RLI Working Paper No. 71

REFUGEE LAW INITIATIVE | SCHOOL OF ADVANCED STUDY UNIVERSITY OF LONDON

'We are family!' The kinship between individual cosponsor and sponsored refugee(s) and its impact on mental health service uptake

Simolen Tala-Jumbam
School of Advanced Study, University of London

stjumbam@gmail.com

May 2024

Abstract

Resettled refugees underutilize mental health services, despite being the immigrant population with the highest incidence of mental health issues. In Canada, individual cosponsors, particularly family members of refugees, play a crucial role in providing social support and fostering a sense of belonging during the resettlement period. These have proven effective in promoting the mental health and overall well-being of refugees. The primary objective of this research is to investigate whether the kinship (family dynamics) between individual cosponsors and refugees influences the refugees' willingness to access mental health services when needed.

Purposive sampling was used to select nine participants. The semi-structure interviews conducted explored the participants' experiences with mental health issues during the sponsorship process. Five individual cosponsors (CS) and four group sponsor representatives (CG) were interviewed. Inductive thematic analysis was used to code and analyze the data. Sixteen sponsorship experiences were discussed during the interviews. CGs identified social support and relationship building as factors influencing refugees' access to mental health services. In contrast, CSs emphasised the role of reducing stigma associated with mental health in facilitating refugees' access to such services.

The results suggest that, despite the presence of social support, sense of belonging, and family dynamics inherent in the kinship between CS and refugee, the stigma surrounding mental health remains a significant determinant of refugee access to services. It is important to note that most participants based their responses on hypothetical scenarios rather than actual experiences, as only two out of the sixteen sponsorships mentioned involved mental health issues.

Keywords *Refugee Mental Health, Refugee Integration, Private Sponsorship of Refugees, Individual Cosponsors, Family Sponsorship*

Contents

1. Introduction

At the end of 2021, a total 89.3 million people worldwide were forced to flee their homes due to conflict, persecution and fear of human rights violations. The conflicts that have emerged in succession within the last decade, including the conflict in Tigray region of Ethiopia, the conflict in Afghanistan, the war in the Ukraine, and other forced displacements due to natural disasters, have shown an even greater need to find solutions for the displaced.

Canada has welcomed over 1,088,015 refugees since 1980[1] through its Private Sponsorship of Refugees (PSR) programme and its Government Assisted Refugee (GAR) programme. Canada created programmes to help with resettlement of refugees from regions of conflict; for the Syrian crisis, the Government of Canada resettled 25,000 Syrian refugees between November 2015 and February 2016[2] through Operation Syrian Refugees[3]. From the crisis in Afghanistan, 22,270 Afghan refugees have arrived in Canada since August 2021; 13,940 of them arriving through both the PSR and GAR programmes[4]. For the Ukraine crisis, over 6,100 Ukrainians have arrived in Canada since January 2022[5]. These programmes rely heavily on private citizens to help with resettlement and majority of these private citizens are family members looking to reunite with their loved ones.

1.1 Family Members in Sponsorship - PSR programme

Family reunification is argued to be at the heart of Canada's PSR programme.[6] For years resettled refugees have used the programme to bring their families to Canada as the program permits Canadian citizens and permanent residents to refer and resettle refugees to Canada as opposed to the GAR program in which the refugees are referred by the United Nations High Commissioner for Refugees (UNHCR) and resettled by the Canadian government. The role of private citizens in resettling refugees is an important part of this study and so a brief look at the PSR program will help shed some light into this role.

The PSR programme allows either individual citizens, groups of citizens or communities to sponsor refugees through four different ways; using a Sponsorship Agreement Holder (SAH), Groups of 5 (G5), Constituent Groups (CG), or Community Sponsors[7]. Individual citizens can partner with a SAH, form a G5, partner with a CG, or partner with a community sponsor to help resettle refugees. In these partnerships they are known as cosponsors[8], with the individual citizen known as an individual cosponsor. In these PSR partnerships all parties agree to provide financial and non-financial settlement (care, lodging, settlement support) to the refugee(s) for at least 12 months from the refugee(s)' arrival to Canada or until the refugee(s) becomes self-sufficient[9], and sometimes longer depending on the refugee(s)' needs. In essence, the refugee(s) relies completely on the sponsors for social and settlement support during the 12-months or more settlement period.

1 Froma Walsh, 'Family Resilience: A Framework for Clinical Practice' (2003) 42 Family process 1.

2 Global Affairs Canada, 'Canada's Response to the Conflict in Syria' (*GAC*, 29 May 2017) <https://www.international.gc.ca/world-monde/issues_development-enjeux_developpement/response_conflict-reponse_conflits/crisis-crises/conflict_syria-syrie.aspx?lang=eng> accessed 17 October 2022.

3 Refugees and Citizenship Canada Immigration, '#WelcomeRefugees: Canada Resettled Syrian Refugees' (24 November 2015) <https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/welcome-syrian-refugees.html> accessed 18 October 2022.

4 Refugees and Citizenship Canada Immigration, '#WelcomeAfghans: Key Figures' (28 August 2021) <https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/afghanistan/key-figures.html> accessed 18 October 2022.

5 Refugees and Citizenship Canada Immigration, 'Canada to Welcome Those Fleeing the War in Ukraine' (3 March 2022) <https://www.canada.ca/en/immigration-refugees-citizenship/news/2022/03/canada-to-welcome-those-fleeing-the-war-in-ukraine.html> accessed 18 October 2022.

6 Stéfanie Morris, Patti Tamara Lenard and Stacey Haugen, 'Refugee Sponsorship and Family Reunification' (2021) 34 Journal of Refugee Studies 130 <https://doi.org/10.1093/jrs/feaa062> accessed 18 August 2022.

7 Refugees and Citizenship Canada Immigration, '2. Private Sponsorship of Refugees Program' (1 November 2003) <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/guide-private-sponsorship-refugees-program/section-2.html> accessed 18 October 2022.

8 ibid.

9 ibid.

1.2 Focus and Scope of Study

As more families apply to resettle their loved ones to Canada, the number of refugee arrivals increases, and proper integration to help the arrived refugees settle becomes an important topic. The task of ensuring that the refugee integrates properly falls on both the family members/private citizens in the case of the PSR programme, and the government of Canada in the case of the GAR programme. Refugees who have fled war-torn countries do not easily integrate into a new country, due to all the trauma that initiated their forced migration. Trauma and mental health issues are a huge barrier to proper refugee integration in the host country[10]. Sponsored refugees are shown to have a higher prevalence of mental health illnesses in their host country than the actual citizens[11]. Yet despite this high prevalence, studies show an underutilization of mental health services by refugees as opposed to the actual citizens[12]. Reasons behind this underutilization of services by refugees have been attributed to cultural, economic, social, religious, linguistics, stigma, general attitude of the host country/communities towards refugees…[13]. Also, possible interventions have been presented as education, awareness, and resources targeting either mental health professionals, health care workers, the refugees themselves and communities[14].

This research studies the role of the kinship between individual cosponsors and the sponsored refugees in the uptake of mental health services so as to inform interventions in refugee mental health wellbeing. The choice of host family members was to study if there is an influence that arises by virtue of the refugee being family - i.e., the social support (social capital), the sense of belonging, and the family dynamics - and if this influence can affect willingness of the refugee to access mental health services. Social support and sense of belonging comes with resettling the refugee and are also important in refugee integration[15]. Family dynamics within refugee families shows a reliance and dependence on each other which creates resilience[16], and this reliance and dependence betray an influence the refugee family members have on each other. With all this in mind the study set out to investigate the influence of individual cosponsors (family relation) on the uptake of mental health services when needed by sponsored refugees. This was summarized in the broad research question: 'Can individual cosponsors, by virtue of being family, have an influence on refugees' willingness to access mental health services?'

1.3 Relevance of Study

Research done on resettlement through the Canadian PSR programme usually focus on the relationship

10 Katharine M Donato and Elizabeth Ferris, 'Refugee Integration in Canada, Europe, and the United States: Perspectives from Research' (2020) 690 The ANNALS of the American Academy of Political and Social Science 7 <https://doi.org/10.1177/0002716220943169> accessed 11 September 2022."plainCitation":"Katharine M Donato and Elizabeth Ferris, 'Refugee Integration in Canada, Europe, and the United States: Perspectives from Research' (2020

11 Emily Satinsky and others, 'Mental Health Care Utilisation and Access among Refugees and Asylum Seekers in Europe: A Systematic Review' (2019) 123 Health Policy 851 <https://www.sciencedirect.com/science/article/pii/S0168851019300399> accessed 11 September 2022."plainCitation":"Emily Satinsky and others, 'Mental Health Care Utilisation and Access among Refugees and Asylum Seekers in Europe: A Systematic Review' (2019

12 ibid; Marit Sijbrandij, 'Expanding the Evidence: Key Priorities for Research on Mental Health Interventions for Refugees in High-Income Countries' (2017) 27 Epidemiology and Psychiatric Sciences 1; Mary Susan Thomson and others, 'Improving Immigrant Populations' Access to Mental Health Services in Canada: A Review of Barriers and Recommendations' (2015) 17 Journal of Immigrant and Minority Health 1895 <https://www.proquest.com/docview/1728508195/citation/B2A323F7C464A10PQ/1> accessed 18 August 2022."plainCitation":"ibid; Marit Sijbrandij, 'Expanding the Evidence: Key Priorities for Research on Mental Health Interventions for Refugees in High-Income Countries' (2017

13 LJ Kirmayer and others, 'Common Mental Health Problems in Immigrants and Refugees: General Approach in Primary Care' (2011) 183 Canadian Medical Association Journal E959 <http://www.cmaj.ca/cgi/doi/10.1503/cmaj.090292> accessed 18 August 2022; Thomson and others (n 12).

14 Mustapha Barry, 'Barriers Associated with Mental Health Services for People with Refugee Background in Douglas County' 27; Kirmayer and others (n 13); Satinsky and others (n 11)."plainCitation":"Mustapha Barry, 'Barriers Associated with Mental Health Services for People with Refugee Background in Douglas County' 27; Kirmayer and others (n 13

15 A Ager and A Strang, 'Understanding Integration: A Conceptual Framework' (2008) 21 Journal of Refugee Studies 166 <https://academic.oup.com/jrs/article-lookup/doi/10.1093/jrs/fen016> accessed 18 September 2022.

16 Walsh (n 1).

and experiences of constituent groups (group sponsors) and the resettled refugee[17]. Not many studies have been done on the relationship between individual cosponsors and sponsored refugees. Therefore, the study included participants from constituent groups to compare and contrast results obtained from both individual cosponsors and constituent groups. The study was carried out in Toronto, Canada, and the participants recruited for the research were affiliated with a SAH in Toronto, Canada.

The study could contribute to research on refugee integration in Canada, especially in the area of improving refugee mental health as this is cited as the top priority concern in refugee integration in Canada[18]. As mentioned above, the study could contribute to insight into the relationship between individual cosponsors and resettled refugees. Also, the participants were asked to provide information on what support they need to be able to help the refugees better access mental health services. This could help inform possible training and resources for SAHs or resettlement organizations to provide to refugees and theirs sponsors.

1.4 Personal Motivations

I am familiar with the topic of refugee resettlement. I work for a SAH organization, and I help cosponsors, both individual and group sponsors, to prepare and submit applications to the Federal Government (Immigration Canada) for refugees to resettle in Canada. A SAH is an incorporated organization in Canada that has signed an agreement with the Federal Government to help sponsor refugees[19]. In my role, I work in advocating for cosponsors and the support they need to help their families integrate.

Mental health is also a topic of interest for me as I studied mental health counseling. Integrating both refugee resettlement and mental health counseling in a study has been a worthwhile challenge.

Lastly, this research project, as challenging as it was, has also been good practice in acquiring skills in qualitative research and analysis, which could open up job prospects in forced migration research.

1.5 Study Outline

The literature review chapter, establishes a link between refugee mental health and its importance in integration, the need for uptake of mental health services by refugees, the importance of social support/capital from family, and the importance of family dynamics, in promoting mental wellbeing in resettled refugees. The frameworks surrounding definition of the concepts refugee integration, refugee mental health, and family dynamics are also looked at.

The methodology chapter covers the methodological approaches (qualitative approach) and the methods (semi-structured interviews) used and why the choice of those approaches. Ethical aspects and limitations, and validity and reliability of the data are looked at as well.

The results section covers the results obtained from comparing both responses from individual cosponsors and group sponsors. Tables were generated from these results and comparisons and contrasts were made.

The discussion section shows correlations and patterns between the results from individual cosponsors and group sponsors, and discusses implications of these results in interventions for refugee mental health. Recommendations for helping sponsors help refugees access mental health services are provided as well.

17 Michaela Hynie and others, 'What Role Does Type of Sponsorship Play in Early Integration Outcomes? Syrian Refugees Resettled in Six Canadian Cities' (2019) 35 Refuge: Canada's Journal on Refugees / Refuge : revue canadienne sur les réfugiés 36 <https://www.erudit.org/en/journals/refuge/1900-v1-n1-refuge04887/1064818ar/abstract/> accessed 18 August 2022; Audrey Macklin and others, 'The Kinship between Refugee and Family Sponsorship' 25; Audrey Macklin and others, 'A Preliminary Investigation into Private Refugee Sponsors' (2018) 50 Canadian Ethnic Studies 35 <https://muse.jhu.edu/article/700979> accessed 18 August 2022.

18 Canadian Council for Refugees, 'Refugee Integration: Key Concerns and Areas for Further Research' (2011) <https://www.unhcr.ca/wp-content/uploads/2014/10/ccr-refugee-integration-research-report.pdf> accessed 22 September 2022.

19 Immigration, '2. Private Sponsorship of Refugees Program' (n 7).

2. Literature Review

2.1 Concepts and Research Frameworks

The concepts that run through the research objective are refugee integration, refugee mental health, family dynamics (influence), and defining these will help better understand the research objective and the literature review as a whole.

2.1.1 Refugee Integration

Refugee resettlement and refugee integration go hand in hand. Once host countries resettle refugees, their integration and wellbeing in the host country becomes an issue of importance. The concept of integration has been the topic of debates in many refugee host countries[20]. Ager and Strang (2004) confirm this when they identify integration as a term without an agreed upon definition[21]. They, however, propose a framework that shows ten factors (sub-domains or indicators) identified as 'indicators of integration'; rights and citizenship, language and cultural knowledge, safety and stability, social bridges, social bonds, social links, employment, housing, education, health[22]. As the name suggests, these indicators are said to influence the process of refugee integration in some way. These domains have been highly researched and enough evidence gathered to indicate their relevance in integration[23].

