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Article abstract

A needs assessment was conducted to identify the needs, challenges, and strengths of Syrian refugee children and families resettled in Canada and of services for these refugees. Ten refugee caregivers and 17 service providers were interviewed. Thematic analyses indicated significant needs and challenges experienced by refugees (e.g., persistent mental health issues, lack of in-person support), as well as challenges related to refugee services (e.g., discontinuity of mental health services). Several refugee strengths (e.g., optimism for the future and strong familial ties) and refugee service strengths (e.g., service collaboration) were identified, highlighting refugees' adaptive capacities and points of service leverage to ensure refugees' well-being and positive resettlement.





A Community-Based Needs Assessment of Resettled Syrian Refugee Children and Families in Canada

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ABSTRACT

A needs assessment was conducted to identify the needs, challenges, and strengths of Syrian refugee children and families resettled in Canada and of services for these refugees. Ten refugee caregivers and 17 service providers were interviewed. Thematic analyses indicated significant needs and challenges experienced by refugees (e.g., persistent mental health issues, lack of in-person support), as well as challenges related to refugee services (e.g., discontinuity of mental health services). Several refugee strengths (e.g., optimism for the future and strong familial ties) and refugee service strengths (e.g., service collaboration) were identified, highlighting refugees' adaptive capacities and points of service leverage to ensure refugees' well-being and positive resettlement.

KEYWORDS

refugee children and families; refugee service providers; needs assessment; community research

RESUMÉ


Une analyse des besoins a été réalisée afin d'identifier les besoins, les défis et les forces des enfants et des familles de réfugiés syriens réinstallés au Canada, ainsi que des services qui leur sont destinés. Dix personnes réfugiées ayant des enfants à charge et dix-sept prestataires de services ont été interrogés. Les analyses thématiques ont révélé d'importants besoins et défis vécus par les réfugiés (par exemple, des problèmes de santé mentale persistants et un manque de soutien offert en personne) ainsi que des défis liés aux services pour les réfugiés (par exemple, la discontinuité des services de santé mentale). Plusieurs points forts des réfugiés (par exemple, un optimisme face à l'avenir et des liens familiaux solides) et des services qui leur sont destinés (par exemple, la collaboration entre les services) ont été identifiés, mettant en évidence les capacités d'adaptation des réfugiés ainsi que la capacité des points de service à assurer leur bien-être et une réinstallation positive.


Parts of the Middle East have been experiencing unprecedented levels of forced migration as a result of heightened violence and political instability ([Internal Displacement Monitoring Centre, 2019](#)). For example, since the


beginning of the Syrian crisis in 2011, more than half of Syria's population of 23 million has been displaced to different countries ([UNHCR, 2022](#)). Since 2015, the Canadian government has resettled over 154,000 refugees,


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more than 70,000 of whom came from Syria families with young children (Government of Canada, 2021; Macklin & Blum, 2021). This trend has been paralleled elsewhere around the world (e.g., neighbouring Middle Eastern countries and Europe; Connor, 2018). Refugees are a vulnerable population facing significant pre- and post-migratory trauma and adversity, as well as disproportionately high social-emotional and mental health challenges (Blackmore et al., 2020; Hassan et al., 2016; Javanbakht et al., 2019; Kirmayer et al., 2011). While some refugees' post-migration stress may decrease with increased time spent in the resettlement country, other refugees' difficulties may persist years after resettlement (Hodes & Vostanis, 2019; Sulaiman-Hill & Thompson, 2012). Initial studies suggest that the negative impacts of the COVID-19 pandemic have exacerbated refugees' extant challenges (e.g., Benjamen et al., 2021; Bernardi et al., 2021; Bukuluki et al., 2021); however, these studies have been either narrow in focus or largely researcher-led and reliant on quantitative questionnaires. As a result, we lack a comprehensive and in-depth understanding of Middle Eastern refugee children's and families' needs, challenges, and strengths, particularly during the pandemic and **from their perspective**.

Community-based needs assessments adopt a bottom-up approach, emphasizing the community as most apt to identify and characterize its specific needs and strengths (Collins et al., 2018). For the current study, we conducted a community-based needs assessment of Syrian refugee children and families in Canada with the aim of identifying their most prominent needs, challenges, and strengths—both in general and in the context of COVID-19. Ultimately, we aimed to deeply inform the prioritization and design

of services for refugees during and beyond this unprecedented period.

