York Women Shelter and Assaulted Women’s Helpline.

PRINCIPAL INVESTIGATORS AND RESEARCHERS FOR THE NEWCOMER YOUTH MENTAL HEALTH PROJECT

**Nazilla Khanlou (Principal Investigator):** Nazilla Khanlou, RN, PhD, is the inaugural Ontario Women’s Health Council (OWHC) Chair in Women’s Mental Health Research in the Faculty of Health at York University and an Associate Professor in its School of Nursing. Nazilla’s clinical background is in psychiatric nursing. Her overall program of research is situated in the interdisciplinary field

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4 In the conference package we included biographies of our YAC members and PRs, but have taken these out to protect their confidentiality as part of this project.
of community-based mental health promotion in general, and mental health promotion among youth and women in multicultural and immigrant-receiving settings in particular. She has received grants from peer-reviewed federal and provincial research funding agencies. Nazila was the Health Domain Leader of the Centre of Excellence for Research on Immigration and Settlement (2001-2008) in Toronto and a Visiting Scholar (2005-2006) at the Wellesley Urban Health Institute. She has published articles, books, and reports on immigrant youth and women, and mental health. She is involved in knowledge translation to the public through media.

Yogendra Shakya (Co-Principal Investigator): Yogendra holds a PhD from the University of Toronto. He currently works as the Director of Research at Access Alliance Multicultural Health and Community Services. Yogendra's research interests include the social determinants of health for newcomers, racialized health disparities, community development, and community-based research (CBR). He currently leads a number of research projects on newcomer health, refugee health, and racialization and health. Together with his colleagues at Access Alliance, Yogendra is also involved in developing and promoting community-based, participatory models of research.

Tahira Gonsalves (Research Coordinator): Tahira is a second year doctoral student in sociology at York University. She has previous experience in international development and feminist policy research, and has taught at Humber College. Her research interests include integration and settlement of second-generation and immigrant youth, the social determinants of health, and religion in the public sphere.

Michelle Lee (Research Assistant): Michelle is a second year doctoral student at the Lawrence S. Bloomberg Faculty of Nursing. She is also a registered nurse specializing in the mental health population. Her interests include: second-generation, ethnicity, Korean Canadian community and adolescents.

Summaries of Conference Events/Workshops:

KEYNOTE TALKS:
Axelle Janczur (E.D. of Access Alliance) gave a talk on research work that Access Alliance has done, including initial work with youth. She discussed the social determinants of health, and especially the importance of mental health, which is often not talked about. She highlighted the need for evidence-based practice, for which more research is needed. In particular, she emphasized the need for research with youth, as there are specific needs that youth have, that are not always addressed by other programs. Youth face tremendous challenges in terms of the roles they have to take on as newcomers, for example as translators for
their parents. However, while this also brings with it power, there are various aspects of powerlessness that they also face. We cannot make assumptions therefore about the situations and needs of newcomer youth, and participatory research must be conducted to fully understand their service requirements.

Martha Ocampo (Across Boundaries (AB)) described the founding of the organization in 1995, and outlined some of the philosophical values of AB. The organization works within an anti-racist, anti-oppression framework, allowing for holistic treatment and a valuing of people’s individual needs as a part of their treatment. Martha also described the Y-connect program and introduced and facilitated a discussion after screening a DVD entitled “Behind the Mask” produced by AB. Behind the Mask is a documentary that explores the lives of some youth in the Jane-Finch neighbourhood of Toronto. It is a low-income neighbourhood with many racialized newcomers. Youth created masks as part of a project, and described their life stories using these masks. Amongst the themes raised by these youth are: systemic discrimination and racism, gang violence, sexism, and sexuality. The DVD sparked some very interesting discussion.

PHOTOVOICE/PHOTO POSTER PROJECT: During one of the initial conference planning sessions, we invited a Community Researcher at Access Alliance to discuss her coordination of a photovoice project with members of the Black Creek community. This project involved an in-house photographer and members of the community, to create beautiful and compelling photographs which were later exhibited at key venues.