The ten sub-domains are grouped under four domains (figure 1);

a) markers and means – employment, housing, education and health
b) social connections – social bridges, social bonds, social links
c) facilitators – language and cultural knowledge, safety and stability
d) foundation – rights and citizenship

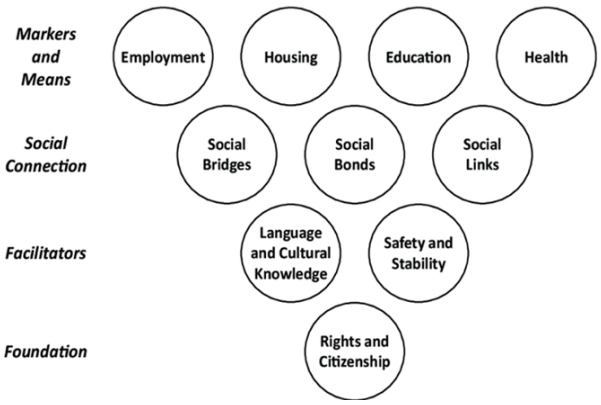

Figure 1: Sources: [24]

Ager and Strang caution against the temptation of using the framework as a 'hierarchy' model in which one

20 Donato and Ferris (n 10); Rinus Penninx and Blanca Garcés-Mascareñas, 'The Concept of Integration as an Analytical Tool and as a Policy Concept' in Blanca Garcés-Mascareñas and Rinus Penninx (eds), *Integration Processes and Policies in Europe: Contexts, Levels and Actors* (Springer International Publishing 2016) <https://doi.org/10.1007/978-3-319-21674-4_2> accessed 11 September 2022."plainCitation":"Donato and Ferris (n 10

21 Alastair Ager and Alison Strang, 'Indicators of Integration: Final Report' 26.

22 ibid.

23 Ager and Strang (n 15).

24 ibid; Ager and Strang (n 21).

indicator precedes the other, or one causes another as the links between the indicators can be more complex than causal or hierarchical links[25]. The indicators under the 'social connections' domain; social bridges, social bonds, social links, were identified by refugees within studied communities as a sense of 'belonging' which reflects integration. By this they meant links and proximity with families, committed friendships, shared values, shared cultural practice, which are connections that made them feel 'settled'[26]. The relationship between a cosponsor and a resettled refugee will fall under the 'social connections' domain. Cosponsors in Canada are part of the social support of refugees and by virtue of being family/friends they play a part in the refugees' sense of belonging and help them navigate the other domains of integration during the settlement period.

2.1.2 Refugee Mental Health

The term 'refugee mental health' describes 'mental health issues related to various aspects of becoming, being, or having been a refugee…'[27]. The Mental Health Commission of Canada (MHCC) is of the opinion that 'Canada's mental health response for incoming refugees should focus on fostering wellness and recognizing the tremendous resilience of refugee populations'[28]. In a plan drawn out to address these two factors; wellness and resilience of the refugee population, the MHCC uses a model by the Mind, Mental Health Foundation, which suggests the importance of understanding well-being, psychological coping strategies, and social capital in building and fostering resilience[29]. See figure 2 below:

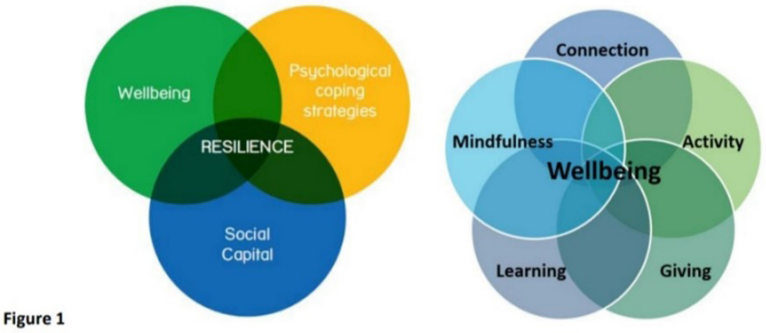

Figure 2: Sources: [30]

In the dynamics between cosponsors and resettled refugees the concept of social capital (figure 2) is relevant. The Mind, Mental Health foundation article mentions social capital i.e., social relationships, as being very crucial in promoting mental wellbeing and preventing mental health problems. Also, Ager and Strang (2008) define social capital/social relationships as the three indicators in the 'social connections' domain on the indicators of integration framework; "social bonds (with family and co-ethnic, co-national, co-religious or other forms of group), social bridges (with other communities) and social links (with the structures of the state)"[31]. It could thus be argued that the relationship between the cosponsor and the resettled refugee (being social capital) is crucial in promoting mental wellbeing and preventing mental health problems.

25 Ager and Strang (n 15).

26 Ager and Strang (n 15).

27 Stephan Zipfel, Monique C Pfaltz and Ulrich Schnyder, 'Editorial: Refugee Mental Health' (2019) 10 Frontiers in Psychiatry <https://www.frontiersin.org/articles/10.3389/fpsyt.2019.00072> accessed 6 September 2022.

28 Branka Agic and others, 'Supporting the Mental Health of Refugees to Canada' (Mental Health Commission of Canada 2016) <https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2016-01-25_refugee_mental_health_backgrounder_0.pdf> accessed 19 September 2022.

29 Mind, Mental Health Foundation, 'Building Resilient Communities: Making Every Contact Count for Public Mental Health' (*Mind, Mental Health Foundation*, August 2013) <https://www.mentalhealth.org.uk/sites/default/files/2022-09/MHF-building-resilient-communities.pdf>.

30 Agic and others (n 28); Mind, Mental Health Foundation (n 30).

31 Ager and Strang (n 15).

2.1.3 Family Dynamics (Influence)

The research objective seeks to understand the influence that individual cosponsors, by virtue of being family, have on resettled refugees' willingness to access mental health services. This warrants an understanding of family dynamics that define refugee families. Although disruptions or shifts in family dynamics as refugees get settled in their host countries are reported to be common, for instance the youth getting used to mainstream culture, or role reversals when women have to work instead etc.[32] these dynamics could be different when it comes to instances such as overcoming adversity. In addition to financial support and orientation, resettled refugees to Canada also rely on the cosponsors (family) for emotional and psychological support in overcoming adversity. Walsh (2003) proposes a framework, the Family Resilience Framework, which could be said to capture the dynamics in the family in terms of overcoming adversity when they move into a new country. Walsh defines resilience as 'the ability to withstand and rebound from disruptive life challenges,'[33] and forced migration is a disruptive life challenge with huge mental health implications. In this framework Walsh highlights the ways families withstand and rebound from adversity, coping together through their shared belief systems (such as making meaning of their situation, promoting hope, and finding spiritual strength)[34]. This framework shows not only a great reliance on each family member but a great influence on each other as well. Ties between relatives and family members promote self-worth and provide guidance and emotional care, portraying the protective role of the family in forced migration[35]. It is this reliance and influence, and how it affects refugee's willingness to access mental health services that this study seeks to understand.

2.2 The Role of Mental Health in Refugee Integration

Given the number of refugees that Canada resettles on average in a year [30,082 refugees in 2021[36]] refugee integration becomes an undertaking by both the government and the public; the task of ensuring that the "process of [the refugee(s)] becoming an accepted part of society" [37] is well done falls largely on the government, the sponsor groups, the communities, and the individual cosponsors.

Although good mental health has been posited to be a "prerequisite for integration… [and a] …positive outcome of successful integration trajectories"[38], poor mental health remains one of the challenges to refugee integration in host societies in general, alongside employment, housing, education, and health indi-

32 mccintersections, 'Changing Power Dynamics for Resettled Refugee Families' (*Intersections*, 6 November 2017) <https://mccintersections.wordpress.com/2017/11/06/power-dynamics-resettled-refugee-families/> accessed 19 September 2022; Miriam Stewart and others, 'Multicultural Meanings of Social Support among Immigrants and Refugees' (2008) 46 International Migration 123 <http://0-search.ebscohost.com.catalogue.libraries.london.ac.uk/login.aspx?direct=true&db=a9h&AN=34545437&site=ehost-live> accessed 13 September 2022; Stevan Weine, 'Family Roles in Refugee Youth Resettlement from a Prevention Perspective' (2008) 17 Child and adolescent psychiatric clinics of North America 515 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3414421/> accessed 20 September 2022.\\uc0\\u8216{}Multicultural Meanings of Social Support among Immigrants and Refugees\\uc0\\u8217{} (2008

33 Walsh (n 1).

34 Co-edited with equal contribution by Jaime Ballard and others, '9.2 Family Theories: A New Direction for Research with Resettled Populations' <https://open.lib.umn.edu/immigrantfamilies/chapter/9-2-family-theories-a-new-direction-for-research-with-resettled-populations/> accessed 19 September 2022."plainCitation":"Co-edited with equal contribution by Jaime Ballard and others, '9.2 Family Theories: A New Direction for Research with Resettled Populations' <https://open.lib.umn.edu/immigrantfamilies/chapter/9-2-family-theories-a-new-direction-for-research-with-resettled-populations/> accessed 19 September 2022.","noteIndex":36},"citationItems":[{"id":192,"uris":["http://zotero.org/users/local/5XAw7bol/items/VEFGBGEB"],"itemData":{"id":192,"type":"article-journal","language":"en","note":"Book Title: Immigrant and Refugee Families, 2nd Ed.\npublisher: University of Minnesota Libraries Publishing","source":"open.lib.umn.edu","title":"9.2 Family Theories: A New Direction for Research with Resettled Populations","title-short":"9.2 Family Theories","URL":"https://open.lib.umn.edu/immigrantfamilies/chapter/9-2-family-theories-a-new-direction-for-research-with-resettled-populations/","author":[{"family":"Ballard","given":"Co-edited with equal contribution by Jaime"},{"family":"Wieling","given":"Elizabeth"},{"family":"Solheim","given":"Catherine"},{"family":"Dwanyen","given":"and Lekie"}],"accessed":{"date-parts":[["2022",9,19]]},"issued":{"date-parts":[["2019",11,20]]}}}],"schema":"https://github.com/citation-style-language/schema/raw/master/csl-citation.json"}

35 Lea-Maria Löbel, 'Family Separation and Refugee Mental Health–A Network Perspective' (2020) 61 Social Networks 20 <https://www.sciencedirect.com/science/article/pii/S0378873319300449> accessed 10 September 2022.

36 'Refugee Statistics' (*UNHCR Canada*, 2022) <https://www.unhcr.ca/in-canada/refugee-statistics/> accessed 20 September 2022.

37 Penninx and Garcés-Mascareñas (n 20).

38 Lena Walther and others, 'Mental Health and Integration: A Qualitative Study on the Struggles of Recently Arrived Refugees in Germany' (2021) 9 Frontiers in Public Health <https://www.frontiersin.org/articles/10.3389/fpubh.2021.576481> accessed 18 August 2022."plainCitation":"Lena Walther and others, 'Mental Health and Integration: A Qualitative Study on the Struggles of Recently Arrived Refugees in Germany' (2021

cators[39]. Exposure to traumas of war, violence, forced displacement, separation from family, which make up part of the migration journey and process of being a refugee, are often the sources of issues such as post-traumatic stress disorder, anxiety, depression, and somatic complaints[40]. A report generated by the Canadian Council for refugees cites mental health of refugees as one of the top priority concerns in refugee integration in Canada[41].

Given the high availability of mental health agencies and mental health service providers in Canada the question becomes what is hindering access to these services. The same report by the Canadian Council for refugees also states that the issue is more "uptake [of services] than the availability of services"[42]. A look at refugee access and utilization of mental health services in the next section will attempt to shed some light on the issue.

2.3 Refugee Access to and Uptake of Mental Health Services

Research shows that resettled refugees are at higher risk of developing mental health issues than the general population in their host countries[43]. Kirmayer et al. report prevalence of psychological disorders in refugees in Canada to be linked to 'adversity experienced before, during, and after resettlement and to policies and practices that determine who gets admittance to Canada'[44]. Kronick provides global statistics of up to 40% of resettled refugees suffering from anxiety, up to 44% suffering from depression, and up to 36% suffering from PTSD[45].

Given the high prevalence of disorders in refugee population, the use of mental health services is highly recommended[46] and access to mental health care and services is important for the well-being of refugees[47]. However, 'help-seeking behavior for psychological problems' in this population is consistently low[48]. Immigrants and refugees are less likely to seek mental health services than the citizens of their host countries even when they experience similar levels of distress[49] hence utilization of mental health services in this

39 Donato and Ferris (n 10).refugees, and asylum seekers have grown worldwide, intense debate has emerged about how long and how well they integrate into host countries. Although integration is a complex process, realized differently by different groups at different times, most prior studies capture, at best, disparate parts of the process. Overcoming this limitation is a tall task because it requires data and research that capture how integration is both dynamic and contextual and requires focusing on conceptual issues, emphasizing how integration varies across spatial scales, and including perspectives of the process through the eyes of both scholars and practitioners. This article reviews recent key studies about refugees in Canada, Europe, and the United States, as a way of putting into context the scholarship presented in this special issue of The ANNALS. We analyze whether and how prior studies capture integration as a dynamic process that unfolds in various aspects of life, such as education, employment, and health. We also consider the extent to which prior studies are shaped by long-standing divides between the terms refugee and migrant, and integration and assimilation, and what those divides mean for research on refugee and migrant integration in the twenty-first century. Throughout, we assess the data needed for researchers to address a wide variety of questions about refugee integration and understand the long-term consequences of the ever-growing number of displaced persons seeking refuge. This volume presents research that uniquely enhances our understanding about the breadth of the integration process in the United States, Canada, and European countries.","container-title":"The ANNALS of the American Academy of Political and Social Science","DOI":"10.1177/0002716220943169","ISSN":"0002-7162","issue":"1","journalAbbreviation":"The ANNALS of the American Academy of Political and Social Science","note":"publisher: SAGE Publications Inc","page":"7-35","source":"SAGE Journals","title":"Refugee Integration in Canada, Europe, and the United States: Perspectives from Research","title-short":"Refugee Integration in Canada, Europe, and the United States","URL":"https://doi.org/10.1177/0002716220943169","volume":"690","author":[{"family":"Donato","given":"Katharine M."},{"family":"Ferris","given":"Elizabeth"}],"accessed":{"date-parts":[["2022",9,11]]},"issued":{"date-parts":[["2020",7,1]]}}],"schema":"https://github.com/citation-style-language/schema/raw/master/csl-citation.json"}

40 Kirmayer and others (n 13).

41 Canadian Council for Refugees (n 18)

42 ibid.

43 Sofie Bäärnhielm and others, 'Mental Health for Refugees, Asylum Seekers and Displaced Persons: A Call for a Humanitarian Agenda' (2017) 54 Transcultural Psychiatry 565 <https://doi.org/10.1177/1363461517747095> accessed 18 August 2022; Barry (n 14); Kirmayer and others (n 13).

44 Kirmayer and others (n 13).

45 Rachel Kronick, 'Mental Health of Refugees and Asylum Seekers: Assessment and Intervention' (2018) 63 Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie 290.

46 Satinsky and others (n 11).yet may face barriers in accessing mental health and psychosocial support (MHPSS

47 Thomson and others (n 12).

48 Anu E Castaneda and others, 'Migrants Are Underrepresented in Mental Health and Rehabilitation Services—Survey and Register-Based Findings of Russian, Somali, and Kurdish Origin Adults in Finland' (2020) 17 International Journal of Environmental Research and Public Health 6223 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7504052/> accessed 18 August 2022.

49 Kirmayer and others (n 13); Thomson and others (n 12).

population remains very low[50]. Sijbrandij references a German paper which shows that in '2015 only 5% of refugees in need of mental health care actually received treatment'[51].

Numerous studies suggest reasons behind this underutilization of mental health services as being; cultural, economic, social, religious, linguistics, systemic discrimination, stigma, general attitude of the host country/communities towards refugees…[52] One of the factors identified as affecting both mental health and access to services is social isolation or reduced social support during resettlement[53] i.e., reduced social capital, as defined by the research framework. The next section will link the role of cosponsors in social support and uptake of mental health services.