REFUGEE CHILDREN AND FAMILIES: NEEDS AND CHALLENGES

Compared with the general population, refugee children and families from war-torn countries are extremely vulnerable due to compounding traumas across the resettlement process (for a review, see Hameed et al., 2018). First, they are often exposed to trauma and risk factors prior to migration, including war-related violence, loss of loved ones, disruptions to education, and experiences living in refugee camps (Fazel & Stein, 2002; Hadfield et al., 2017; Sirin & Rogers-Sirin, 2015). Second, refugees' challenges can persist because of obstacles in their resettlement countries, such as acculturative stress, discrimination, and low socio-economic status (Agrawal, 2019; Edge & Newbold, 2013; Elsayed et al., 2019; Hadfield et al., 2017; Speidel et al., 2021). Third, as a result of their migratory challenges, refugee children and families are more likely to suffer from mental health and related developmental difficulties, often evidenced by post-traumatic stress disorder and emotional dysregulation (Elsayed et al., 2019; Kazour et al., 2017; Khamis, 2019; Malti, 2020). Refugee children also show developmental challenges and delays due to disruptions of critical developmental periods (e.g., the average refugee child loses three to four years of schooling; UNHCR, 2016).

While pre-migratory challenges are relatively well documented and understood (Hadfield et al., 2017), stakeholders are still uncovering and addressing the nuances of refugees' post-migratory needs throughout the resettlement process. Numerous services have been developed to help refugees across economic (e.g., establishing financial independence), health (e.g., mental health sup-

port), social (e.g., forming a new social network), and cultural (e.g., adjusting to a novel culture) domains (Praznik & Shields, 2018). Although these services provide vital support during a major transitional period, ensuring uptake by refugees remains a challenge because of cultural differences, financial constraints, mistrust, and long wait times (Salami et al., 2019; Soukenik et al., 2022; Tay et al., 2019). Language difficulties, feelings of loneliness, and acculturative stress were also found to impede refugees' engagement with supports (Woodgate et al., 2017).

REFUGEE NEEDS AND CHALLENGES DURING THE COVID-19 PANDEMIC

The COVID-19 pandemic has posed other challenges and is theorized to have interactive and compounding negative effects on refugee children and families alongside unique existing stressors. For example, refugees may relive their pre-migratory traumas as they experience isolation, restricted mobility, and fear from lockdown orders, as well as the threat of prospective illness (Alemi et al., 2020). Stress from the pandemic may also manifest clinically for refugees who are already at the tipping point as they heal from pre-migratory trauma and navigate the daily hassles of resettlement (Brickhill-Atkinson & Hauck, 2021).

In support of this theorizing, a few studies have documented how COVID-19 has exacerbated disparities in refugee children's and families' well-being and disrupted their access to community services and support. For instance, a needs assessment of Ugandan refugees uncovered negative pandemic-related changes in social and occupational life and accompanying feelings of fear, panic, helplessness, and isolation that ultimately hindered resettlement (Logie et al., 2021). However, this study was restricted to refugee youth within a resource-scarce environment.

Another needs assessment broadly included newcomer families in the United States but focused narrowly on needs and challenges within the academic domain, reporting added difficulties for newcomer children and parents because of COVID-19 school disruptions (Santiago et al., 2021).

Other needs assessments of refugees during COVID-19 focused on the point of view of service providers. These efforts are more comprehensive, but they still rely heavily on questionnaires and surveys instead of interviews. According to a survey of Canadian clinicians who serve refugees ($n = 77$ provided questionnaire responses and $n = 11$ participated in semi-structured interviews), pandemic-induced social isolation, educational and employment disparity, and cancellation of language and integration resettlement services ranked among the most significant concerns for refugee mental health during COVID-19 (Benjamin et al., 2021). Another broad-scope needs assessment—relying on brief phone interviews and web surveys—found that refugee families in the United States faced significantly more social, economic, and health-related pandemic hardships than their non-refugee counterparts (Lyons et al., 2021). While these initial studies shed some light on the unique and relative stressors for refugee children and families during COVID-19, they also highlight the dearth of comprehensive, community-based approaches using in-depth interviews to include the voices of both service providers and refugees themselves.