The YAC and PRs from the Newcomer Youth Mental Health (NYMH) project were so taken with this idea and the powerful impact it could have, that they decided that they wanted to do a photovoice project of their own for the conference. However, given our shorter time frame and given that we had not initially received ethics approval to do photovoice, we decided instead to make it more of a personal biography piece that would be displayed on a poster. After some discussions, YAC members and PRs decided on six themes based on which they would take photographs: a self portrait (which did not have to be their face, but could be an object for instance, that they felt best represented themselves); something that represented the past; something that represented the future; something that represented a positive space for them; and something that represented a negative space; and finally a picture representing their present.

Each person was given a digital camera (from Access Alliance) and they went out and took photographs. A consent form was created and received ethics approval for YAC members and PRs to photograph friends and family for this project.
The result was a provocative and moving set of photographs that each team member took and that gave us a glimpse of their very personal journeys as newcomers or immigrants to Canada.

MENTAL HEALTH AND STIGMA: The purpose of this presentation within our conference was to promote mental health awareness with our youth audience. The YAC/PR group created a presentation that would promote a discussion around mental health, mental illness and the North American media’s impact on our views of mental health and well-being.

Yogendra Shakya, the Co-PI, brought up the idea during one of the YAC/PR meetings when we were discussing details about the conference. Based on the positive feedback from the group, Michelle Lee, the RA, provided a presentation for the group, further discussing the definition of mental illness stigma and its impacts on the social determinants of mental health.

The group members researched famous people, songs and movies pertaining to mental health and mental illness on the Internet. These images and types of media were to portray mental health and mental illness. The images were placed into a PowerPoint Presentation template. The group then viewed these compiled images and chose the most appropriate ones for the presentation. The PowerPoint Presentation brought up a wealth of discussion, including the fact that there was a lack of ethnic diversity around the media and mental health/mental illness. Many of the music videos related to the current Canadian youth culture. However, no media catered to youth who were of diverse ethnic backgrounds. This promoted discussion within the groups and the need for ethnic representation within mental health campaigns to increase the accessibility for youth. Many attendees voiced this concern during the discussion.

FORUM THEATRE WORKSHOP: The YAC members and PRs did two Forum Theatre Workshops with Mixed Company – a local theatre company in Toronto. Forum theatre is a style of drama that involves the audience as “spect-actors”, where they participate in finding solutions and strategies for community issues. Mixed Company has evolved its own style of forum theatre that draws from the original founder’s work (Brazilian director Augusto Boal), but also incorporates elements of the Sweet Medicine Teachings of the Métis Medicine Society amongst others.

The YAC members and PRs as well as the RC and RA enjoyed these workshops tremendously and found them to be a particularly appropriate method for stimulating discussion on issues of mental health and settlement. The YAC members and PRs had initially wanted to do a short film, elaborating on some
themes that emerged in the preliminary findings from the data collection for the NYMH Project. Upon reflection, however, we all realized that doing a short film would have involved more time and resources, which we did not have. Many YAC members and PRs were also busy with end of year school/university exams and the work that would have gone into this was not feasible given our time constraints. Thus, the script that the team wrote was turned into a mini-play instead!

This mini-play explored a day in the life of a young character named Juan who hailed from Mexico. Juan came to Canada recently with his mother and the play detailed some of Juan’s challenges as a newcomer, in terms of his mother’s lack of employment, discrimination meted out to him from his Canadian girlfriend’s mother, and his struggle to deal with life in general in a new country. The play was broken up into very short scenes and the conference attendees were asked to participate as audience members, discussing these issues related to settlement and how they can impact a young person’s mental health.

Despite the fact that this was the last workshop of the day on a Saturday afternoon, the audience participation was excellent! The ice-breaker activities that were done prior to staging the play as well as the cookies that were available at this time may have had some part to play!

Summary of conference evaluations:
Approximately 535 attendees came to the conference, not including the research team, YAC members, PRs, or keynote speakers. The majority of the participants were youth (between the mid-teens to late 20s). Many of the service providers who attended were also youth themselves (up to age 30). We received 21 evaluations. Participants enjoyed the variety and innovative nature of the workshops and presentations during the conference. Some also wanted more input from service providers and government representatives, while others were happy with more youth-focused event.

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5 This number is approximate, as some people during the afternoon sessions and did not sign-in at the registration desk.
APPENDIX D: YAC/PR EVALUATION QUESTIONS

These questions were entered into a survey format through the online survey tool – Survey Monkey.