2.4 Individual Cosponsors (family/social support) and Uptake of Mental Health Services

Family separation as a result of the migration process has huge mental health impacts on all family members, and thus a huge impact on refugee integration for those family members that get resettled in a host country[54]. The Canadian PSR program has been used as a family reunification process since Canadian citizens and permanent residents, i.e. the cosponsors, tend to mostly identify refugee relatives for the sponsorship program. Thus, the cosponsors, who provide social support[55] for resettled refugees, are more likely to be the ones expected to provide orientation in the host country, including orientation to mental health services. Stewart et al. (2008) define social support in a culturally relevant manner to mean the immediate support of family and friends[56]. This definition was identified by majority of the refugees in Stewart et al.'s study as interdependence on each other based on experiences in their countries of origin, and as a duty 'dictated by cultural factors.' Stewart et al. mention the fact that social support has an influence on refugee's sense of belonging and isolation, thus affecting mental health[57]. If cosponsors, who are family and/or friends, provide social support to resettled refugees, and social support affects both mental health and access to services, then it could be argued that cosponsors can affect/influence refugee's access or willingness to access mental health services.

2.5 Addressing Gaps in the Research

As mentioned in the introduction, not much research has been done about individual cosponsors and resettled refugees. Research done on resettlement through the Canadian PSR programme usually focus on the relationship and experiences of group sponsors and the resettled refugee[58]. Group sponsors are usually organizations or volunteer groups with no relations with the sponsored refugee, and research often portrays the relationship between group sponsors and refugees as strained, with the groups criticized for meddling in refugees' personal affairs; excess intrusiveness[59]. The relationship dynamics could be different

50 Thomson and others (n 12).

51 Sijbrandij (n 12).

52 Kirmayer and others (n 13); Thomson and others (n 12).

53 Thomson and others (n 12).

54 Bäärnhielm and others (n 45); Donato and Ferris (n 10); Michaela Hynie, 'The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review' (2018) 63 The Canadian Journal of Psychiatry 297 <https://doi.org/10.1177/0706743717746666> accessed 10 September 2022."plainCitation":"Bäärnhielm and others (n 45

55 Hynie and others (n 17).

56 Stewart and others (n 34).resettlement, and search for refuge, yet there is a gap in our understanding of these newcomers' views of the specific meanings of social support and their support needs and resources. The purpose of this study was to understand the meanings of social support for immigrants and refugees in Canada, and to explore the types and adequacy of formal supports. Individual interviews were conducted with 60 service providers and policymakers initially (Phase 1

57 Ibid. pg. 126

58 Hynie and others (n 17); Macklin and others, 'The Kinship between Refugee and Family Sponsorship' (n 17); Macklin and others, 'A Preliminary Investigation into Private Refugee Sponsors' (n 17).

59 Morton Beiser, 'Resettling Refugees and Safeguarding Their Mental Health: Lessons Learned from the Canadian Refugee Resettlement Project' (2009) 46 Transcultural Psychiatry 539.

between that of an individual cosponsor who is usually family or friend of the refugee. Hence, there is a gap in research with regards to studying individual cosponsors and the dynamics of their relationships with resettled refugees which the objective of this research would cover.

As shown earlier there is a huge underutilization of mental health services by immigrants and refugees when they come to Canada. Even though much research has been done to identify the barriers that exist[60], much still needs to be done to bridge the gap in refugee and immigrant utilization of mental health services. With the literature showing the impact of social support and the importance of family reunification on refugee mental health and wellbeing family, the study of understanding the influence of individual cosponsor on refugee access to mental health will contribute to bridging this gap. Also, studying how access and uptake of mental health services in refugees can be affected by post-migration determinants, including the social support they receive from the hosts, both family and community, can inform the design of programs/training to foster refugees' mental wellbeing and thus proper integration.

60 Barry (n 14); Sijbrandij (n 12); Thomson and others (n 12).

3. Chapter 3 - Methods and Methodology

3.1 Research Problem and Questions

The literature review has shown that social capital/support, that is, a sense of 'belonging' fostered through 'social connections' like proximity with families, committed friendships[61], and through immediate support from family and friends[62] has been shown to be 'very crucial in promoting mental wellbeing and preventing mental health problems'[63]. The research objective seeks to explore the role of this social capital/support in promoting refugee utilization of mental health services. The broad question that guided the methodology, methods and procedures in this research was; 'Can individual cosponsors, by virtue of being family, have an influence on refugees' willingness to access mental health services?'

Some of the questions that helped probe the subject further included:

- Would the sponsors have been able to approach the refugee to suggest they consider seeking mental health services? Why or why not?
- Would the refugee have listened to the suggestions to access mental health services if there was a need? Why or why not?

Given the dynamics of refugee families captured in the Family Resilience Framework, that of bonding together in adversity to form resilience and reliance on each other[64], it could be argued that cosponsors who are family might have an influence on their resettled family members.

3.2 Methodological Approach

A qualitative approach was used to conduct the research and analyze the data obtained. This approach was apt since the research question sought to collect raw primary data on the beliefs, experiences and the interactions[65] of the cosponsors with the resettled refugees, a topic with little to no existing data. This gathering of personal opinions of participants as data is associated with the epistemological 'constructivist' stance, which believes that "meanings are constructed, interpreted, and constantly reconstructed by people in their perceptions and social interactions"[66].

Qualitative data was collected through semi-structured interviews with mostly open-ended questions generated based on the research questions and objectives. The semi-structured interviews allowed participants the freedom to speak about matters important to them and that way enough information gathered as primary data. Seeking data through semi-structure interviews also aligns with the epistemological stance that "reality is socially constructed and interpreted in line with the worldviews of participants"[67]. Also, since research participants interviewed were from culturally different groups, the qualitative approach allows

61 Ager and Strang (n 15).

62 Stewart and others (n 34).resettlement, and search for refuge, yet there is a gap in our understanding of these newcomers' views of the specific meanings of social support and their support needs and resources. The purpose of this study was to understand the meanings of social support for immigrants and refugees in Canada, and to explore the types and adequacy of formal supports. Individual interviews were conducted with 60 service providers and policymakers initially (Phase 1

63 Mind, Mental Health Foundation (n 30).a

64 Walsh (n 1).

65 Vibha Pathak, Bijayini Jena and Sanjay Kalra, 'Qualitative Research' (2013) 4 Perspectives in Clinical Research 192 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3757586/> accessed 4 October 2022.

66 Stephen Castles, 'Understanding the Relationship between Methodology and Methods', *Chapters* (Edward Elgar Publishing 2012) <https://ideas.repec.org/h/elg/eechap/14062_1.html> accessed 11 October 2022.

67 Theophilus Azungah, 'Qualitative Research: Deductive and Inductive Approaches to Data Analysis' (2018) 18 Qualitative Research Journal 383 <https://www.proquest.com/docview/2133411195/abstract/F4D5B25ACD344CC0PQ/1> accessed 13 October 2022.

for exploration of varying perspectives of diverse groups within a community[68]. A quantitative approach would not have worked for the research objectives of this study as the opinions and perspectives sought after from participants cannot be easily reduced to numbers. Also, the sample size for this study (9) is very small which poses a challenge for quantitative analysis but works best for qualitative analysis.

3.3 Researcher's Positionality

Before delving further into the methodology and the process of collecting data I, the researcher, would like to describe my positionality in the research. I acknowledge my position as an immigrant to Canada who has experienced the challenges of immigrating to a new country alone despite growing up in a large African family in which social support and looking out for each other is seen as 'a duty as dictated by cultural factors'[69]. I understand the need for, and the importance of a social support system to help navigate the initial stages of being in a new country. My first few years adjusting to a new country was riddled with mental health struggles which went unattended in part due to lack of knowledge and the support to access these services. Hence the 'push' to find ways to get assistance for immigrants, including refugees. However, I recognize that I did not come to Canada as a refugee and my immigration experiences will not be the same as those of a refugee newcomer to Canada. I also recognize that immigrants to Canada have varying degrees of need for mental health services, and some may not need at all. I acknowledge that my experience of family as a community with an implied 'duty' to take responsibility for each other influenced my interest in seeking out how family can influence the willingness of their refugee family member to seek mental health support, especially as the refugee communities I interviewed also view their families, immediate and extended, as a community.

I have a Master of Arts degree in Mental Health Counseling which I pursued after my undergraduate studies in order to understand mental health illnesses, particularly my own symptoms. Even though I do not have work experience in the mental health field, my academic background influenced my choice of studying mental health in refugees as a topic. Also, I currently work with individual cosponsors and group sponsors in refugee resettlement and sponsorship in Canada, a position I acquired with the intention of pursuing a path in refugee mental health. My choice of dissertation topic seemed a 'no-brainer' with my academic background and my experience working with sponsors. Even though my academic background and work experience may position me as having some knowledge in the field, I recognize the 'expertise' of the participants in their own stories and experiences.

3.4 Data Collection

3.4.1 Type of Participants

The participants consisted of two groups of sponsors – one group of individual cosponsors (CS) and the other representatives from group sponsors/constituent groups (CG) selected from a SAH in Toronto, Canada. The SAH works with community leaders of mostly faith communities in the Greater Toronto Area to identify CSs looking to resettle their refugee family/friends abroad to Canada. This SAH also works with CGs, mostly Church groups, to resettle those refugees overseas who are selected for resettlement by the SAH but do not have family in Canada. The CGs play the role of 'family' for these refugees in providing the settlement and social support needed during the resettlement year. Sometimes these resettlement 'relationships' become 'like family'[70]. Both CSs and CGs who were participants had sponsored a refugee through

68 Looi Theam Choy, 'The Strengths and Weaknesses of Research Methodology: Comparison and Complimentary between Qualitative and Quantitative Approaches' (2014) 19 IOSR Journal of Humanities and Social Science 99 <http://www.iosrjournals.org/iosr-jhss/papers/Vol19-issue4/Version-3/N0194399104.pdf> accessed 4 October 2022.

69 Stewart and others (n 34).resettlement, and search for refuge, yet there is a gap in our understanding of these newcomers' views of the specific meanings of social support and their support needs and resources. The purpose of this study was to understand the meanings of social support for immigrants and refugees in Canada, and to explore the types and adequacy of formal supports. Individual interviews were conducted with 60 service providers and policymakers initially (Phase 1

70 Macklin and others, 'The Kinship between Refugee and Family Sponsorship' (n 17).

the SAH organization. Emails were written to each community leader, and to the director of the SAH with attached consent letters requesting to approach CSs in the communities (letters to community leaders), and consent to approach the Church CGs (letter to the director of the SAH). The signed consent letters were obtained from the leading members of a Syrian community, an Iraqi community, and an Eritrean community.

3.4.2 Sampling Criteria

The participants were selected using purposive sampling based on the following criteria; for CSs, they have sponsored at least one refugee in Canada within the last 4 – 5 years (so they can recall the resettlement period), and they are relatives of the refugees they sponsored, and for Church CGs, they have helped resettle refugees in the last 4 – 5 years. The CSs that fitted the sampling criteria were selected by the community leaders who acted as 'gatekeepers' i.e., mediators who could facilitate access to the participants[71]. The community leaders contacted participants to let them know they would be contacted with regards to a research project. For CGs, a list was generated by the SAH organization from among the Church groups that work with the organization to resettle refugees with no family in Canada.

Purposive sampling was apt for this study as it involves selection of individuals or groups of individuals proficient and well informed with a topic of research interest[72], such as resettling refugees in the case of this study, and especially to maximize the use of available resources by selecting the 'information-rich' cases.

3.4.3 Sample Size:

Participation consent forms were sent by email to each participant identified. All the CSs selected were Arabic-speaking (from both Syria and Iraq), so the participation consent form was translated into Arabic, and both English and Arabic consent forms (see appendix A) were provided to all Arabic-speaking participants. The first follow-up on receipt of the consent forms was done via email after 5 days if response had not been received, and every 3 days after that for a week via email or phone call. The researcher stopped following up after that week even when a response was not received from the participant. With regards to sampling size, the researcher reached out to a total of seven (7) Church CGs (2 declined to participate, 1 did not respond even after follow-up), and seven (7) CSs (2 did not respond even after follow-up). With regards to response rate, four (4) Church CGs and five (5) CSs agreed to participate, for a total of nine (9) participants.

3.4.4 Interviews:

Interview questions were crafted to elicit participants' opinions about their sponsorship experience, their relationship with the refugee(s), their knowledge of mental health issues and services, their ability to influence the refugee's willingness to access mental health services. Two questions asked to start off the discussions were:

- When was your last sponsorship period?
- What was your sponsorship experience like?

The rest of the questions, including the research questions, follow-up questions, clarifying questions, came in any order depending on the flow of the interview.

One-hour virtual interviews were scheduled on zoom, within a span of one week, for all participants once the consent forms were received; 2 participants gave verbal consent on video. The nine interviews were conducted in English by the primary researcher and were on average about 25 minutes long. Before each

71 Johnny Andoh-Arthur, 'Gatekeepers in Qualitative Research' (2019).connections with\nor membership in a research poapulation. Furthermore, gatekeepers may also comprise persons or those\nin charge of formal institutions (e.g., heads of institutions such as headmasters and principal officers of\norganisations

72 Ilker Etikan, 'Comparison of Convenience Sampling and Purposive Sampling' (2016) 5 American Journal of Theoretical and Applied Statistics 1 <http://www.sciencepublishinggroup.com/journal/paperinfo?journalid=146&doi=10.11648/j.ajtas.20160501.11> accessed 4 October 2022.

interview, the aim of the research was explained, the fact that participation was voluntary was reiterated, and participants were made aware that they could withdraw at any time during the interview. Verbal consent was obtained to record the interview for later transcription. The questions for the semi-structured interview were mostly open-ended, except questions regarding the refugee's demographics (country of origin, reason for fleeing…).

3.4.5 Data Transcription and Storage

The video and audio recordings of the interviews generated by the zoom software were stored in Dropbox and in google drive. The recordings were transcribed by uploading the audio file on the Microsoft Word 'Transcribe' feature, which provided the following information; the full transcript of any words capture on the audio, distinguished the conversation by speakers, and provided time stamps on the conversations on the audio. There are no set guidelines to follow when transcribing a verbatim account[73]. However, the transcriptions from Microsoft word were edited further by listening to the audio recordings to ensure that the transcriptions captured what the participants actually said. The edited transcripts were then anonymized by replacing the participant names with codes to be used in the results and discussion sections. The participant code was generated as a combination of the date of the interview (MM/DD) and the type of participant (cosponsor-CS, group sponsor-CG), for instance, the code 09/16-CS refers to the cosponsor who was interviewed on September 16, 2022. If more than one cosponsor was interviewed in a day, then numbers were used on the code to denote position, for instance 09/16-CS1 denotes the first cosponsor interviewed on September 16, 2022. Also, all names on the body of the transcripts were replaced with first letter of the name, for instance, Mary becomes M. The edited transcripts were stored in google drive.