THE BENEFITS OF COMMUNITY-BASED RESEARCH FOR UNDERSTANDING AND PROMOTING REFUGEE CHILD AND FAMILY MENTAL HEALTH

Over the last 25 years, community-based research has increasingly become recognized

as a valuable approach for gathering targeted and timely information on issues in specific populations, all while reducing inequities in research by prioritizing the perspectives and ideas of community members (see Malti & Cheah, 2021; Wallerstein et al., 2020). Community members and stakeholders can provide a nuanced understanding of the most relevant and pressing needs within their group, and their needs and concerns can be synthesized with those of researchers, maximizing practical and scientific impacts (Drahota et al., 2016; Stone et al., 2020). The tailored and equitable aspects of community-based research are particularly beneficial for understanding complexities within vulnerable populations like refugees. Refugees vary considerably in how they manage traumatic and stressful experiences (Leipold & Greve, 2009); based on their social-emotional capacities, resilience, and coping mechanisms, some refugees experience severe psychological consequences while others overcome their experiences and even thrive (Dangmann et al., 2021; Speidel et al., 2021). Conducting in-depth, open-ended interviews with different refugee community members can help capture these nuanced responses to extreme adversities that would otherwise be difficult to comprehend for those without first-hand experience.

While most community-based approaches to date have focused on refugees' adversities and resulting challenges, recent approaches have stressed the importance of understanding and emphasizing refugees' strengths and resilience during resettlement (Liu et al., 2020). **Resilience** is defined as the process, capacity, or outcome by which individuals and communities successfully adapt to or cope with adversity or stress (Masten et al., 1990). Among refugees, different resilience factors have been identified as protective against mental health issues and

difficulties (Arnetz et al., 2013), including a future orientation, social support, and involvement in volunteer work (Thomas et al., 2011; Walther et al., 2021). In general, a strengths-based approach can trigger a self-sustaining process by which refugees focus on their resilience and inner resources to empower them in the face of adversity, regardless of the particularities of their context. Indeed, Syrian refugee caregivers and children are regarded as highly resilient (Hassan et al., 2016; Renner et al., 2020). They have been shown to adopt a variety of coping strategies and resources to overcome traumatic and life-threatening experiences, including optimism and other-oriented capacities (Speidel et al., 2021), social support (Boswall & Akash, 2015; Hasan et al., 2018), and a focus on future goals and aspirations (Khawaja et al., 2008). Recent evidence suggests that some of these growth tactics have continued to be deployed by refugees during the pandemic (Browne et al., 2021; Bukuluki et al., 2021). Community-based approaches that incorporate strengths may thus provide a comprehensive account of avenues to improve the development and mental health of Syrian refugee children and families.

CURRENT STUDY

Our general understanding of refugee needs, challenges, and strengths during the resettlement process and beyond COVID-19 remains limited because few studies with this scope have prioritized and directly incorporated the perspectives of different stakeholders from the refugee community. Thus, our main goals for the present study were to (a) comprehensively identify the needs, challenges, and strengths of refugee children and families and existing services for refugees from the perspectives of both refugee caregivers and service providers who work with refugees; and (b) through the

same approach, highlight COVID-19 impacts on refugee and service needs, challenges, and strengths.

METHOD

Participants

Key informants were refugee caregivers (9 Syrian and 1 Palestinian), as well as 17 service providers who worked with refugee families resettled in Canada ($N = 27$). At the time of study, the refugee caregivers, who were all biological mothers, lived in Hamilton, Ontario ($M_{\text{length of stay}} = 4.54$ years, $SD = 0.50$; 9 government assisted, 1 privately sponsored). Prior to arriving in Canada, they reported interim stays in other countries, including Turkey, Lebanon, Jordan, Kuwait, and Egypt ($M_{\text{length of stay}} = 3$ years, $SD = 1.80$). All caregivers were originally displaced from Syria; nine identified as Syrian and one identified as Palestinian. All identified as Muslim and reported Arabic as their first language. Caregivers reported their highest level of education as follows: 40% university, 30% primary school, 20% preparatory school, and 10% high school. Caregivers had four children on average ($N = 40$; $M_{\text{age}} = 10.56$ years; range = 7–15 years; 48.1% girls).

Service providers worked with Middle Eastern refugees and newcomers in Calgary, Alberta ($n = 10$), and the Greater Toronto and Hamilton Area, Ontario ($n = 7$). Among them were two psychotherapists, two mosque administrators, a child and youth psychologist, a family physician, a private sponsor, and ten general service providers working in client-facing roles or as program managers/directors. Service providers' organizations provided supports to refugees and newcomers in a variety of areas, including resettlement, mental health, basic needs, language, employment, recreation, family services, housing, and youth outreach.

Procedure

Recruitment

After obtaining University of Toronto Research Ethics Board approval, refugee caregivers were recruited from a pool of participants who had participated in a previous study (see [Speidel et al., 2021](#)). These caregivers were initially recruited at community locations and events, such as local food banks and Saturday school, as well as through partnering resettlement agencies (i.e., via flyers inviting Middle Eastern refugees within their organizations to share their experiences). To recruit from this pool, we contacted previous participants via email or phone. Interested participants were provided with a study overview and booked for a virtual interview. Purposive and snowball sampling methods were used to recruit service providers. Specifically, they were contacted through connections within the researchers' partnering organizations and were asked to refer other service providers.