1. Are you a Youth Advisory Committee (YAC) member or a Peer Researcher (PR)?

2. Why did you decide to get involved in this project?

3. Which parts of the Newcomer Youth Mental Health (NYMH) project did you enjoy? (Check all that apply. Please note that only the YAC received anti-oppression/anti-racism and community based research training. Only the PRs recruited youth for this project.

<table>
<thead>
<tr>
<th></th>
<th>YAC</th>
<th>PRs</th>
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<tbody>
<tr>
<td>Training workshops</td>
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<tr>
<td>(anti-racism/anti-oppression, community based research, forum theatre)</td>
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<tr>
<td>Meetings</td>
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<tr>
<td>Youth conference preparation</td>
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<tr>
<td>Recruitment of youth</td>
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4. Please elaborate on any one of your answers above. In particular, please tell us more about any parts of the NYMH project that you did not like.

5. For each of the following statements, please check off one box to indicate whether you agree, disagree, or are not sure/undecided.

<table>
<thead>
<tr>
<th>Statement</th>
<th>I Agree</th>
<th>I Disagree</th>
<th>I’m Not Sure</th>
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<tbody>
<tr>
<td>I clearly understood my roles and responsibilities within the project</td>
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<tr>
<td>I felt that my participation was valued and encouraged by the research team</td>
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<tr>
<td>I felt that my participation was valued and encouraged by my colleagues (YAC and PRs)</td>
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<tr>
<td>I felt that there was adequate training that helped me understand the issues more deeply</td>
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<tr>
<td>The Research Coordinator and Research Assistant communicated effectively throughout the project</td>
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<tr>
<td>I was happy with the way in which, and the extent to which I participated in the project</td>
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6. Please explain any of your answers above (if you want to).
7. Please list 2-3 things you learned from this project that you feel are useful. How would you use this knowledge in the future?

8. Participating in a project like this may affect participants in different ways. The following statements suggest some of the ways that taking part in this project may have affected you. Check off one box for each of the following questions, to show your level of agreement, disagreement, or if you are not sure/don’t know.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don’t Know/Not Sure</th>
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</thead>
<tbody>
<tr>
<td>I learned a lot about the key mental health issues faced by newcomer youth</td>
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<td>I developed new skills and knowledge that have already helped me towards achieving my educational or career goals</td>
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<td>I developed new skills and knowledge which I expect will help me towards achieving my educational or career goals</td>
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<td>I learned about the experiences and perspectives of people with ethno-cultural backgrounds that are different from mine</td>
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<td>I made new friends with whom I plan to stay in touch</td>
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<td>I feel better about myself as a person than I did before I got involved in the project</td>
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<td>I feel more hopeful about the future than I did before I got involved</td>
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<td>I have more people to whom I can talk when I have a problem than before I got involved</td>
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<td>I feel inspired to get involved in my community in new ways.</td>
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9. Please describe any other ways that participating in this project has made a difference in your life.

10. Please suggest anything that could have been done to make the project better. You can also use this space to write down anything else you want to say about the NYMH project.
APPENDIX E: SELECTED EXAMPLES OF PROJECT DISSEMINATION


Building Research Partnerships to Explore Mental Health Issues for Newcomer Youth: Some Thoughts on Power, Participation, and Practice

Building Equitable Partnerships Symposium 2008
Dr. Nadia Khansari, MT (York University), Dr. Yogeeta Shah, Co-Founder (Access Alliance), & Nada Gourion, Coordinator (University of Toronto)

Outline of Presentation
- Overview of Newcomer Youth Mental Health Project
- Recruitment and data collection
- Preliminary findings
- Our model of Community-academic partnership
- Challenges
- Opportunities
- Discussion

Newcomer Youth Mental Health Project, Khansari, Shryba & Gonzales, Nov. 2006

Newcomer Youth Mental Health Project Overview
- Funded by the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (2007-2009)
- Community-academic partnership
  - CBIR
    - Youth Advisory Committee
    - Peer Researchers
- Mixed Methodology
  - Focus Group and Interviews with newcomer (arrived within last 5 years) youth (14-18) and parents from Afghan, Colombian, Sudanese, and Tamil communities and Service Providers
- Questionnaire