3.4.6 Data Analysis

Thematic analysis was used to analyze the transcripts and to create codes that identify repeated patterns or 'themes' in the data collected[74]. Both the transcription and analysis of the data were done by the researcher. An inductive approach to analysis was used to derive codes from the data during analysis. The inductive approach "[provides] a broader, more expansive analysis of the entire body of data"[75], which seemed a good place to start especially as the topic has not been widely studied. Analysis was done on transcriptions obtained from all CSs and all CGs separately to allow the researcher to compare and contrast results from both. Both analyses were done using Microsoft Word, and followed guidance from Braun & Clarke's (2006) six-phase guide to carrying out thematic analysis[76].

The first phase comprised of 'familiarizing self with the data', and this entailed transcribing the interviews on Microsoft Word, editing the transcriptions using Microsoft Word, reading the interviews over once and writing down preliminary notes on repeating patterns on a notepad.

In the second phase of analysis 'generating initial codes,' after getting familiar with the data, the researcher created a column on the word document and wrote short notes/words on the side of each transcript describing information in each section of the transcribed data. After this was done for all the transcripts, the short responses (codes) from the columns were grouped into two separate documents i.e., responses from CSs and responses from CGs.

In the third phase 'searching for themes' some codes were renamed based on inference of meaning from participants responses, giving rise to latent themes based on underlying ideas in the data[77]. For instance, a code could be 'mental illness is a taboo' and another code "Mental illness means you are crazy" could both be written down using a similar theme 'mental illness stigmatized' wherever the participant described any-

73 Virginia Braun and Victoria Clarke, 'Using Thematic Analysis in Psychology' (2006) 3 Qualitative Research in Psychology 77 <http://0-search.ebscohost.com.catalogue.libraries.london.ac.uk/login.aspx?direct=true&db=a9h&AN=20391875&site=ehost-live> accessed 11 October 2022.

74 Michelle E Kiger and Lara Varpio, 'Thematic Analysis of Qualitative Data: AMEE Guide No. 131' (2020) 42 Medical Teacher 846 <https://www.tandfonline.com/doi/full/10.1080/0142159X.2020.1755030> accessed 11 October 2022.

75 ibid.

76 Braun and Clarke (n 73).

77 ibid.

thing about mental illness not accepted in their culture. Another instance was 'settlement support' used as a theme to describe codes to do with 'job search' 'housing' language learning'…. This was done through all the transcripts grouping codes that had to do with a particular topic into a theme. The themes were then color coded and collated based on responses to the main research questions. For instance, for this data analysis, the themes color-coded orange were responses to the question 'would the sponsors have been able to approach the refugee to suggest they consider seeking mental health services? Why or why not?' Those color-coded red were responses to the question 'would the refugee have listened to the suggestions to access mental health services if there was a need? Why or why not?' Lastly, the themes color-coded blue were in response to the question 'what support would sponsors need during the resettlement period to help the refugees access mental health services or seek help?'

The fourth and fifth phases, which entailed reviewing, defining and naming themes were done together. The number of times a theme appeared in all the transcripts were recorded for each question. For instance, the theme "mental health stigmatized (9)" shows that this theme appeared 9 times in the responses provided by those participants for a particular question. These responses were grouped under the following categories:

- Reasons sponsors did not or could not approach refugee
- Reasons sponsors approached or would've approached the refugee
- Reasons refugee(s) would not have listened to sponsors
- Reasons refugee(s) would listen to sponsors
- Support needed by sponsors to help refugees access mental health services

3.5 Ethical Aspects and Limitations

3.5.1 Ethical Considerations

Informed consent was required of all participants through signature on a participation consent form. The consent form gave a summary of the study and the rights of the participants in the study. Verbal consent was obtained on record from two of the participants who were unable to send their consent form on time. The consent form was also translated into Arabic to provide the Arabic-speaking participants ease in providing full consent to participate in the research[78].

The participant consent form mentioned that participation was entirely voluntary. The form was read at the beginning of each interview to assure the participant of the voluntary nature of the research and their choice to withdraw at any moment during the research.

To promote anonymity and confidentiality, the data was anonymized and the participants names coded and all the data generated saved in DropBox, and in the google drive of a private Gmail account. The participant codes were used when writing the results and discussion sections of the paper to preserve anonymity. The participants were also assured that if they chose not to continue with the research even in the middle of the interview, the transcript/recording already generated would be destroyed.

The questions asked were about mental health, and also required that the participants talk about the relationship with the sponsored refugee during the settlement period, which could be a source of distress if the relationship was strained. During the interviews the researcher watched for, and was ready to pause the interview at any signs of distress. The researcher also had the phone number of the Catholic Family Services (a counseling agency) handy to refer to the participant if it was needed.

Both the participants selected for the research and the researcher are affiliated with the same SAH organization; the participants having sponsored refugees through the SAH, and the researcher being a staff at the SAH. To prevent participants from thinking that participating in this research will influence their ability to sponsor a refugee through the SAH organization, the participation consent form indicated that the re-

78 Mahnaz Sanjari and others, 'Ethical Challenges of Researchers in Qualitative Studies: The Necessity to Develop a Specific Guideline' (2014) 7 Journal of Medical Ethics and History of Medicine 14 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4263394/> accessed 12 October 2022.

search is an independent study and not part of work with the SAH. It also indicated that participants were free to participate and withdraw at any time during the interview. Interviews were scheduled after work hours and on weekends, when participants were available.

The selection of participants by community gatekeepers and by the SAH organization posed a challenge to the confidentiality/anonymity of the participants. This was countered by selecting a few participants from the list of participants provided and keeping the selection anonymous.

3.5.2 Limitations:

In qualitative research, data collection and analysis are subjective and prone to the researcher's bias[79]. The researcher's 'personal experience and knowledge can influence observations and conclusions'[80]. This was countered by self-reflective practices and also checking in with the supervisor to get feedback on the research and paper. Also stating the researcher's positionality helped reveal the researcher's biases since it is a reflection of the researcher's world view, or political and social view point vis a vis the research topic, research participants, and research context[81].

The sample size for the study was not diverse. The CS participants selected were from the same community. The time-limited aspect of the research did not allow the recruiting from other communities. However, there was enough data from the interviews to perform a thematic analysis.

Getting responses to interview schedules, and participation consent forms back from participants was a challenge as participants were not quick to respond to emails. To counter this the researcher would either call and remind the participant and/or ask the participant during the interview to declare their verbal consent to participate in the study.

During the interview, some of the participants who were Arabic speaking had difficulties understanding the interview questions, thus, some of the responses were not related to the question. The researcher was able to rephrase the questions every time the participant answer was unrelated to the question asked.

Thematic Analysis, especially when done manually, is time-consuming and needs skilled interviewers to collect data. This was the first time the researcher was conducting these types of interviews and the researcher is not skilled in data analysis which might have caused particular issues in the data to go unnoticed[82]. The limited time allotted to carry out the research hindered extensive coding and analysis. However, the research questions were enough to guide the analysis and helped generate the themes. Also, using resources on how to conduct data analysis, and consulting with my supervisor were helpful.

Conducting virtual interviews after work hours was posed a challenge to maintain confidentiality with people coming in and out of the participant's video frame. These were usually family members of the participant. The researcher tried to counter this effect as much as possible by pausing and not asking questions when someone walked by the frame.

3.6 Validity and Reliability of the Data

Since the qualitative data collected is based on opinions, ideas, and viewpoints of participants, measurements of validity and reliability have to ensure the 'trustworthiness' and credibility of the findings[83], unlike

79 Azungah (n 67).

80 Choy (n 68).

81 Andrew Gary Darwin Holmes, 'Researcher Positionality - A Consideration of Its Influence and Place in Qualitative Research - A New Researcher Guide' (2020) 8 Shanlax International Journal of Education 1 <http://shanlaxjournals.in/journals/index.php/education/article/view/3232> accessed 3 October 2022."plainCitation":"Andrew Gary Darwin Holmes, 'Researcher Positionality - A Consideration of Its Influence and Place in Qualitative Research - A New Researcher Guide' (2020

82 Choy (n 68).

83 Helen Noble and Joanna Smith, 'Issues of Validity and Reliability in Qualitative Research' (2015) 18 Evidence-Based Nursing 34 <https://ebn.bmj.com/content/18/2/34> accessed 4 October 2022."plainCitation":"Helen Noble and Joanna Smith, 'Issues of Validity and Reliability in

quantitative data in which there exists statistical methods that can establish validity and reliability of the data recorded. Here are some of the strategies as shown by Noble and Smith (2015) that were applied in the research study to ensure validity and reliability of the study[84]:

i) Self-reflexivity and positionality ensured accounting for and acknowledging personal biases and working towards reducing those. Acknowledging the researcher's positionality in the study and the process of reflecting on this position as the study was being conducted helped pinpoint biases and limitations, and ways to curb them.
ii) Also, acknowledging potential limitations and ethical challenges at the different stages of the research helped expose them and work towards finding ways to correct these limitations, as discussed in the ethics and limitations sections above.
iii) Establishing a comparison between CSs and CGs in the research to study similarities and differences ensured that different perspectives were represented.
iv) Verbatim descriptions of participants accounts were incorporated in some instances in the analysis/results to support findings/results.
v) Thought processes and steps during the data analysis and interpretations were clearly described.
vi) There was a lot of iteration of the data during the data collection phase: interviewing the participants, transcribing the interviews, and analyzing the collected data. Constant referral of the transcripts (during transcription) helped to ensure accuracy of the data analyzed.

Qualitative Research' (2015

84 ibid.or the integrity in which a study is conducted, and ensure the credibility of findings in relation to qualitative research. Concepts such as reliability, validity and generalisability typically associated with quantitative research and alternative terminology will be compared in relation to their application to qualitative research. In addition, some of the strategies adopted by qualitative researchers to enhance the credibility of their research are outlined.\n\nAssessing the reliability of study findings requires researchers and health professionals to make judgements about the 'soundness' of the research in relation to …",""container-title":"Evidence-Based Nursing",""DOI":"10.1136/eb-2015-102054",""ISSN":"1367-6539, 1468-9618",""issue":"2",""language":"en",""license":"Published by the BMJ Publishing Group Limited. For permission to use (where not already granted under a licence

4. Results

4.1 Summary of the Interviews

Table 1 gives a summary of the interviews; participants that were interviewed, both CSs and CGs, the number of refugees sponsored, i.e., the number of sponsorships mentioned during the interview; the country of origin of the refugees; the sponsorship year; the relationship between refugee and participant; and a summary of the responses during the interview on the last three columns. For instance, the first entry shows that participant '09/14-CG' was a group sponsor representative who mentioned two sponsorships during the interview, both were single refugees from Sudan. The first refugee was sponsored from 2021 to 2022, and the year for the second sponsorship was not mentioned during the interview. For both sponsorships 09/14-CG mentioned there was a family-like relationship between the group sponsors and the refugees. For the first refugee, the sponsor did not approach about seeking mental health support because the refugee did not appear to be in need, but the sponsor was sure the refugee would have listened if there was a need for mental health support. For the second refugee 09/14-CG approached the refugee to suggest mental health support because the refugee had mental illness, and the refugee listened.

Participant	Gender	Type of Participant	Refugees Sponsored	Country of Origin	Sponsorship Year	Relationship with participant	Did participant approach to	Would refugee have listened if approached?	Summary of Responses - From interview with sponsors
09/14-CG	F	Group Sponsor	Single	Sudan	2021-2022	Family-like	No	Yes	Refugee did not appear in need of mental health support but would have listened if there was a need and he was approached by sponsor
			Single	Sudan	Not mentioned	Family-like	Yes	Yes	Refugee had mental health illness
09/15-CG	F	Group Sponsor	Single	Eritrea	2019-2020	Family-like	No	Yes	Refugee did not appear in need of mental health support but would have listened if there was a need and he was approached by sponsor
			Couple	Syria	2018-2019	Husband more cooperative	Yes	No	The wife had mental health illness and sponsors allied with husband to provide help. Wife would not have listened if approached by sponsors
09/16-CG	F	Group Sponsor	Family	Iraq	2019-2020	Not good	No	No	Refugee settlement expectations beyond what sponsors could provide, hence relationship soured
			Single	Sudan	Not mentioned	Good	No	Not mentioned	Refugee did not request mental health services
			Single	Sudan	Not mentioned	Good	No	Not mentioned	Refugee did not request mental health services
			Single	Sudan	Not mentioned	Good	No	Not mentioned	Refugee did not request mental health services
			Family	India	Not mentioned	Distanced	No	Yes	Refugees moved closer to their religious community before sponsorship period was over and lost contact
09/18-CG	F	Group Sponsor	Single	Not mentioned	2019-2020	Family-like	No	Yes	Refugee did not request mental health services or appear in need, but would have listened if there was a need and he was approached by sponsor
09/14-CS	M	Individual Cosponsor	Single	Iraq	2014-2015	Family (Sister)	No	Yes	Mental health stigmatized in refugee culture. Refugee would listen if mental health services were presented in a way to disociate it from stigma
			Family	Iraq	2016-2017	Family (Cousins)	No	Yes	Mental health stigmatized in refugee culture. Refugee would listen if mental health services were presented in a way to disociate it from stigma
09/16-CS1	F	Individual Cosponsor	Single	Iraq	2021-2022	Family (Nephew)	No	Yes	Refugee did not appear in need of mental health support but would have listened if there was a need and he was approached by sponsor
09/16-CS2	M	Individual Cosponsor	Single	Middle East (not s	2016-2017	Family (a relative)	No	No	Refugee would not listen, mental health stigmatized in the refugee's culture
09/16-CS3	F	Individual Cosponsor	Single	Middle East (not s	2016-2017	Family (a relative)	No	No	Refugee would not listen, mental health stigmatized in the refugee's culture
09/17-CS	M	Individual Cosponsor	None		Still pending	Family (a relative)	No	Yes	Cosponsor answered questions based on experience helping as a group sponsor

Table 1: Summary of the Interviews

Table 1 shows that 9 participants were interviewed; 4 CGs and 5 CSs. For the CGs, a total of 10 sponsorships were talked about during the interviews, 8 of them were described as close relationships between refugee and sponsors with the words 'good' or 'family-like' or 'cooperative'. Of the 10 sponsorships mentioned, the participants only approached the refugees with regards to mental health support or services two times and both times the refugees had mental health illness. For the refugees whom they did not approach they stated the refugee 'did not appear in need of mental health support', or the refugee 'did not request mental health services.' Majority of the responses to the questions were thus based on a speculation of what would have happened if the need for mental health services had come up. When asked if the refugees would have listened if the sponsors approached to suggest support if there was a need, in 5 sponsorships the sponsors mentioned the refugees would have listened. For the other 5 sponsorships, 3 did not mention if the refugees would listen, and the other 2 mentioned a difficult relationship would prevent the refugees from listening.

For the CSs, a total of 6 sponsorships were mentioned during the interviews. All the refugees sponsored were family of the cosponsors, and all had close relationships with the cosponsors. Of the 6 sponsorships mentioned, none of the cosponsors approached their relatives with regards to seeking mental health services with majority of the reasons being 'mental health stigmatized in refugee culture.' Since none of the cosponsors actually approached the refugees, majority of the questions were also based on speculation on what would have happened if the need for mental health services had come up. In 4 of the sponsorships

the cosponsors mentioned the refugees would listen to them if the cosponsors approached to suggest they seek support.

The sections marked 'Not mentioned' on the table denotes those times when the participant did not disclose the information and the researcher forgot to follow-up with questions to get the missing data.