Interviews

For both key informant groups, a semi-structured interview approach—consisting of open-ended questions with probes to further elicit participants' views—was employed. Interviews were approximately 60 minutes in length and took place between October 2020 and May 2021. Due to COVID-19 restrictions (e.g., social distancing, closure of public spaces; see [Appendix C, Figure 1](#)), all interviews took place over an encrypted online platform (Microsoft Teams). At the beginning of each interview, participants were read a consent form, after which they gave verbal consent. All participants consented to being audio-recorded. Caregiver interviews were conducted in Arabic by two fluent research assistants, while service provider interviews were conducted in English by three

research assistants. To ensure standardization of delivery, all interviewers were trained to follow the interview script and utilize probes consistently. Data were anonymized and stored on a secure server within the researchers' university. A gift card was given to refugee caregivers for their participation.

The semi-structured interviews followed a guide that consisted of key questions and prompts to explore refugee needs and challenges, service needs and challenges, refugee strengths, service strengths, and recommendations. For example, participants were asked about the greatest strengths, resources, and capacities within refugee children, families, and communities; the greatest needs and challenges experienced by newcomer refugee children and families in meeting children's well-being and development; and the types of services and supports that would be most helpful in supporting the well-being and development of refugee children and their families. Additionally, participants reported specific COVID-related effects and considerations for each of the aforementioned topics as applicable (see [Appendix A](#) for details on the questions and probes). The focus of interview questions was theoretically and community driven. Theoretically, the questions were informed by social-emotional developmental theory ([Malti, 2020](#)), underscoring the importance of social-emotional capacities, such as emotion regulation and empathy for the self and others, and the ability to establish and maintain healthy relationships with peers and adults. At the community level, the questions were developed in direct collaboration with community advisers, who informed the cultural and practical applicability of the interview questions and prompts.

Data Analytic Approach

Thematic analysis—a method of identifying, analyzing, and reporting themes within

qualitative data to obtain a representative and detailed description of trends ([Braun & Clarke, 2006](#))—was used. All interviews were transcribed verbatim (Arabic interviews were first translated to English) and then coded using an iterative, inductive, and bottom-up approach. First, two coders independently identified distinct groups of quotes from five randomly selected transcripts. Second, they came together to discuss disagreements and synthesize their quote groupings, consulting the project supervisor when necessary. Third, they met with the project supervisor to succinctly collapse these groupings into overarching themes that were applicable across all interview topics. Finally, a coding scheme was created that described the themes and general coding rules developed to ensure consistency (see [Appendix B](#) for themes and their definitions). As will be discussed, this coding scheme was then used by four reliable coders to establish the final codes for all interviews. Quotes that did not fall under any of the identified themes were tabulated separately. However, only one quote was identified across all interviews that did not fall under any of the themes: namely, one service provider mentioned transportation to and from refugee clients as a personal challenge. Coder consensus and community adviser consultation were used to validate the identified themes. First, two independent groups of coders evaluated the transcripts and identified the same overarching themes. Specifically, the four coders who joined the initial two coders identified themes that matched themes that were initially identified by the first two coders. Second, we invited our community partners, given their thorough understanding of the Middle Eastern refugee community, to contribute to the review and revision of the coding themes.

For the four coders, interrater reliability was consistently acceptable across five in-

interviews (over 18% of the interviews) and tended to improve and plateau over time ($k_{iS} = 0.72, 0.69, 0.80, 0.94,$ and $0.88,$ respectively). Thus, the coders proceeded to code the remainder of the interviews independently, meeting weekly with other coders to prevent drift and to come to a consensus on any challenging codes when needed. The thematic results were then tabulated and organized into five main sections for clarity of presentation: (a) refugee needs, challenges, and negative COVID-19 impacts; (b) service needs, challenges, and negative COVID-19 impacts; (c) refugee strengths; (d) service strengths; and (e) service recommendations.

RESULTS

See [Table 1](#) for an overview of the results, including prototypical examples for high-, medium-, and low-frequency themes within each interview section (for bar charts depicting the precise prevalence of themes within each interview section for both refugee caregivers and service providers, see [Appendix C, Figures 2–6](#)). For the sake of brevity and prioritization of the most pertinent issues, only high-frequency themes within each section are elaborated on below.¹ [Appendix B](#) contains descriptions of the themes and corresponding examples.