Newcomer Youth Mental Health Project, Khansari, Shryba & Gonzales, Nov. 2006

Project Overview cont’d
- Project Objectives:
  - Explore how newcomer youth from diverse cultural backgrounds understand and conceptualize mental health and mental illness;
  - Explore the mental health needs and help-seeking behaviors of newcomer youth;
  - Explore access and barriers to community-based mental health services;
  - Propose integrated policies and recommend proactive practices that improve access and reduce barriers for mental health services for newcomer youth in Ontario; and,
  - Actively engage newcomer youth in the research process. The outcomes from this project will help to inform Access Alliance’s strategic goal for developing youth-focused mental health services.

Newcomer Youth Mental Health Project, Khansari, Shryba & Gonzales, Nov. 2006

Recruitment and Data Collection (to date)
- Recruitment of Youth Advisory Committee
- Recruitment of Peer Researchers
- Recruitment of Focus Group participants
- Focus Groups – Afghan, Colombian (2), Sudanese, Service Providers
- Questionnaires – 28
- Interviews – 2
- Field logs

Newcomer Youth Mental Health Project, Khansari, Shryba & Gonzales, Nov. 2006

Participant Demographics
- Afghans: 6 (5 female, 1 male)
- Colombians: 17 (9 female, 8 male)
- Sudanese: 5 (2 female, 3 male)
- Service providers: 7 (5 female, 2 male)

Newcomer Youth Mental Health Project, Khansari, Shryba & Gonzales, Nov. 2006
Some Preliminary Findings

- Acculturation Stressor
  "On the first day that I came, I wasn't wearing pants or shirt, I was wearing what I wear in my country, so when I went to the school, everybody was wearing shirts and pants, so on that day I kind of felt isolated from the school, from people from the school..." (Afghan, male, 15)

Preliminary Findings cont'd

- Role of religious institutions in providing informal settlement support
  "Well I am Christian, so it's like a big family. Actually one of the days last week, he [church priest] called me and I don't have a dad. He's always checking up on me so that really shows me that he cares and that if I have any problems I can go up to him or anyone in the church" (Colombian, male, 17)

Preliminary Findings cont'd

- High incidences of family separation during migration process
  "Usually the dad comes in the beginning and they settle down for a month or so. So they sort all this stuff out. Then if you have a guy in the house, then he takes all of the responsibility when his dad leaves" (Sudanese, male, 16)

Preliminary Findings cont'd

- Parental unemployment a major stressor on family and youth
  "Sometimes my mom regrets coming from Colombia to here because she had a really good job over there too and she had everybody there to support her...and she also had to start by cleaning and stuff and now she has an okay job she's not very happy with it. But I think coming from that great job that you had, coming to something lower is very hard for them because they want the best for their kids" (Colombian, female, 14)

Preliminary Findings cont’d

- Changes in parent-child relationship with newcomer youth having to take on adult roles and act as mediators/navigators in new host culture for their parents
  - In focus groups, many youth discussed having to fill out health and work-related forms for their parents, and to act as translators with medical and social service providers.

Preliminary Findings cont’d

- Stigma and service/support gaps associated with addressing mental health
  "In our community...there is no socialization and social networks. When something happens here, they call 911. Back home, the neighbours helped each other out. There is also the stigma within the culture. When a person is taking a medication for depression. Everyone will see him as a crazy man or crazy woman. No one will talk to him. Back in your country, people will do everything to help you, even find a spouse for you. That social support there is not here" (Service Provider, from ethno-specific agency)
Preliminary Findings cont’d

- Youth resilience
  - Despite tremendous hardships faced in their home countries and the often traumatic conditions under which they migrate to and settle in Canada, youth displayed remarkable resilience and a sense of hope. Many described Canada as a place where people are equal, even if they didn’t feel Canadian. “I don’t feel Canadian, but then I feel like I’m not less than them…” (Afghan, female, 16)

Preliminary Findings cont’d

- The Politics of home countries in Canada
  - “I have my best friend. She’s from the South. They had war together, but that’s back in Sudan. But here we’re best friends” (Northern Sudanese, female, 18).
  - “[In Canada] Afghans will argue depending on whether they’re Shia or Sunni or the region they’re from” (Afghan, female, 16)

Preliminary Findings cont’d

- Discrimination
  - While youth did not always frame it in terms of discrimination, or racism in particular, they mentioned having heard comments from teachers in the classroom, such as, “you should go back to your country”.
  - Service providers highlighted racism as a significant factor that newcomers must contend with.