4.2 Data Results – Themes and Tables

4.2.1 Themes Common to both Participant Groups

The tables on this section (2a, 2b, 3a, 3b) give an overview of the themes that were common in the conversations with the participants. The number in the brackets shows the number of times that theme was mentioned during the interviews for a particular question. The themes that were common in conversations with both group of participants, from most mentioned to least mentioned, are as follows:

- Relationship built (13)
- Did not appear to need mental health support (12)
- Trust built (8)
- Mental health stigmatized in refugee culture (7)
- Refugee will not disclose need for mental health support – taboo in culture (6)

i) Relationship built

This theme combined all the information that participants regarded as being important and that helped in building a relationship with the refugee.

> "I think it relies on an ongoing relationship, it's difficult if you don't interact with the person often… We met probably once a week just to see how things were going and so on… So I think that's part of it is that it was part of a larger relationship, right?" *(09/14-CG)*

> "… we'd gotten in the habit of getting to know them by e-mail or over WhatsApp before they even arrived… We know a lot about them and they know a lot about us, and so the relationship has begun even before they get here..." *(09/18-CG)*

> "So for the relationship, we are communicating because they are relative… So my job to do this Uh, communicate with the people and those guys, they're my relative so I go to them home, they come to my home because you know, they have to visit each other, uh, when we have time in the weekend." *(09/14-CS)*

Codes such as 'frequent interactions' 'frequent meet-ups' 'communications before arrival in host country' 'frequent visits with refugee' are mentioned to have helped in building relationships with the refugee. This theme was mentioned more times in conversations with CGs than in conversations with CSs. However, the theme of 'relationships' was mentioned several times throughout conversations with both CGs and CSs but were named a different theme based on the questions asked and the responses obtained from participants. For instance, themes such as 'family-like relationship,' 'good relationship with family' 'family relationship' 'trust built' 'rapport built' could all fall under the theme 'relationships'

ii) Did not appear to need mental health support

This theme combined reasons as to why the participants did not think the refugees needed mental health support. These reasons were largely in response to the questions as to why the participants never broached the topic of mental health services/support with the refugees:

> "In terms of mental health, no, we have not had, they've seemed healthy, they are somewhat independent, you know, they were up and running very quickly." *(09/18-CG)*

> "So mentally he was ready. Adjusting was good… He speaks English well. Uh, he was prepared...

> Look, because people, when they come, when they reject being here, it was difficult. He was accepting to come..." *(09/16-CS1)*

This theme came up more in conversations with CGs than in conversation with CSs. From the quotations above the codes 'seeming healthy' 'independent' 'adjusting good' 'accepting being in Canada' as some indicators the participants used to show the refugees 'did not appear to need mental health support'

iii) Trust built

This theme showed the number of times the participants emphasized trust as being important in building a relationship with the refugees:

> "Because he's like close …there are people and you sponsor them not the family or you work with them not a family. Could be there is because he has a good trust between each other like, it is a trust relationship..." *(09/16-CS1)*

> "We just built that level of trust that we, they knew whether we said it or not. We're here for you, like whatever you need, you know?" *(09/18-CG)*

The quotations above, and on the transcripts, were coded 'trust built' based on the content of the conversation, building trust. This theme was mentioned frequently in conversations with CGs than CSs.

iv) Mental health stigmatized in refugee culture

This theme was most prominent in conversations with CSs than CGs. It came up mostly in response to reasons as to why refugees will not listen to suggestions to access mental health services even if they are needed:

> "Mental illness in Middle East in my back home it means if we go to treat if he go to the doctor to treat it means is a crazy." *(09/14-CS)*

> "Regarding to mental health as you know, we are from Middle East countries. And our culture consider that any visiting to psychiatric or mental health doctors or others like this… it's not a big shame, but sometimes it is very restricted because they thought that is only psychiatric for mad people." *(09/16-CS2)*

The theme of mental health being stigmatized was mentioned several times during discussions with CSs. Some of the codes that described the stigma in this theme were 'crazy' 'shame' 'mad people'

v) Refugee will not disclose need for mental health support – taboo in culture

This theme also speaks to mental health as a stigma in refugee culture but has a separate theme based on responses to questions why the participants did not approach the refugees to suggest they seek mental health support. This also came up mostly in discussions with CSs.

> "Yeah, 'cause culturally, especially for Syrians. You know…admitting that I have mental illness or a mental health issue and that I need a counselor to talk to that's really taboo." *(09/15-CG)*

> "…So all this problem and if we all this stress the refugee when arrives, he is already full with this psychiatric problems. But nobody can announce them, nobody can tell that I have this problem" *(09/16-CS2)*

4.2.2 Themes Unique to each Participant Group

From the tables below, the following themes were present in the interviews with CSs but did not come up in interviews with CGs. Only the themes that were mentioned 3 times and above in the interviews are considered.

i) Focused on settlement/social support to help refugee cope with mental health issues; used to de scribe the things the CSs did to help refugees cope with mental health issues

"And the first thing to avoid or to prepare or to suppress this mental effect of mental issue is to settle the refugee, especially the first few months and the first year… so they have to find a job… and we helped him to find a job also. We help him to see the undiscovered area and don't give them alone because staying there alone would helping her or his thinking always this increase or facilitate or exaggerate the case." *(09/16-CS2)*

ii) There is a need for mental health support; the cosponsors acknowledge the need for mental health services by recalling refugee migration experiences

"I told you, maybe 80% of us they need these services. Nobody left his country by himself for vacation. So our mind, it's fully with this stuff with this remind, when we remember everything… It's hard, so we need these services…" *(09/14-CS)*

iii) Explain the nature of the illness and explain why they need the services – remove stigma; the cosponsors describe instances in which mental health illness was explained to the refugee in a way as to remove the stigma and this had positive results

"It's happened with my mother-in-law. So we told her you have to go there because, I mean, it's illness. It's kind of like you have the flu, you have to go to the doctor to give you the meds. And she went there, and she get it now, now she's feeling very good." *(09/14-CS)*

iv) Encourage the refugees to have their symptoms checked out by non-mental health specialist; ways in which the participants encouraged the refugees to seek help for their symptoms.

"so we are encourage him to go to that family doctor in this regard. So what we are doing because we know, I had this feeling I had it because they tried to kidnap me and it's happened with me, myself. years I remember when I sleep, I remember them characters in front of me when I try to get me… so we encourage him to go to the family doctor and because he has a specialist" *(09/14-CS)*

For the CGs, the themes that were unique to the conversation with those participants are:

i) Family-like relationship; the participants described the things that made their relationship with the refugees feel like family

"they've always been appreciative of our help, we remain in touch. I still get Mother's Day greetings from many of them. Yeah, yeah, it's really, it's really beautiful. I was invited to a birthday party of a 6-year-old. Mum came here pregnant and so the connections are still there. And the Africans call me mum, which I just love." *(09/18-CG)*

ii) Allied with refugee family/friends to provide support; the participants described the help provided to support the refugee by working with their family. In this excerpt a CG speaks about getting a husband involved to get his wife the mental health support she needed

"I explained to her husband that, you know, here's what I found 'cause he was open to anything we could do to help [his wife]. He was Beside himself; he was in tears... he opened himself fully with us and so we did all that we could to help and then we got to her [his wife] through him. And so I told him, you know, about counseling." *(09/15-CG)*

iii) Rapport built; the participants described the importance of building rapport with the sponsored refugees

"a relationship of trust and so with this young man, because he is about the age of one of my own sons, you know, it was somewhat easy to establish a bit of a rapport sort of a, you know mother-aunty kind of role" *(09/14-CG)*

4.2.3 Research Question 1 Results

Tables 2a and 2b both show the themes that made up the responses for research question 1 for CSs (Table 2a) and CGs (Table 2b). The responses for the research question 'would the sponsors have been able to approach the refugee to suggest they consider seeking mental health services? Why or why not?', were separated into two categories; 'Reasons sponsors approached or would've approached the refugee' and 'Reasons sponsors did not or could not approach refugee.'

For Table 2a, the CSs who approached the refugees to suggest mental health services, or those who would've approached if there was a need for mental health support, provided the following reasons as motivation (based on responses mentioned more than once):

- The cosponsors recognized a need for mental health support for the refugees
- The cosponsors had good relationship with the refugee (family)
- The cosponsors were already providing support, settlement and social to the family
- Encouraged the refugees to have their symptoms checked out by non-mental health specialists

The reasons they did not, or could not approach the refugee to request they seek services were as follows:

- The refugees did not appear to need mental health support
- The refugees would not disclose need for mental health support as this is a taboo
- The cosponsors focused on providing settlement/social support as way to help refugees cope with mental health issues

For Table 2b, the CGs provided the following as reasons why they were able to approach or would've approached the refugee to suggest mental health services if there was a need:

- The relationship built with the refugees
- Some went right ahead and brought up the need for mental health services
- Familiarity with the refugee story

The CGs who did not or could not approach the refugees gave the following reasons:

- The refugees did not appear to need mental health support
- The sponsors were unsure if the refugees needed mental health support
- Some sponsors had no mental health concerns about the refugees
- Refugees had different priorities than seeking mental health services
- Refugees did not request mental health services
- Cultural beliefs hindered provision of settlement/social support
- The need for support was broached by family/friends, not sponsor

1) During the resettlement period did the sponsors, or would the sponsors have approached the refugees to suggest seeking mental health services? Why or why not?	
Individual Cosponsor Results	
Reasons sponsors approached or would've approached the refugee	**Reasons sponsors did not or could not approach refugee**
There is a need for mental health support (3)	Did not appear to need metal health support (5)
Good relationship with family (2)	Refugee will not disclose need for mental health support – taboo in culture (5)
Providing settlement/social support to families (2)	Focused on settlement/social support to help refugee cope with mental health issues (5)
Encourage the refugees to have symptoms checked out by non-mental health specialist (2)	Approaching refugees directly to suggest they seek mental health services makes it worse
Uses help of members of the sponsor group and their expertise to approach refugees	Cosponsor believes family relies on support of each other than professional help
Cosponsor empathizes with refugee	Cosponsor did not broach need for mental health services with refugee
	Sometimes a talk with a community leader is enough
	Cosponsor experienced the stigma associated with mental health
	Refugee was prepared and accepted being in Canada

Table 2a: Results for Research Question 1– Individual Cosponsor Results

1) During the resettlement period did they, or would they have approached the refugees to suggest seeking mental health services? Why or why not?	
Group Sponsors Results	
Reasons sponsors approached or would've approached the refugee	**Reasons sponsors did not or could not approach refugee**
Relationship built (4)	Did not appear to need mental health support (7)
Broached need for mental health services with refugee (2)	Sponsors unsure if refugees needed mental health services (2)
Familiarity with refugee story (2)	No mental health issues or concerns with refugee (2)
Family-like relationship	Refugees had different priorities (2)
Rapport built	Refugees did not request mental health services (2)
	Cultural beliefs hindering provision of settlement/social support (2)
	Need for support broached by family/friends (2)
	Sponsors were more focused on providing settlement/social support
	Communication stopped between sponsors and refugee
	Refugees had social/cultural issues not mental health issues
	Refugee approached to inquire about mental health services
	Refugee will not disclose need for mental health support – taboo in culture
	Refugee had other sources of support, family/friends
	Refugee will not talk about emotions
	Relationship between sponsors and refugee distant

Table 2b: Results for Research Question 1 – Group Sponsors Results

4.2.4 Research Question 2 Results

Tables 3a and 3b both show the themes that made up the responses for research question 2 for CSs (Table 3a) and CGs (Table 3b). The responses for the research question 'would the refugee have listened to the suggestions to access mental health services if there was a need? Why or why not?' were separated into two categories; 'Reasons refugee(s) would listen' and 'Reasons refugee(s) would not have listened to sponsors.' Once more the responses taken into account in these results observations were those that were mentioned at least twice during the interviews.

For table 3a, the CSs stated that the refugees would listen or did listen to their suggestions to seek mental health services if needed because:

- Cosponsor provided settlement and social support for the refugee
- Cosponsor explained the nature of the illness and services to refugees to reduce stigma

For the cosponsors who stated that the refugees would not have listened or did not listen, the reasons were:

- Mental health is stigmatized in the refugee's culture
- Getting help from a psychiatrist for mental health considered a taboo
- Refugees were not comfortable disclosing private information with strangers

- Refugees had different priorities than mental health
- It was difficult to change refugee perspective on seeking mental health support

2) Would the refugee have listened, or did they listen to the suggestion to seek mental health services? Why or why not?	
Individual Cosponsor Results	
Reasons refugee(s) would listen to sponsors	**Reasons refugee(s) would not have listened to sponsors**
Cosponsor provided settlement and social support for the refugee (4)	Mental health stigmatized in refugee culture (6)
Explain nature of the illness and explain why they need the services – remove the stigma (3)	Getting help from a psychiatrist for mental health is a taboo (3)
Family relationship	Refugee not comfortable disclosing private information with strangers (2)
	Refugees prioritized different kind of support (2)
Refugee advised to get mental health support and keep it quiet – reduces stigma	Difficult to change refugee perspective on seeking mental health support (2)
Encourage the refugees to have symptoms checked out by non-mental health specialist	Refugee might prefer talking to cosponsor than seek mental health support
Cosponsor had good relationship with refugee	Stigma on mental health prevents refugee from seeking mental health support
Wording the services appropriately influences accessing mental health services	Refugees prefer to handle their mental health matters within their community
The younger refugees (kids) more familiar with concept of counselor	Refugee did not believe in professional help
	The older refugees more likely not to seek medical help for mental health issues

Table 3a: Results for Research Question 2 – Individual Cosponsors Results

2) Would the refugee have listened, or did they listen to their suggestion to seek mental health services? Why or why not?	
Group Sponsors Results	
Reasons refugee(s) would listen to sponsors	**Reasons refugee(s) would not have listened to sponsors**
Relationship built (9)	Refugees' settlement expectations beyond what sponsors could provide (4)
Trust built (7)	Relationship between sponsors and refugee was not good (3)
Allied with refugee's family/friend to provide support (6)	Sponsors found it challenging to communicate with refugees (2)
Family-like relationship (5)	Cultural beliefs hindering provision of settlement/social support (2)
Refugee experienced intense symptoms from his mental illness (3)	Refugee non-responsive to suggestions from sponsors
Rapport built (3)	Mental health stigmatized in refugee culture
Having refugee's interest at heart (3)	Language barrier
Encouragement from family/friends to seek support	
CG knowledge of the mental health symptoms eased conversation	
Refugees certain of CG support	
Assured the refugee of support during the process	
Accompanying refugee to mental health appointments	
Respecting refugee right to make decisions	

Table 3b: Results for Research Question 2 – Group Sponsors Results

For table 3b, the CGs mentioned the refugees would listen to suggestions to seek mental health services if needed because:

- The relationship built between refugee and sponsors
- The trust built between refugee and sponsors
- The sponsors allied with refugee's family/friend to provide mental health support
- Family-like relationships built with refugees
- Refugee experienced intense symptoms from mental illness
- Rapport built between refugee and sponsors
- Refugees knowing sponsors have refugees' interests at heart

For the times the refugee did not listen or the CGs were sure that the refugee would not listen to suggestions to access services, they gave the following points as reasons why:

- The refugees' settlement expectations were beyond what the sponsors could provide
- The relationship between the refugees and the sponsors was not good
- Sponsors found it challenging to communicate with the refugees
- Cultural beliefs of the refugees hindered provision of settlement/social support

5. Discussion

The themes that were identified in the results as common, and those that were identified as prominent (from the number of times mentioned) to both participant groups are discussed in this section

5.1 Common Themes for both Participant Groups

5.1.1 Refugees did not appear to need mental health services

From the interviews most of the participants, both CGs and CSs, were able to identify what mental health issues are and how their symptoms could manifest, either from lived experience or from reading the refugee narrative:

> "Nobody left his country by himself for vacation. So our mind, it's fully with this stuff… we remember everything. Actually, when you remember the past, like you're building your friends, your school. And you lost everything in a second. Just cut and go out. They kick us out then. It's hard. It's hard, so we need these services" *(09/14-CS)*

> "Find out if they have this illness. I think they will never mention or tell you 'I have this thing' but if you read their story …you read their story they mentioned 'I have a difficulty with…' *(09/14-CS)*

> "Our experience is generally that all of the people we've sponsored at this point, like about 15 people over, you know, five or six years, all have PTSD of one form or another.
>
> I think it's a question of the degree that they have it and how it's manifesting or if it's manifesting at this time." *(09/14-CG)*

Hence, to some extent, the participants would have been able to identify a need for mental health services. Despite the realization of a need for mental health support, Table 1 in the results section shows that majority of the participants did not approach the refugee to broach the topic of mental health services because the refugees 'did not appear to need mental health support.' This could be explained by the phenomenon known as the 'Healthy Immigrant Effect' (HIE) theory, which suggests that immigrants show better health qualities than the domestic-born in the host country[85], however this health advantage decreases over the years 'due to stress and other integration challenges'[86]. The quote below seems to betray a possible understanding of this phenomenon by a participant:

> "…when you see somebody anxious to get to work…so they don't mind the early hours and the hard work and they're just so happy. And that's not someone with mental health. Now, 10-15 years down the road, will something surface? I don't know. But for the immediate, no, they're happy… they wanna pick up their life and move on and not waste any more time." *(09/18-CG)*

The quote also confirms what research shows as evidence for HIE for mental health, that immigrants, including refugees, are less likely to exhibit symptoms of mental health when they immigrate, however HIE disappears after 10 years of living in Canada and the immigrant health 'deteriorates to Canadian-born levels of mental health'[87].