Refugee Needs and Challenges

Refugee Health Challenges

Service providers pointed out that health-related challenges mainly concerned mental health. Even after years of resettlement, post-traumatic stress disorder (PTSD), depres-

sion, and anxiety were still prominent among Middle Eastern refugees, particularly youth and women. One service provider stated:

Anxiety is through the roof, even depression because some of these kids just don't know how to be part of the society and even though they are grateful for the opportunity, they are grateful for being taken out of a war-torn country and brought into a safe country, that doesn't mean they know how to be part of us and how to fit in. Another thing I would say would be, well, it depends where they came from and how bad [of a situation] they had to deal with, but PTSD is a huge one. You see it in a lot of kids when they come across something that reminds them of something back home.

Children were also reported to suffer from sleep disorders and increased behavioural symptoms, such as hyperactivity, difficulty focusing, and acting out. Most service providers linked these challenges to stigma held by refugees against mental health issues, presenting a barrier to treatment. Highlighting the sensitivity of this topic, one service provider said, "Even to mention the word **mental health** is a complete stigma, [it is a] stigmatized word to these parents and families, like it's a complete no."

Both refugee caregivers and service providers agreed that the COVID-19 pandemic has exacerbated refugee families' mental health challenges. Beyond issues shared by many other Canadians, the pandemic has been a "double trauma" for refugees, with isolation and stress reopening the wounds of related pre-migratory traumas. According to one service provider:

I would definitely say that we have heard from our clients that [COVID-19] has triggered what has happened to them in the past in their settlement journey. ... This is more around adults, whether they have been imprisoned in the past, this might be a trigger for that.

Refugee Social and Interpersonal Challenges

Refugee caregivers frequently reported a lack of in-person support from extended

¹For each interview section, low-, medium-, and high-frequency cut-offs were determined using the most frequently cited theme as an anchor and dividing its frequency by 3 to establish bins. For example, in the refugee strengths interview section, the most frequent theme was cited 24 times across the participants: $24 \div 3 = 8$; hence, themes cited 1–8 times = low frequency, 9–16 times = medium frequency, and 17–24 times = high frequency.

Table 1 Overview of Low-, Medium-, and High-Frequency Themes and Corresponding Examples for Each Interview Section.

Interview section	High frequency	Example	Medium frequency	Example	Low frequency	Example
Refugee needs, challenges, and negative COVID-19 impacts	1. Health 2. Social and interpersonal	1. Mental health challenges 2. Lack of extended family support	1. Religion and culture 2. Financial	1. Preserving values 2. Unaffordable housing	1. Learning 2. Parenting 3. Language	1. Education gaps 2. Navigating discipline styles 3. Language barriers
Service needs, challenges, and negative COVID-19 impacts	1. Service quality	1. Unsustainable services / service discontinuity	None	None	1. Learning 2. Health 3. Financial 4. Language 5. Religion and culture 6. Social and interpersonal 7. Other	1. Client distrust 2. Service uptake 3. Program funding cuts 4. Language barriers 5. Mental health stigma 6. Social stigma attached to service use 7. Service provider transportation barrier
Refugee strengths	1. Resilience factors 2. Social and interpersonal	1. Positive outlook for the future 2. Spousal and community support	1. Parenting	1. Supportive parenting	1. Religion and culture 2. Learning 3. Language 4. Financial 5. Health 6. Other	1. Religion as source of coping/strength 2. Love for learning 3. Eager to learn English 4. Employment as source of strength 5. Positive outlook on health 6. Adherence to COVID-19 restrictions

Continued on next page

Table 1 *Continued.*

Interview section	High frequency	Example	Medium frequency	Example	Low frequency	Example
Service strengths	<ol style="list-style-type: none"> 1. Learning 2. Health 3. Service quality 	<ol style="list-style-type: none"> 1. Resettlement supports 2. Mental health supports 3. Inter-agency collaboration 	<ol style="list-style-type: none"> 1. Social and interpersonal 2. Financial 	<ol style="list-style-type: none"> 1. Recreational supports 2. Housing and basic needs supports 	<ol style="list-style-type: none"> 1. Language 2. Parenting 3. Religion and culture 	<ol style="list-style-type: none"> 1. English-language supports 2. Parenting supports 3. Religious services from mosques
Recommendations	<ol style="list-style-type: none"> 1. Service quality 2. Learning 	<ol style="list-style-type: none"> 1. Culturally sensitive supports and mentorship 2. Psychoeducation to combat mental health stigma 	<ol style="list-style-type: none"> 1. Financial 	<ol style="list-style-type: none"> 1. Funding to sustain programs 	<ol style="list-style-type: none"> 1. Health 2. Social and interpersonal 3. Religion and culture 4. Language 5. Parenting 	<ol style="list-style-type: none"> 1. Mental health supports for men 2. Accessible recreation programs 3. Religious education for children 4. Resources provided in Arabic 5. Childcare supports to ease caregivers' service access

family, as family members back home would share tasks of childrearing. One refugee mother said:

I have my oldest son—he's a little bit difficult. If we were back home, I would tell my parents, my siblings, you know? His grandparents, his aunts, or his uncles would talk to him but over here no one can talk to him or guide. My family, they talk to him about it over the phone but it's not the same as talking about it in person.

Service providers also discussed obstacles for refugee teenagers, particularly negative peer influence and its impact on academic and behavioural functioning. One program manager working closely with Syrian refugees said, "I would say 7 out of 10 [adolescents], they told me that they were influenced in a negative way by their peers or by their friends." A refugee mother echoed this, stating, "Honestly, I feel that all mothers ... they're afraid for their kids to be pulled into things here. Like weed here is legal, that's the biggest fear for moms."

Refugee caregivers and service providers also agreed that the COVID-19 pandemic has added additional social stress. Many refugee caregivers also expressed concerns about impacts on their children's fledgling friendships due to closures of key community resources, adding to the difficulty of forming new friendships in a foreign country. As one mother reminisced, "We used to go to the pool at YMCA every week or there would be a basketball lesson."

Service Needs and Challenges

Service Quality Challenges

One of the most notable service issues mentioned by service providers was the unsustainable nature of programs. For example, some services offered in the early years of refugees' resettlement are no longer funded, creating a sense of being "stranded." Other services, particularly counselling programs,

experience significant turnover. One service provider noted:

Well, the first thing that comes to my mind is just longevity and continuity, and there is quite a bit of turnover among workers, and to be supporting a family effectively, there often isn't the same person involved over time ... so that can obviously be challenging.

This was seen as compromising service quality but also refugees' well-being as they recount the details of severe traumatic experiences to revolving staff. Staff shortages were also commonly cited (given large numbers of refugees with unique, chronic needs). "We're at capacity," one psychotherapist said. She added:

I am the only mental health worker in the entire program and I have a waiting list right now. Again, it's dependent on the family, right, like I have one family [of three]. ... Every single member has had some sort of mental health-related issue, so that one family is equivalent to three clients. And then we do separate work with each of them. If it's a family of seven, there's a major family dynamic—it's difficult for me to follow every single person when I have a lot of other clients on my case load. So, you can imagine how difficult it would be to be the only mental health worker, doing the job with COVID and without COVID ... it's quite the same.

Shifting to virtual services with COVID-19 has resulted in a lack of interpersonal connection during virtual sessions, technological difficulties, and a loss of privacy for clients (as their homes are not suitable for counselling sessions). Many service providers have also highlighted difficulties establishing trust through a screen with a population whose traumas and adversities have already eroded their capacity for trust. One psychologist said, "For [refugee] children, before you do any mental health services, anything, you need to build rapport and a trusting relationship with them. There have been families with whom I have not been able to do that virtually."

Refugee Strengths

Refugee Resilience

Many refugee caregivers held an optimistic vision of their future and the futures of their children, and they showed their determination to pursue aspirations in the face of daily adversity. One mother commented on behalf of the refugee community, “The majority of the community is here to work, they have dreams and aspirations to work and make a future, and serve Canada.” Service providers also emphasized refugees’ “incredible resilience and huge desire to learn and to move forward” and remarked on their self-motivation to learn the English language, achieve financial stability, and pursue their education (as evidence of their resilience and adaptability). No quote was identified highlighting positive impacts of COVID-19 on refugees’ resilience.

Refugee Social and Interpersonal Strengths

Refugee caregivers underlined the importance of their spouses’ support and strong familial ties as sources of strength. More broadly, there was consensus among refugee caregivers and their service providers that refugees’ strong communal ties within their own ethnic community provided an additional source of strength, expressing how important it was for refugee families to live near other refugee families. As one refugee mother noted:

We’re a few families and we’d go out together. I’d feel that the kids were really happy, their spirits would change. Like even us, the women, we’d get happy from these gatherings. Like you’d feel a support. It’d make us forget about being far from our families.

And a service provider echoed:

[The refugees] had strong ties within the family, but, as well, the fact that they came as a big group at once helped them create a strong community,

so they were fairly organized quickly and as a community they are helping one another.