Discussion cont’d

- Community involvement in research

NONE A LOT

Top-down—Consultation—Collaboration—Partnership—Community-led

(Adapted from Silver and May, 2000)

Track Record of CBR Leading to Positive Social Change

- Research on Homeless Immigrants and Refugees
  - Interpreters services in shelters
  - More coordination between shelters, health, and settlement agencies
- Research on internationally trained Social Workers
  - Led to creation of Bridging Program for internationally trained social workers at Ryerson University

Our Model of Community-Academic Partnership

- Equitable collaboration in all stages of the project including
  - Project Design
  - Establishing operational processes
  - Writing and applying for grant
  - Applying for Ethics Review
  - Hiring project staff
  - Data collection, Analysis, Dissemination
Operational Processes to Promote Equitable Partnership

- Memorandum of Understanding signed between academic and community member
- Initial proposal to have one project staff in university and one in community
- Project staff jointly supervised
- Project budget is transparent and jointly managed
- Initial proposal included funding to cover admin costs for community partner (not supported by funder)

Operational Processes to Promote Equitable Partnership cont’d

- Monthly meetings with detailed minutes (minutes and ‘Action Items’ thoroughly reviewed at next meeting)
- Ongoing communication through email and phone
- Partnership issues/tensions addressed immediately
- Both involved in data collection, analysis, dissemination
- Each partner bring to the project their strengths/resources: Eg
  - access to university resources from academic partner
  - links to community groups by community partner
  - training in CBR for YAC by community partner

Challenges

- Funding Challenges
  - Admin costs for community agency
- Administrative Challenges
  - Hiring constraints
  - Meeting institutional payroll and financial processes
- Ethics

Challenges cont’d

- Recruitment Challenges:
  - Reaching out to and engaging youth
  - Issue of parental "involvement"
  - "Drop-off" rate
  - The ethics of honoraria payments
  - ‘Research fatigue’ among community agencies and community at large

Challenges cont’d

- Socio-cultural and linguistic Challenges:
  - Linguistic barriers
  - Stigma and barriers to talking about and conducting research mental health issues;
  - Cultural definitions of "youth"; and
  - Need of language specific information based on above

Opportunities – Hiring of Peer Researchers

- YAC
- Peer Researcher model at Access Alliance
- Peer Researchers hired based on their contacts with target population, fluency in relevant language/s, ability to work within philosophical framework of Access Alliance, and an interest in receiving training
Discussion

- Do our experiences on this project with regards to academic-community partnership and CBR resonate with those of others?
- What are challenges you have faced and how have you addressed them?
- In particular, what are the challenges and best practices for doing CBR with youth?
- What are best practices in addressing the growing "research fatigue" among community agencies and community groups?
- How can collaborative projects be improved to reflect the needs of the community for whom our research is directed and to whom we are therefore accountable?

References

- Khas nou, N., Tohka, V., & Muntzinger, C. (2007-2009). Health services for newcomer youth: Bridging gaps and enhancing access. (Submitted by Provincial Centre of Excellence for Child and Youth Mental Health at CIUHCL)

Thank-you!

- If you have any questions please contact:
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The Mental Health and Well Being of Newcomer Youth

11th National Metropolis Conference
Frontiers of Canadian Migration
Calgary, March 21st 2009
Tahira Goneses & Michelle Lee (Presenters)
Nasliha Khanou, RN, PhD (Principal Investigator)
Yogendra Shaiya, PhD (Co-Principal Investigator)

Outline of Presentation
- Overview of Newcomer Youth Mental Health Project
- Objectives
- Context
- Preliminary Quantitative findings
- Preliminary Qualitative findings

Newcomer Youth Mental Health Project Overview
- Funded by the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (2007-2009)
- Community-academic partnership (Access Alliance & University of Toronto)
- Community Based Research (CBR)
  - Youth Advisory Committee
  - Peer Researchers
- Mixed Methodology
  - Focus Groups and Interviews with newcomer youth (visited within last 5 years) (between 14-18) and parents from Afghan, Colombian, Sudanese, and Tamil communities and Service Providers
  - Questionnaire