---

85 Sarah Elshahat, Tina Moffat and K Bruce Newbold, 'Understanding the Healthy Immigrant Effect in the Context of Mental Health Challenges: A Systematic Critical Review' [2021] Journal of Immigrant and Minority Health <https://doi.org/10.1007/s10903-021-01313-5> accessed 16 October 2022."plainCitation":"Sarah Elshahat, Tina Moffat and K Bruce Newbold, 'Understanding the Healthy Immigrant Effect in the Context of Mental Health Challenges: A Systematic Critical Review' [2021] Journal of Immigrant and Minority Health <https://doi.org/10.1007/s10903-021-01313-5> accessed 16 October 2022.","noteIndex":88},"citationItems":[{"id":235,"uris":["http://zotero.org/users/local/5XAw7bol/items/AVEAFKAP"],"itemData":{"id":235,"type":"article-journal","abstract":"The "Healthy Immigrant Effect" (HIE

86 Statistics Canada Government of Canada, 'The Mental Health of Immigrants and Refugees: Canadian Evidence from a Nationally Linked Database' (19 August 2020) <https://www150.statcan.gc.ca/n1/pub/82-003-x/2020008/article/00001-eng.htm> accessed 16 October 2022.

87 Farah Islam, 'Examining the "Healthy Immigrant Effect" for Mental Health in Canada' (2013) 90 University of Toronto Medical Journal 169.

5.1.2 Relationship Building

In the literature review, social support/social capital was shown to be important in creating a sense of belonging which promotes mental wellbeing[88]. Ager and Strang likened this social capital to proximity with family, friendships, social bonds and immediate support from family and friends[89], hence relationship building is an important theme.

The CSs were already family members with the refugees and they described their relationship as good. Not many themes were used to describe the relationship between the CSs and the refugees, probably because they were already family. For them the theme relationship-building was most times associated with providing settlement/social support to the refugees, and ensuring that the refugees are settling in well;

> "…they're my relative so I go to them home, they come to my home because you know, they have to visit each other, when we have time in the weekend." *(09/14-CS)*

> "From continuous going because we don't leave the refugee, especially on arrival as I told you at least for a few months. So from going to there, visiting there continuous visiting there. Continuous supply what they need… so these people can survive well." *(09/16-CS2)*

The CGs on the other hand emphasized 'relationship building' and 'trust building' as very important especially for building 'family-like' relationships. Since the CGs were total strangers to the refugees at the beginning, this relationship building seemed to be what turned them into 'family' and change the relationship dynamics from foreign to trust.

> "They become family and in all these cases it never really took long to impress upon them, you know what, this is all about you. like you've been through enough already. We wanna make things good from this point moving forward. Yeah, so that Trust was always established. Always, always. And they do become family." *(09/14-CG)*

> "when you're picking them up from the airport on a frigid cold evening and you're bringing them home for a home cooked meal…you follow up and you take them to the bank, and you take them to the doctor and you take them to The grocery store and like They become family" *(09/18-CG)*

Designating the relationship as 'family-like' denotes 'mutual obligations and expectations of support' and also classifies it as profound and enduring since family is important to people[90]. Since the refugees did not appear to be in need of mental health support it could be argued that the social and settlement support provided by both groups fostered the sense of mental wellbeing felt by the refugees[91], that alongside the phenomenon of HIE mentioned earlier.

5.1.3 Mental Health Stigmatized in Refugee Culture

The refugees and CSs were from a culture in which mental health is highly stigmatized.

> "And our culture consider that any visiting to psychiatric or mental health doctors or others like this… it's not a big shame, but sometimes it is very restricted because they thought that is only psychiatric for mad people." *(09/16-CS2)*

The CSs made references to mental health services as associated with hospital treatment for severely ill and psychotic patients [92]

> "I told you when we have a uh our culture if somebody go to the doctor for this thing, it's mean he

88 Ager and Strang (n 15).

89 Stewart and others (n 34).resettlement, and search for refuge, yet there is a gap in our understanding of these newcomers' views of the specific meanings of social support and their support needs and resources. The purpose of this study was to understand the meanings of social support for immigrants and refugees in Canada, and to explore the types and adequacy of formal supports. Individual interviews were conducted with 60 service providers and policymakers initially (Phase 1

90 Macklin and others, 'The Kinship between Refugee and Family Sponsorship' (n 17).

91 Ager and Strang (n 15).

92 Kirmayer and others (n 13).

is crazy." *(09/14-CS)*

Most of the responses with this theme were mentioned in interviews with CSs as reasons refugees would not listen if suggested to seek mental health services.

5.2 Influence on refugee uptake of mental health services

5.2.1 Influence of CGs

The CGs credited relationship building, trust building and rapport building formed with the refugees that arose from providing settlement and social support (the factors behind forming 'family-like' relationships) as being the reasons they think the refugees would listen to suggestions to access mental health services. Table 3b (results section) mentions the following themes; relationship built, trust built, family-like relationship, rapport built, having refugee's interest at heart…, all about building relationship. Conversely, the CGs attributed the reasons why the refugees would not listen to suggestions to access mental health services to sour relationships from misunderstandings due to:

i) 'Refugees' settlement expectations beyond what sponsors could provide'

"And then when the sponsorship time finished, they kept coming back and say no, no, you have to help us. You have to give us money. And then the priest had to tell them no…" *(09/16-CG)*

ii) 'Relationship between sponsors and refugee was not good'

"They wanted us to sponsor [their married daughter] and we said, no, it doesn't work this way… they thought we were mean and we were bad, and they were not happy at all for us to tell them that" *(09/16-CG)*

iii) 'Sponsors found it challenging to communicate with refugees'

"And she slept all day and listened to her Syrian music and her Syrian broadcasts and did not want to listen to me or S, my counterpart in the resettlement. Uhm, there was nothing we could say to convince her that" *(09/15-CG)*

It should be noted, however, that provision of settlement and social support does not always lead to relationship building with the refugee as was the case in which relationship expectations of the refugees were far beyond what the sponsors could provide. In this case the cosponsor had provided all the support needed and more but the refugees kept asking for more and the relationship soured once this was not provided

"We felt we were very generous with what we did for them. but maybe because of the standard of living they had back in Iraq or some expectation…" *(09/16-CG)*

5.2.2 Influence of CSs

Contrary to the CGs the study did not show that the CSs being family would have any effect on refugees' willingness to uptake mental health services. The trust, rapport or relationship built that make up a 'family-like' relationship as identified by CGs above, though not lacking in CSs by virtue of being family members, were not what the CSs identified as having an influence on whether the refugees access mental health services or not. The sense of belonging that comes with being family is important, and family reunification is important for mental health and wellbeing[93].

The CSs identified stigma associated with mental health in the refugee culture as the main reason why the refugees would not listen to suggestions about accessing mental health services even if they needed it (see Table 3a). This thread about mental health being stigmatized was also shown in the other themes; 'getting

93 C Choummanivong, GE Poole and A Cooper, 'Refugee Family Reunification and Mental Health in Resettlement' (2014) 9 Kōtuitui: New Zealand Journal of Social Sciences Online 89 <https://doi.org/10.1080/1177083X.2014.944917> accessed 17 October 2022.

help from psychiatrist for mental health is a taboo' 'refugee not comfortable disclosing personal information to strangers,' 'refugees prioritizing other supports' other than mental health support, and 'difficulty changing refugee perspective on seeking mental health support.'

> "But when you go to doctor and go to office and to clinic and you have to do some procedure. You have to get appointment for him and, actually, the older guys they think never go to the this kind of doctor, just for crazy, but it's not all of them" *(09/14-CS)*

> "I found the family were stress about going to professional…Yeah, either they don't believe in the in professional help like that, or they don't want to talk like reveal some like of their like privacy." *(09/16-CS1)*

> "And our culture consider that any visiting to psychiatric or mental health doctors or others like this… it's not a big shame, but sometimes it is very restricted because they thought that is only psychiatric for mad people." *(09/16-CS2)*

The cosponsors are from the same culture as the refugees and most of them were refugees as well. Though aware of the need for mental health support in their community, they did not approach the refugees to suggest they request mental health support. The stigma of mental health diagnosis affects not only the patients but also their family members[94].

> "we've experienced this, this whole viewpoint on mental health services and seeking mental health or help for mental health issues. So we've experienced it on our own, but we're obviously aware of it because we understand now" (09/16-CS3)

Their responses as to why they would not approach the refugees to suggest mental health services (see Table 2a) also had to do with the fact that mental health is stigmatized in refugee culture.

Interestingly, Table 1 (see results) shows that for majority of sponsorships mentioned during the interview, the cosponsors did acknowledge that the refugees would listen to them if they were to approach to request that they seek mental health services if needed. Meaning, despite the barrier of mental health being stigmatized there are ways to influence the refugees to access mental health services. The responses provided (see Table 3a) as to why the refugees would be influenced to request mental health services revolved mostly around reducing the stigma of mental health:

i) 'Explaining nature of the illness and explain why they need services – remove the stigma'

In this scenario, the cosponsor likened going to get mental health services to going to the hospital for any other illness

> "It's happened with my mother-in-law. So we told her you have to go there because, I mean, it's illness. It's kind of like you have the flu, you have to go to the doctor to give you the meds. And she went there, and she get it now, now she's feeling very good" *(09/14-CS)*

ii) Refugee advised to get mental health support and keep it quiet – reduces stigma

> "So they can't go to the psychiatric, or some of them… through the committee, we can advise them to call [the psychiatrist] and keep secret. Sometime just give the refugee relief" *(09/16-CS2)*

iii) Encourage the refugees to have symptoms checked out by non-mental health specialist

The cosponsors explained that having the refugees see other specialists and not psychiatrists, they are willing to go.

> "I told you when we have a our culture if somebody go to the doctor for this thing, it's mean he is crazy. So it's not in his direct, but we ask him to go to Social services." *(09/14-CS)*

iv) Wording the services appropriately influences accessing mental health services

In this scenario the cosponsor had responded to a question about how it was a taboo going to see a psy-

94 Kirmayer and others (n 13).

chiatrist and when the researcher asked about other services such as one on one counseling or support groups, the cosponsor responded that the refugees would go because the word 'services' was used instead:

> "Because you said it's a service is not a doctor…I believe they will go… They feel free to go because there's nothing as much. We don't see the doctor with the shame of doctor, they see counselor and he can help you, I think they go." *(09/14-CS)*

Also, in their communities it seems as though counselling services are not stigmatizing like psychiatric services[95]. This was confirmed when a cosponsor mentioned that counseling services could be more accepted because they are used to especially as their children see guidance counselors in school

> "Actually, the older guys they think never go to this kind of doctor, just for crazy, but it's not all of them…Our kids in a school, they have counselor and everything…and they usually go there." *(09/14-CS)*

5.3 Implications of the Results

Given the discussion, it might be tempting to conclude that the kinship between CS and refugee family may not be important in influencing access to mental health services. However, it could also be seen that the CS's knowledge of their families and of their culture is what brought about the discussion on ways in which the refugees could be influenced to access mental health services. Having lived in Canada for years, they understand what mental health is and realize the need for mental health services for their families and their communities:

> "we've experienced this, this whole viewpoint on mental health services and seeking help for mental health issues…we're obviously aware of it because we understand now, having lived in the West for many years, we understand what it is and how important it is to take care of our mental health and to address all of these issues. But it's still something that we ourselves struggle with." *(09/16-CS3)*

Research articles talk about stigma being a great deterrent in refugee seeking mental health services[96], and as this study shows seeking mental health services is not influenced by the kinship between a refugee and a CS, meaning relationship building, trust or rapport building. This arguably points to the huge roadblock that stigma associated with mental health places on seeking support.

Usually when the articles state that destigmatizing mental health will help promote access to services, the ways to carry out this destigmatization mostly involve psychoeducation, awareness, and training[97]. These are great tools, but perhaps a more practical approach can also be useful, such as the ones suggested by cosponsors in this study to help reduce the stigma. In essence, an intervention that includes families (CS) and takes into account the knowledge that these families who have been in the host country for a while have of their culture, their relatives (the refugees), and also fortifies these families (CS) with increased mental health knowledge could be a great combination in encouraging newcomer refugees access mental health services when needed. More research is needed firstly on how to incorporate families (CS) in interventions aimed at destigmatizing mental health illness, and secondly on how to include them and their support into planning effective interventions for their relatives (the refugees).

95 Leah Petersen, 'Engaging Newcomers in Mental Health Promotion: Suggestions for Service Delivery' 9 <https://www.mosaicbc.org/wp-content/uploads/2016/12/Engaging-Newcomers-in-Mental-Health-Promotion-Suggestions-for-Service-Delivery.pdf>.

96 Sarah DeSa and others, 'Barriers and Facilitators to Access Mental Health Services among Refugee Women in High-Income Countries: A Systematic Review' (2022) 11 Systematic Reviews 62 <https://doi.org/10.1186/s13643-022-01936-1> accessed 17 October 2022; Petersen (n 98); Huaibo Xin, 'Addressing Mental Health Stigmas among Refugees: A Narrative Review from a Socio-Ecological Perspective' (2020) 8 Universal Journal of Public Health 57.