Only three quotes across all interviews highlighted positive impacts of COVID-19; these fell within the **Social and Interpersonal** theme. One noted social media as a central resource for refugee families to stay connected, while the others reflected on the quality time spent with family members. Notably, a private sponsor of a refugee family whose older son is involved in gang activity mentioned:

The mother, strangely, is loving COVID because she has everybody close. Everyone is home, they are around, particularly the eldest boy. Her worst time for the family was when he was off at all hours of the night with who knows what gang of people.

Service Strengths

Learning

Service providers were highly regarded as providing vital knowledge during the initial steps of resettlement, including legislative assistance, schooling support, psychoeducation, and parenting workshops. The service providers themselves highlighted a focus on the most immediate barriers to integration. For example, describing how their organization went beyond the scope of their program to help refugee fathers, who are rarely of focus during the resettlement process, one service provider said:

We wanted to help those fathers, so we built partnerships with an organization and they provide job opportunities. ... They help with your résumé, interviews, connections, and networking, so we did workshops with them, [the fathers] would attend, and they would learn more about what they needed.

No quote was identified highlighting positive impacts of COVID-19 on learning-related service strengths.

Health

In line with (and perhaps in response to) mental health being cited among the most significant challenges for refugees, many service providers noted the high quality of mental health services available to this community. One service provider said, "We would meet mostly one on one with the students, but then we would still meet as much as we could with the parents to provide them some support and offer them some strategies and provide a more holistic approach." Others remarked on the success of psychoeducation workshops for parents and children with a focus on managing emotions—in particular, it was noted that such workshops were held at school, making them more accessible and less obviously focused on mental health. Some service providers made clever adaptations to overcome refugees' biases against mental health. As one early childhood education case manager noted:

We do have a lot of challenges, especially the mental health, like this thing [stigma] would be hanging, but I think [location of service] has a lot of support and maybe labelling or naming the service differently so that the family will not put up those barriers right away and say no to the service. So for her [the psychotherapist who works at their organization] service for example, we call it "health and wellness" rather than psychotherapy. ... Even for some of our workshops we had to figure out different names. ... In one of the workshops we wanted to talk about bullying because a lot of our families would face this and we know they are facing discrimination in schools ... but the time we had that bullying workshop name, a lot of our clients did not even want to attend, and the time we changed it to school information, a lot of community members came out.

No quote was identified highlighting positive impacts of COVID-19 on health-related service strengths.

Service Quality

Other service strengths raised by service providers were relatively idiosyncratic and thus fell under the more general **Service Quality** theme. Among these strengths was refugee service providers' connectivity, particularly the circle of collaboration and communication among different agencies to overcome the barriers and limitations of their own services. As one service provider explained:

If we can't help for any reason, then we connect with other organizations that can, or the crisis counsellor on site. And even we connect with the schools, their teachers, and we're always connected with the teachers because they see a side of their students that we don't see in the office when they come, so we are always connected, we're always sharing, always updating each other, so even if I don't catch a red flag, and the teacher does, they would immediately send us an email and we would notify their families if they're under 18.

No quote was identified highlighting positive impacts of COVID-19 on service quality strengths.

Recommendations

Learning Recommendations

Most service providers recommended continued psychoeducation to help refugees overcome mental health stigma during and beyond COVID-19, but many cautioned about the need to simultaneously account for cultural considerations. One psychotherapist noted:

When I am sitting there doing my assessments for kids, I am looking at the sociological perspective, the psychosocial, the spiritual, and everything because you need to know that cultural piece, you need to know the child's history, you need to know where they came from, what refugee camp, what country, what did they experience? Was there a war, was there rape, was there a genocide? Like the history and all those foundations completely

matter with kids and youth because it shapes their entire experience and their experiences shape who they are. And if you don't catch these things early, later on they are going to have a difficult time.

Some service providers also noted that even though there are numerous refugee-serving organizations across Canada, refugees lack awareness of these resources. It was therefore strongly recommended to organize more workshops aimed at informing refugees about the services that are available to them.

Financial Recommendations

Given the large number of refugees welcomed to Canada each year, most service providers advocated increased funding to meet demand. Some service providers were also worried about their organizations' over-reliance on volunteers and contract employees as opposed to long-term employees, implicating this as a potential source of turnover and resulting negative effects for vulnerable refugees.

Service Quality Recommendations

Refugee caregivers and service providers suggested that more Arabic-speaking specialists and settlement workers should be included to bridge linguistic and cultural gaps between service providers and the refugee community. One service provider corroborated this:

We don't think it should just fall on the immigrant service sector, and we know you can't find enough Arabic specialists to work with every specialization and every mandate that's out there, so we are hoping to connect them more and more to interpretation services so that we can fill the capacity.