Project Objectives
- Explore how newcomer youth from diverse cultural backgrounds understand and conceptualize mental health and mental illness;
- Explore the mental health needs and help-seeking behaviours of newcomer youth;
- Explore access and barriers to community-based mental health services;
- Propose integrated policies and recommend proactive practices that improve access and reduce barriers for mental health services for newcomer youth and;
- Actively engage newcomer youth in the research process. The outcomes from this project will help Access Alliance's strategic goal of developing youth-focused mental health services

Context
- Exploring issues of mental health among newcomer youth from racialized groups is particularly important, given their higher levels of economic and social disadvantage as compared to the general Canadian population (Gomeses, 2006)
- Gabbay (2004) and others have argued that discrimination can negatively impact the mental health and well-being of racialized groups

Demographic Overview of Questionnaire Respondents (n = 42)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Scholar Grade</th>
<th>Level</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>Grade 8</td>
<td>1</td>
<td>15.8 years (SD = 1.4 yrs)</td>
</tr>
<tr>
<td>Female</td>
<td>Grade 9</td>
<td>5</td>
<td>15.8 years (SD = 1.4 yrs)</td>
</tr>
<tr>
<td></td>
<td>Grade 10</td>
<td>10</td>
<td>15.8 years (SD = 1.4 yrs)</td>
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<tr>
<td></td>
<td>Grade 11</td>
<td>15</td>
<td>15.8 years (SD = 1.4 yrs)</td>
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<tr>
<td></td>
<td>Grade 12</td>
<td>20</td>
<td>15.8 years (SD = 1.4 yrs)</td>
</tr>
<tr>
<td></td>
<td>University</td>
<td>3</td>
<td>15.8 years (SD = 1.4 yrs)</td>
</tr>
</tbody>
</table>

Ethnicity Length of Residence in Canada

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Average Length</th>
<th>Year (SD = 3 mos.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghan</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Colombian</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Sudanese</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Taiwan</td>
<td></td>
<td>17</td>
</tr>
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</table>
Parental Demographics

<table>
<thead>
<tr>
<th>Parent</th>
<th>Educational Level</th>
<th>No education</th>
<th>Elementary school</th>
<th>High school</th>
<th>College/University</th>
<th>Postgraduate Education</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>2 (4.8%)</td>
<td>4 (9.9%)</td>
<td>8 (19.9%)</td>
<td>25 (60.0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>3 (7.1%)</td>
<td>1 (2.2%)</td>
<td>6 (14.3%)</td>
<td>23 (54.8%)</td>
<td></td>
<td>2 (4.4%)</td>
<td>7 (16.2%)</td>
</tr>
</tbody>
</table>

Trend of downward mobility for both parents when attempting to obtain employment when migrating into Canada.

CSE Preliminary Results - Question #1: What things made you feel good about yourself?
- "Knowing I have a great family and friends supporting me" (Sudanese female, 14).
- "Every single thing that I feel in my life is good (sports skills, parents, what people buy me and how people and family treat me)" (Tamil male, 15).
- "I can understand people; I'm caring and stuff like that make me feel good about myself" (Colombian female, 14).
- "Workplace; friends around me; parents; school" (Afghan male, 18).

Question #2: What things made you not feel good about yourself?
- "When I get any report cards home and see the bad marks!" (Afghan female, 14).
- "Physical appearance; thoughts; actions" (Colombian male, 15).
- "Can't find a job; haven't done the best that I could" (Sudanese female, 16).
- "My best friend's parents are fighting and it hurts for me to see my friend cry..." (Tamil female, 14).

Question #3: What things can you do to feel good about yourself?
- "Helping; doing meditation; making my parents feel proud" (Tamil female, 18).
- "Go to the gym and work; get some fresh air" (Sudanese male, 16).
- "... have a good relationship with my parents" (Colombian female, 14).
- "To become a lawyer and help my back home people" (Afghan male, 18).