97 DeSa and others (n 99); Petersen (n 98); Xin (n 99).

5.4 Limitations Encountered

The following limitations encountered during the research have to be acknowledged to give an overview of the challenges and how they were corrected for during the study:

Since the responses were influenced by the number of times a theme came up in the conversations, a particular theme could have been the topic of just one participant's interview making the results not generalizable. This was adjusted by coding each theme once per response, for instance a two-minute response on the importance of trust in relationship building would have been coded once for 'trust built' and 'relationship built'.

The responses from participants are mostly verbatim and since not all the participants were native English speakers, the transcriptions were not always accurate. The researcher had to listen to the audio or video recordings to be able to infer the meaning accurately for those areas in which the transcriptions were not clear.

The results show that of all the sponsorships mentioned only two were actual experiences in which the refugees had mental illness. Majority of the responses were thus based on assumptions on what would have happened since the refugees did not appear to be in need of mental health services. However, the participants' extensive knowledge and years of experience in refugee resettlement makes it easy to consider the probability in their responses.

The CSs were also part of sponsor groups (not represented in study) and they tended to answer the questions based on their experiences as part of a sponsor group. When that happened, the researcher rephrased the question to ask the cosponsor to respond based on their experience as CSs sponsoring their family member.

Both research participant groups are affiliated with the same SAH organization. The results from the CGs might not be generalized to CGs from other SAH organizations. The CSs are able to sponsor refugees through different SAHs, however most of them are members of a CG under the same SAH organization.

5.5 Recommendations for Support/Interventions

An extra question was asked to the participants during the interview; 'what support would you need during resettlement to help the refugees access mental health services?' This is worth mentioning and could be worth exploring as all the participants have worked in refugee sponsorship for years and have extensive knowledge of refugee resettlement. The tables are included in Appendix B.

A summary of the responses are as follows:

- Education and awareness about refugee mental health for sponsors
- Providing mental health professionals who speak the language of the refugee
- Education about mental health illness and trauma for refugees
- Knowledge for mental health professionals on the situation in refugee's country of origin
- Start providing mental health support to refugees when they are in their countries of asylum (programs by groups such as the UNHCR)
- Education for refugees about cultural/social issues in Canada (or the host country)

6. Conclusion

The study had as objective to investigate whether individual cosponsors by virtue of being family can influence the willingness of their sponsored refugee relative to access mental health services. The literature review established a link between refugee mental health and its importance in integration, the necessity of the uptake of mental health services by refugees, the importance of social capital/social support (family) in promoting mental health and wellbeing in resettled refugees, and it also showed that family dynamics in refugee family fostered a reliance on each other which could be a powerful influence. If individual cosponsors provided social support to resettled refugees, and social support affects both mental health and access to services as the literature review showed, then it followed that cosponsors can affect/influence refugee's access or willingness to access mental health services.

However, the results of the study seemed to suggest that despite the kinship (family dynamics) between refugee and individual cosponsor, the social support and sense of belonging provided by being with family (which CGs in the study credited for helping influence refugees access mental health), the stigma on mental health is a powerful deterrent to seeking mental health services. The study also showed that individual cosponsors were able to provide practical ways to reduce mental health stigma which would work based on their culture and their family member. Interventions to include host family members who have lived in the host country for years in treatment of refugees was suggested, as well as more research incorporating refugee families into ways to reduce stigma surrounding mental health. This could be invaluable in influencing refugee access to mental health services.

7. Bibliography

Ager A and Strang A, 'Indicators of Integration: Final Report' 26

Ager A and Strang A, 'Understanding Integration: A Conceptual Framework' (2008) 21 Journal of Refugee Studies 166 <https://academic.oup.com/jrs/article-lookup/doi/10.1093/jrs/fen016> accessed 18 September 2022

Agic B and others, 'Supporting the Mental Health of Refugees to Canada' (Mental Health Commission of Canada 2016) <https://www.mentalhealthcommission.ca/wp-content/uploads/drupal/2016-01-25_refugee_mental_health_backgrounder_0.pdf> accessed 19 September 2022

Andoh-Arthur J, 'Gatekeepers in Qualitative Research' (2019)

Azungah T, 'Qualitative Research: Deductive and Inductive Approaches to Data Analysis' (2018) 18 Qualitative Research Journal 383 <https://www.proquest.com/docview/2133411195/abstract/F4D5B25ACD-344CC0PQ/1> accessed 13 October 2022

Bäärnhielm S and others, 'Mental Health for Refugees, Asylum Seekers and Displaced Persons: A Call for a Humanitarian Agenda' (2017) 54 Transcultural Psychiatry 565 <https://doi.org/10.1177/1363461517747095> accessed 18 August 2022

Ballard C with equal contribution by J and others, '9.2 Family Theories: A New Direction for Research with Resettled Populations' <https://open.lib.umn.edu/immigrantfamilies/chapter/9-2-family-theories-a-new-direction-for-research-with-resettled-populations/> accessed 19 September 2022

Barry M, 'Barriers Associated with Mental Health Services for People with Refugee Background in Douglas County' 27

Beiser M, 'Resettling Refugees and Safeguarding Their Mental Health: Lessons Learned from the Canadian Refugee Resettlement Project' (2009) 46 Transcultural Psychiatry 539

Braun V and Clarke V, 'Using Thematic Analysis in Psychology' (2006) 3 Qualitative Research in Psychology 77 <http://0-search.ebscohost.com.catalogue.libraries.london.ac.uk/login.aspx?direct=true&db=a9h&AN=20391875&site=ehost-live> accessed 11 October 2022

Canada GA, 'Canada's Response to the Conflict in Syria' (*GAC*, 29 May 2017) <https://www.international.gc.ca/world-monde/issues_development-enjeux_developpement/response_conflict-reponse_conflits/crisis-crises/conflict_syria-syrie.aspx?lang=eng> accessed 17 October 2022

Canadian Council for Refugees, 'Refugee Integration: Key Concerns and Areas for Further Research' (2011) <https://www.unhcr.ca/wp-content/uploads/2014/10/ccr-refugee-integration-research-report.pdf> accessed 22 September 2022

Castaneda AE and others, 'Migrants Are Underrepresented in Mental Health and Rehabilitation Services—Survey and Register-Based Findings of Russian, Somali, and Kurdish Origin Adults in Finland' (2020) 17 International Journal of Environmental Research and Public Health 6223 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7504052/> accessed 18 August 2022

Castles S, 'Understanding the Relationship between Methodology and Methods', *Chapters* (Edward Elgar Publishing 2012) <https://ideas.repec.org/h/elg/eechap/14062_1.html> accessed 11 October 2022

Choummanivong C, Poole G and Cooper A, 'Refugee Family Reunification and Mental Health in Resettlement' (2014) 9 Kōtuitui: New Zealand Journal of Social Sciences Online 89 <https://doi.org/10.1080/1177083X.2014.944917> accessed 17 October 2022

Choy LT, 'The Strengths and Weaknesses of Research Methodology: Comparison and Complimentary between Qualitative and Quantitative Approaches' (2014) 19 IOSR Journal of Humanities and Social Science 99 <http://www.iosrjournals.org/iosr-jhss/papers/Vol19-issue4/Version-3/N0194399104.pdf> accessed 4

October 2022

Darwin Holmes AG, 'Researcher Positionality - A Consideration of Its Influence and Place in Qualitative Research - A New Researcher Guide' (2020) 8 Shanlax International Journal of Education 1 <http://shanlaxjournals.in/journals/index.php/education/article/view/3232> accessed 3 October 2022

DeSa S and others, 'Barriers and Facilitators to Access Mental Health Services among Refugee Women in High-Income Countries: A Systematic Review' (2022) 11 Systematic Reviews 62 <https://doi.org/10.1186/s13643-022-01936-1> accessed 17 October 2022

Donato KM and Ferris E, 'Refugee Integration in Canada, Europe, and the United States: Perspectives from Research' (2020) 690 The ANNALS of the American Academy of Political and Social Science 7 <https://doi.org/10.1177/0002716220943169> accessed 11 September 2022

Elshahat S, Moffat T and Newbold KB, 'Understanding the Healthy Immigrant Effect in the Context of Mental Health Challenges: A Systematic Critical Review' [2021] Journal of Immigrant and Minority Health <https://doi.org/10.1007/s10903-021-01313-5> accessed 16 October 2022

Etikan I, 'Comparison of Convenience Sampling and Purposive Sampling' (2016) 5 American Journal of Theoretical and Applied Statistics 1 <http://www.sciencepublishinggroup.com/journal/paperinfo?journalid=146&doi=10.11648/j.ajtas.20160501.11> accessed 4 October 2022

Government of Canada SC, 'The Mental Health of Immigrants and Refugees: Canadian Evidence from a Nationally Linked Database' (19 August 2020) <https://www150.statcan.gc.ca/n1/pub/82-003-x/2020008/article/00001-eng.htm> accessed 16 October 2022

Hynie M, 'The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review' (2018) 63 The Canadian Journal of Psychiatry 297 <https://doi.org/10.1177/0706743717746666> accessed 10 September 2022

——, 'What Role Does Type of Sponsorship Play in Early Integration Outcomes? Syrian Refugees Resettled in Six Canadian Cities' (2019) 35 Refuge: Canada's Journal on Refugees / Refuge : revue canadienne sur les réfugiés 36 <https://www.erudit.org/en/journals/refuge/1900-v1-n1-refuge04887/1064818ar/abstract/> accessed 18 August 2022

Immigration R and CC, '2. Private Sponsorship of Refugees Program' (1 November 2003) <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/guide-private-sponsorship-refugees-program/section-2.html> accessed 18 October 2022

——, '#WelcomeRefugees: Canada Resettled Syrian Refugees' (24 November 2015) <https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/welcome-syrian-refugees.html> accessed 18 October 2022

——, '#WelcomeAfghans: Key Figures' (28 August 2021) <https://www.canada.ca/en/immigration-refugees-citizenship/services/refugees/afghanistan/key-figures.html> accessed 18 October 2022

——, 'Canada to Welcome Those Fleeing the War in Ukraine' (3 March 2022) <https://www.canada.ca/en/immigration-refugees-citizenship/news/2022/03/canada-to-welcome-those-fleeing-the-war-in-ukraine.html> accessed 18 October 2022

Islam F, 'Examining the "Healthy Immigrant Effect" for Mental Health in Canada' (2013) 90 University of Toronto Medical Journal 169

Kiger ME and Varpio L, 'Thematic Analysis of Qualitative Data: AMEE Guide No. 131' (2020) 42 Medical Teacher 846 <https://www.tandfonline.com/doi/full/10.1080/0142159X.2020.1755030> accessed 11 October 2022

Kirmayer LJ and others, 'Common Mental Health Problems in Immigrants and Refugees: General Approach in Primary Care' (2011) 183 Canadian Medical Association Journal E959 <http://www.cmaj.ca/cgi/doi/10.1503/cmaj.090292> accessed 18 August 2022

Kronick R, 'Mental Health of Refugees and Asylum Seekers: Assessment and Intervention' (2018) 63 Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie 290

Löbel L-M, 'Family Separation and Refugee Mental Health–A Network Perspective' (2020) 61 Social Networks 20 <https://www.sciencedirect.com/science/article/pii/S0378873319300449> accessed 10 September 2022

Macklin A and others, 'A Preliminary Investigation into Private Refugee Sponsors' (2018) 50 Canadian Ethnic Studies 35 <https://muse.jhu.edu/article/700979> accessed 18 August 2022

——, 'The Kinship between Refugee and Family Sponsorship' 25

mccintersections, 'Changing Power Dynamics for Resettled Refugee Families' (*Intersections*, 6 November 2017) <https://mccintersections.wordpress.com/2017/11/06/power-dynamics-resettled-refugee-families/> accessed 19 September 2022

Mind, Mental Health Foundation, 'Building Resilient Communities: Making Every Contact Count for Public Mental Health' (*Mind, Mental Health Foundation*, August 2013) <https://www.mentalhealth.org.uk/sites/default/files/2022-09/MHF-building-resilient-communities.pdf>

Morris S, Lenard PT and Haugen S, 'Refugee Sponsorship and Family Reunification' (2021) 34 Journal of Refugee Studies 130 <https://doi.org/10.1093/jrs/feaa062> accessed 18 August 2022

Noble H and Smith J, 'Issues of Validity and Reliability in Qualitative Research' (2015) 18 Evidence-Based Nursing 34 <https://ebn.bmj.com/content/18/2/34> accessed 4 October 2022

Pathak V, Jena B and Kalra S, 'Qualitative Research' (2013) 4 Perspectives in Clinical Research 192 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3757586/> accessed 4 October 2022

Penninx R and Garcés-Mascareñas B, 'The Concept of Integration as an Analytical Tool and as a Policy Concept' in Blanca Garcés-Mascareñas and Rinus Penninx (eds), *Integration Processes and Policies in Europe: Contexts, Levels and Actors* (Springer International Publishing 2016) <https://doi.org/10.1007/978-3-319-21674-4_2> accessed 11 September 2022

Petersen L, 'Engaging Newcomers in Mental Health Promotion: Suggestions for Service Delivery' 9 <https://www.mosaicbc.org/wp-content/uploads/2016/12/Engaging-Newcomers-in-Mental-Health-Promotion-Suggestions-for-Service-Delivery.pdf>

'Refugee Statistics' (*UNHCR Canada*, 2022) <https://www.unhcr.ca/in-canada/refugee-statistics/> accessed 20 September 2022

Sanjari M and others, 'Ethical Challenges of Researchers in Qualitative Studies: The Necessity to Develop a Specific Guideline' (2014) 7 Journal of Medical Ethics and History of Medicine 14 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4263394/> accessed 12 October 2022

Satinsky E and others, 'Mental Health Care Utilisation and Access among Refugees and Asylum Seekers in Europe: A Systematic Review' (2019) 123 Health Policy 851 <https://www.sciencedirect.com/science/article/pii/S0168851019300399> accessed 11 September 2022

Sijbrandij M, 'Expanding the Evidence: Key Priorities for Research on Mental Health Interventions for Refugees in High-Income Countries' (2017) 27 Epidemiology and Psychiatric Sciences 1

Stewart M and others, 'Multicultural Meanings of Social Support among Immigrants and Refugees' (2008) 46 International Migration 123 <http://0-search.ebscohost.com.catalogue.libraries.london.ac.uk/login.aspx?direct=true&db=a9h&AN=34545437&site=ehost-live> accessed 13 September 2022

Thomson MS and others, 'Improving Immigrant Populations' Access to Mental Health Services in Canada: A Review of Barriers and Recommendations' (2015) 17 Journal of Immigrant and Minority Health 1895 <https://www.proquest.com/docview/1728508195/citation/B2A323F7C464A10PQ/1> accessed 18 August 2022

Walsh F, 'Family Resilience: A Framework for Clinical Practice' (2003) 42 Family process 1

Walther L and others, 'Mental Health and Integration: A Qualitative Study on the Struggles of Recently Arrived Refugees in Germany' (2021) 9 Frontiers in Public Health <https://www.frontiersin.org/articles/10.3389/fpubh.2021.576481> accessed 18 August 2022

Weine S, 'Family Roles in Refugee Youth Resettlement from a Prevention Perspective' (2008) 17 Child and adolescent psychiatric clinics of North America 515 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3414421/> accessed 20 September 2022

Xin H, 'Addressing Mental Health Stigmas among Refugees: A Narrative Review from a Socio-Ecological Perspective' (2020) 8 Universal Journal of Public Health 57

Zipfel S, Pfaltz MC and Schnyder U, 'Editorial: Refugee Mental Health' (2019) 10 Frontiers in Psychiatry <https://www.frontiersin.org/articles/10.3389/fpsyt.2019.00072> accessed 6 September 2022

8. Appendices

جامعة لندن

الرقم المرجعي المؤسسي:

تستخدم للمقابلات القياسية ويتم تكييفها لتناسب الاستبيان عبر الإنترنت

ورقة معلومات المشاركة ونموذج الموافقة على المشاركة

النموذج الأساسي

1. ورقة معلومات المشاركة

وصف مشروع البحث والمؤسسة التي يتم استضافتها
تستضيف كلية الدراسات المتقدمة بجامعة لندن مشروع البحث الخاص بي. حيث سأقوم بالبحث والتحقيق في موضوع : أثر المسؤولين عن الرعاية الفرديين (العلاقة الأسرية) في برنامج الرعاية الخاصة باللاجئين على الاستفادة من خدمات الصحة العقلية من قبل اللاجئين المكفولين عند الحاجة. لذا سأسعى للإجابة على سؤال عام وهو: هل يدرك الرعاة المشاركون في هذا البرنامج احتياجات الصحة العقلية للاجئين الذين يكفلونهم، وهل يمكنهم، بحكم كونهم أسرة، التأثير على رغبة اللاجئين في الوصول إلى خدمات الصحة العقلية؟ حيث أنه من الممكن أن يكون هناك هدف آخر وهو فهم الطريقة المناسبة التي يحتاجها الرعاة لتقديم الدعم وتشجيع اللاجئين المكفولين على الاستفادة من خدمات الصحة العقلية عند الحاجة من أجل تحديد التدريب أو التعليم الذي يمكن اعتماده من قبل منظمات إعادة التوطين أو مقدمي خدمات التوطين الآخرين لإعداد الرعاة الفرديين لإعادة توطين ودمج اللاجئين مع المجتمع.
وصف ما هو مطلوب من المشاركين (يتضمن تفاصيل خاصة حول مقدار الوقت المطلوب من المشاركين)
سيتم اختيار المشاركين من بين نوعين من الرعاة - أ) الرعاة الفرديين ب) الرعاة الممثلين لمجموعة من الرعاة (من خارج العائلة إلى اللاجئ) للمقارنة. سيتم إجراء مقابلات شبه منظمة حيث سيتم طرح بعض الأسئلة المفتوحة على المشاركين لقياس علاقتهم مع اللاجئين المكفولين، وفهمهم لاحتياجات الصحة العقلية للاجئين المكفولين، وما هي احتياجاتهم بصفتهم رعاة ليكونوا قادرين على دعم احتياجات الصحة العقلية للاجئين المكفولين. ستستغرق المقابلات حوالي ساعة على الأكثر، وقد تتضمن بريد إلكتروني أو مكالمة واحدة للمتابعة (لا تزيد عن 15 دقيقة) إذا لزم الأمر لتوضيح الرد. ستتم المقابلات عبر برنامج زوم أو سكايب أو واتساب أو فيس تايم، ويفضل أن تكون وسيلة تسمح بتشفير المكالمات من طرف إلى طرف لأغراض السرية كما سيتم تسجيل المقابلات لنسخها. سيتم اختيار الرعاة الفرديين بناءً على المعايير التالية, أن يكونوا أقارب اللاجئين الذين يتم رعايتهم، كما يجب أن يكون لديهم خبرة في رعاية لاجئ واحد على الأقل في كندا خلال السنوات الأربع الماضية (حتى يتمكنوا من استرجاع فترة إعادة التوطين). سيتم اختيار ممثلي رعاة المجموعة من مجموعات الكنيسة التي تعمل مع منظمتنا لإعادة توطين اللاجئين الذين ليس لديهم عائلة في كندا، والذين ساعدوا في إعادة توطين اللاجئين في السنوات الأربع الماضية
بيان سرية وأمن المعلومات: تفاصيل حول من سيتمكن من الوصول إلى المعلومات الشخصية والأغراض التي سيتم استخدام معلومات المشاركين من أجلها، بما في ذلك المعلومات التي تساعد على التعرف على المشاركين في أي مادة منشورة.
ستكون المعلومات والردود المقدمة سرية للغاية. لن يتمكن أحد من رؤية المعلومات سوى الباحث (أنا) والمشرف الذي يقوم بتوجيهي إذا لزم الأمر. كما لن يتم ذكر أسماء المشاركين في أي مواد منشورة (ورقة الرسالة النهائية). سيتم تخزين البيانات التي تم جمعها من المقابلات في ملفات مشفرة محمية بكلمة مرور أو على اخزين يحابي آمن مثل دروبوكس. سيتم نسخ معلومات المشاركين وترميزها للحصول على معلومات لعرض نتائج مشروع الدراسة. وكذلك إبلاغ المشاركين بطرق جمع بياناتهم واستخدامها وتخزينها.
إقرار بأن المشاركة في البحث تطوعية بالكامل، وأن المشاركين لهم الحرية في الانسحاب في أي وقت دون تعرضهم لأي ضرر أو عواقب سلبية، وأن عدم المشاركة لن يؤثر على حقوق الفرد أو حصوله على الخدمات أو وسائل الرعاية أخرى (على سبيل المثال في حالة المرضى)
أقر بأن لمشاركة في هذا البحث تطوعية تمامًا، وأن للمشاركين الحرية في الانسحاب في أي وقت دون تعرضهم لأي ضرر أو عواقب سلبية. هذا البحث هو دراسة مستقلة وليس له علاقة بالعمل في (مكتب أبرشية تورنتو للاجئين). سيكون المشاركون مجهولين الهوية ولن تؤثر المشاركة أو عدم المشاركة

جامعة لندن

الرقم المرجعي المؤسسي:

في البحث على المشاركين الذين يتطلعون إلى رعاية أو إعادة توطين اللاجئين من خلال مكتب أبرشية تورنتو للاجئين. في حالة الانسحاب من المقابلة، سيتم تسليم أي نسخة من المقابلة إلى المشارك أو التخلص منها، ولن يتم الاحتفاظ بنسخة من المقابلة.
بيان حول أي مخاطر وأضرار أو فوائد محتملة للمشاركين:
المخاطرة: قد تكون المقابلة حول العلاقة بين الراعي واللاجئ مصدر قلق إذا كانت العلاقة بينهما متوترة. **الفوائد:** نأمل أن تكون المعلومات سببًا في توفير الدعم والموارد للرعاة المشاركين لمساعدة أحبائهم على الاندماج بشكل أفضل في كندا.
فيما يلي تفاصيل الاتصال بالباحثين (والمشرف عندما يكون الباحث الرئيسي طالبًا) في حالة كان المشارك بحاجة لمزيد من المعلومات:
سيمولين تالا جمبام (الباحث الرئيسي - الطالب) - simolen.research@gmail.com ديانا ريس (المشرف على الرسالة) - drayes1@jhmi.edu
للاتصال بالمؤسسة، يرجى توجيه مراسلاتك إلى: خدمات البحوث، جامعة لندن البريد الإلكتروني: Research.ethics@sas.ac.uk هاتف: 02078628825 فاكس: 02078628657 جميع السياسات والإجراءات متوفرة هنا: https://www.sas.ac.uk/research/research-office/research-ethics
توقيع المحاور والتاريخ:
يُطلب من المشاركين في البحث تأكيد مشاركتهم على النحو التالي: (يرجى تحديد الكل) ☐قرأت المعلومات الخاصة بالبحث أو الدراسة. ☐ أتيحت لي الفرصة لطرح الأسئلة ومناقشة هذه الدراسة. ☐ تلقيت إجابات مرضية على جميع أسئلتي. ☐ تلقيت معلومات كافية حول هذه الدراسة. ☐حصلت على تفاصيل الاتصال بالباحث وخدمات البحث إذا احتاجوا إلى مزيد من النصائح أو المعلومات.

2. نموذج موافقة المشارك [يرجى تأكيد الخيارات المناسبة أو الخيارات ذات الصلة فقط]

يُطلب من المشاركين في البحث تأكيد مشاركتهم على النحو التالي:

أنا (يرجى وضع علامة حسب رغبتك)

☐ أوافق على المشاركة في المقابلة الخاصة بالبحث الذي أجرته سيمولين تالا جمبام فيما يتعلق بالعمل في أبحاثها كما هو موضح في ورقة معلومات المشاركة.

☐ أتفهم ه سيتم تسجيل المقابلة صوتيًا أو فيديو وقد يتم تحديدها بالاسم.

☐ أتفهم أن المقابلة ستستغرق ما يصل إلى ساعة، مع إمكانية زيادة مدتها إذا لزم الأمر.

☐ لدي حرية الانسحاب من هذه الدراسة:

أ- في أي وقت (أو حتى هذا التاريخ الذي لن يكون الانسحاب فيه ممكنًا، وقد أخبرت بهذا التاريخ).
ب- دون إبداء سبب للانسحاب
ت- إذا كنت أنوي أن أصبح طالبًا في جامعة لندن، فلن تؤثر المقابلة على مستقبلي في الجامعة.

جامعة لندن

الرقم المرجعي المؤسسي:

☐ أتفهم أنه في حالة الانسحاب من المقابلة فسيتم تسليمي أي شريط يتم تسجيله من المقابلة أو سيتم التخلص منه، ولن يتم عمل نسخة من المقابلة.

☐ أتفهم أنه عند الانتهاء من المقابلة، يمكن استخدام الشريط ومحتوى المعلومات للمقابلة على النحو التالي (يرجى ذكر الخيارات المفضلة لديك من خلال تحديد المربع المناسب:

☐ يمكن اقتباس المعلومات الموجودة في الأوراق البحثية في رسالة الماجستير من سيمولين تالا جمبام، ونسبها إلي.

☐ يمكن اقتباس المعلومات من هذه المقابلة في الأوراق البحثية وورقة رسالة ماجستير سيمولين تالا جمبام، لكني أرغب في عدم الكشف عن هويتي.

☐ يجب أن تظل تعليقاتي سرية، ما عدا المعلومات التي سيستخدمها سيمولين تالا جمبام في كتابة رسالة الماجستير الخاصة به فقط وقد لا يتم اقتباسها.

☐أرغب في الحصول على نسخة مطبوعة من المقابلة.

☐ قد احتاج إلى تعديل أجزاء من المقابلة في النسخة النهائية .

☐ أتفهم أنه في ختام هذه الدراسة الخاصة، سيتم الاحتفاظ بشريط ونسخة من المقابلة في الملفات المشفرة بكلمة المرور أو باستخدام التخزين السحابي الآمن مثل دروبوكس أو ون درايف وأنه سيتم الاحتفاظ بالبحث الكامل لاستخدام العام من قبل الجامعة من لندن.

توقيع (المشارك)	تاريخ الموافقة
الاسم بالحروف:	
توقيع (أحد الوالدين / الوصي / غير ذلك) (إذا كان سن المشارك أقل من 18 عامًا)	تاريخ الموافقة
الاسم بالحروف:	
العنوان أو تفاصيل الاتصال:	

سيتم تخزين جميع نماذج الموافقة الموقعة بشكل آمن من قبل الباحث.

إشعار الخصوصية

يجمع باحثو الجامعة البيانات كجزء من مشروع بحث أكاديمي رسمي. كما يخضع ذلك للسياسات والإجراءات الأكاديمية بالجامعة ولجنة أخلاقيات البحث. يجب أن يشرح لك نموذج موافقة المشاركين في البحث أعلاه ما سيحدث لبياناتك بشكل كامل. يرجى الاتصال بالباحث الخاص بك إذا كنت ترغب في التأكد من أي شيء.

هناك نوعان من البيانات التي سيتم جمعها خلال المشروع:

- البيانات التي تم جمعها في المقابلات أو الاستطلاعات وتم استخدامها في البحث.
- تفاصيل الاتصال والنماذج ذات الصلة المستخدمة لإدارة مشروع البحث.

أساسنا القانوني عند معالجة بياناتك هو استخدامها للمهام التي تخدم الصالح العام، في حالة البحث الأكاديمي الذي تقوم به الجامعة. أما أساسنا القانوني عند جمع المعلومات الخاصة، مثل المعلومات المتعلقة بعرقك أو صحتك أو حياتك الجنسية أو ولائك السياسي أو معتقدك الديني، استخدامها لأغراض البحث.

جامعة لندن

الرقم المرجعي المؤسسي:

بعد اكتمال مشروع البحث، يمكن الاحتفاظ بالبيانات وإعادة استخدامها. في بعض الحالات، كما ستتم إضافته إلى مخزن البيانات ليستخدمه باحثون آخرون منا أو من الهيئات الأكاديمية الأخرى، نحن مطالبون بموجب القانون بوضع ضمانات كافية لحماية بياناتك وهويتك (على سبيل المثال عن طريق إخفاء هوية البيانات أو استبدال الأسماء بمعرفات أخرى).

ما لم ينص على خلاف ذلك، فإن جامعة لندن هي المتحكم في البيانات التي يتم جمعها في المشاريع البحثية. كما تخضع للائحة العامة لحماية البيانات وقانون حماية البيانات في المملكة المتحدة لعام 2018. يمكنك معرفة المزيد حول حماية البيانات في الجامعة، بما في ذلك تفاصيل الاتصال بمسؤول حماية البيانات بالجامعة على موقع الجامعة على الويب (ببساطة اكتب "حماية البيانات" 'في مربع البحث أو قم بزيارة الرابط التالي: https://london.ac.uk/about-us/how-university-run/policies/data-protection

إذا كنت ترغب في الاتصال على المستوى المؤسسي، يرجى توجيه مراسلاتك إلى
خدمات البحوث، جامعة لندن
البريد الإلكتروني: Research.ethics@sas.ac.uk
هاتف: 02078628825 فاكس: 02078628657

Appendix B

3) What support would sponsors need to be able to help refugees seek mental health services?

Individual Cosponsor Results

Support needed by sponsors to help refugees access mental health services
Mental health professionals who speak the language of the refugee (2)
Provide refugees with the resources he needs to settle and start life in a new country (2)
Start providing mental health support to refugees when they are in the host country
Mental Health Professionals should have knowledge of the situation in the refugee's country of origin.
Education for refugees about mental health illness and how trauma can cause mental illness
Working with mental health centers and SAH organizations to find ways to provide mental health support to newcomers
UNHCR to provide mental health screening and support to refugees in country of asylum before they get to their host country
Referring refugees to get counseling

Table 4a: Results for Research Question 3 – Individual Cosponsors Results

Group Sponsors Results

Support needed by sponsors to help refugees access mental health services
Education and awareness about refugee mental health for sponsors (3)
Mental health professionals who speak the language of the refugee
Education and awareness about mental health and services for refugees Resources, such as community health centers, that provide resources to learn about other refugee mental health illnesses, other than PTSD
Education and awareness of for sponsors of other mental health issues that plague refugees
Education for both newcomer refugees and group sponsors on general physical health and general mental health.
Education for refugees about cultural/ social issues in Canada

Table 4b: Results for Research Question 3 – Group Sponsors Results