CSE Preliminary Results - VAS Scale
- Analogue scale asking youth to rate their self-esteem over the course of the last week.
  - Average Score: M = 7.89 (SD = 1.98)
  - Males: M_males = 8.03 (SD = 1.34)
  - Females: M_females = 7.42 (SD = 2.41)
- There is no statistically significant difference between the two groups (t(28.05) = 1.63, p = 0.11)

Qualitative Findings - Individual Level
- Challenge - Lack of English fluency:
  - Across all four communities, youth stated that their lack of fluency (in most cases) was a significant barrier to integration in terms of understanding the culture, making friends, and doing well at school. While English as a Second Language (ESL) classes are necessary and important, there is also a stigma attached to being an ESL student and those who are in ESL want to leave it as soon as possible.
Individual Level

- Challenge – School Bullying:
  - In many of the communities, some newcomer youth experienced bullying from other students who were of other cultures and students who were of the same culture, but had been born here or had lived here longer.
  - "And it was the immigrants who got beaten up the most. Most of them are Canadians (those who have been 2 or 3 generations in Canada) that beat up the immigrants." (Afghan male, 14, talking about school bullying).

Individual Level

- Best practice – ESL and other teachers:
  - Many students described very positive experiences with ESL or other teachers, guidance counselors or settlement workers in schools (SNWS). Often what made the difference for youth was that teachers took a special interest, teaching youth about Canadian culture, and encouraging them to get involved in activities and to interact with students from different cultural backgrounds.

Family Level

- Challenge – Parental under or unemployment:
  - "At least they can give you tests and exams...what level you are in the Canadian way. So they can give it to you, they can just forget whatever you've done. And they make you start from scratch. It's not that easy, especially when you have a lot of degrees and you have a lot of work, but you don't have a lot of Canadian experience which is dumb to ask for because, you didn't used to live in Canada. How would you have Canadian experience?" (Sudanese male, 16 - talking about his father).

Family Level

- Challenge – Changes in Family Roles:
  - "...my dad came for my graduation a little bit ago and when he left she [participant's mother] said she felt alone...she had to start all over because my dad would help her out with a lot of things and she also had to start by cleaning and stuff..." (Colombian female, 14, discussing role changes when first coming to Canada).

Family Level

- Best practice – Educational and bridging programs:
  - Some youth talked about how their older siblings and parents (qualified as doctors or engineers in their home countries) were now going back to school here to retrain in different or allied fields.
  - Peer Researcher benefited from program on providing newcomers with Canadian work experience – Newcomer Opportunities for Work (NOW).

Family Level

- Challenge – Lack of community:
  - "...people come from cultures that have a lot of community life. The neighbour knows you, the shopkeeper knows you, People help you, come to your aid. It doesn't exist here and I think that's the most painful thing" (Service Provider working with youth with mental illness).
  - "...there is no socialization and social networks. When something happens here, they call 911. Back home, the neighbours helped each other out..." (Service Provider from ethnic-specific agency).
Societal Level

- **Best Practice – Informal Community Supports:**
  - “...My parents talk to people that already did everything. They talk to them and ask them questions so they can feel good...They are mainly the people you go to if you have a question or anything you need help with...”
    (Colombian female, 14).
  - Religious centres act as informal settlement supports.

Societal Level

- **Challenge – Discrimination:**
  - “When I go to school I wear the bindi and I braid my hair...So most people look at me weirdly wearing a bindi and going to school braided...one of my grade six teachers...told me, ‘Who does the braids for you?’ And I told him, ‘my mom.’ He told me ‘when you’re coming to school, wear your braids. And when you’re in school, take them off and be Canadian, and after school, braid it back so your mom won’t find out’”
    (Tamil female, 14).

Societal Level

- **Best Practice – Youth centres, workshops, peer leader programs:**
  - While discrimination functions both at individual and societal levels, and is not always easy to overcome, programs that foster inter-group dialogue and activities go a long way in bolstering youth self-esteem, which in turn can help create cultural awareness and sensitivity.

Funding

- This project is funded by the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (2007-2009). Dr. Nadia Khateri is the Principal Investigator, (OICR Chair in Women’s Mental Health Research at York University), Dr. Yogendra Shalaya is the Co-Principal Investigator (Director of Research and Evaluation at Access Alliance Multicultural Health and Community Services), and Dr. Carol Muntzner is the Co-Investigator (University of Toronto).

Thank you

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References

References cont’d...