Some refugee caregivers affirmed this; one caregiver stated:

They should use the assistance of Arab people when they're working with the community ... and just because we're Middle Eastern that doesn't

mean we all understand each other. It would have to be a Syrian person, for example, if it's related to Syrian issues.

Service providers also creatively recommended mentorship programs between newly resettled refugee families and well-established refugee families to ease the transition and create a zone of proximal development whereby newcomers can learn from those who recently experienced their hardships. One service provider nonetheless emphasized the importance of carefully selecting families to serve as mentors, noting, "I talked about mentorship, but you have to make sure that the mentoring families would have a really clear idea, with understanding and trust, of the Canadian system." This theme of mentorship was also voiced by a refugee mother of a high school student:

For people who have new kids like us, we don't know the high school system and how to choose universities. We want our kids to be successful and to go to university. We find difficulties in it, and we try to ask around [for people] who would tell us their experience. Since we are new, we don't know what is good and what is not good. So, for this thing, we would love to have programs that introduce the parents to high school.

DISCUSSION

The current findings meaningfully add to the body of research on Middle Eastern refugee children's and families' needs, challenges, and strengths, both in general and during the COVID-19 pandemic, by prioritizing the voices of refugee caregivers and their service providers. We identified prevalent challenges and needs faced by refugees and services offered to them that may hinder refugee children's and families' adjustment during resettlement. Some of these unique migratory challenges were exacerbated by specific aspects of the pandemic. The analyses also revealed strengths among the refugee population and helpful service

recommendations, which may support refugees' growth. Below, we provide a synthesized discussion of our comprehensive results. To further enhance this discussion, we incorporate low- and mid-frequency themes (see Appendix C, Figures 2–6) that are pertinent to our discussion of the high-frequency themes that comprised our core results.

Understanding Refugee Children's and Families' Needs and Challenges

This study's results made it clear that addressing the needs and challenges of refugees with proactive strategies is just as important as understanding and building on their strengths. Service providers highlighted some of the unique challenges among Syrian refugees linked to pre-migration experiences, such as war exposure and trauma, as well as to post-migration experiences, such as separation anxiety and the added burdens of resettlement in a new country (concurring with Hameed et al., 2018). Despite service providers' mobilization and support efforts, these challenges were cited as impeding refugees' access to and utilization of services, especially mental health services (for similar concerns, see Immigration, Refugees, and Citizenship Canada, 2019).

According to our needs assessment, mental health stigma is one of the most pervasive challenges among Syrian refugees. For example, refugees held social stigma or shame with regard to disclosing mental illnesses that were seen to contradict family social standing, even when their personal attitudes towards mental health treatment were positive. This stigma is thought to contribute to the persistence of mental health issues among refugee families and their children, as well as to a lack of access to mental health services (see Ciftci et al., 2013). Our findings confirm pre-pandemic research citing mental health stigma as a paramount

barrier (Shannon et al., 2015; Zolezzi et al., 2018). For example, refugees in Ontario had the lowest utilization of mental health services when compared with long-term residents and Canadian-born citizens (Blackmore et al., 2020; Durbin et al., 2014; Kirmayer et al., 2011). The current findings suggest that stigma continues to hamper refugee mental health service access and utilization in current times and with the onset of COVID-19. The value of addressing stigma is underscored by the high quality of mental health services available to refugees (which our service provider participants corroborated); unlocking access to these services by addressing stigma may be a cost-effective way to capitalize on extant resources and improve refugee well-being.

Increased psychoeducation was one such recommendation provided in our needs assessment. Psychoeducation is a frequently used evidence-based psychotherapeutic technique that aims to educate individuals and their families about positive lifestyle changes and new skills, as well as to increase their knowledge and understanding of mental health and coping strategies (Colom, 2011). Psychoeducation has been shown to facilitate the understanding of mental health consequences and symptoms (Lukens & McFarlane, 2004) and to increase reporting of mental health symptoms among non-refugees (Srivastava & Panday, 2016). However, there is a need for culturally appropriate psychoeducation led by community mental health workers who understand and are familiar with refugee community dynamics, such as family ties and structure, religious and cultural values, attitudes, language, and communication styles. This common ground may help build rapport, trust, and retention, all of which are significant factors in the effectiveness of psychoeducation initiatives (O'Brien et al., 2021).

Another notable challenge reported by service providers was refugees' lack of trust in confidentiality. Refugees' mistrust likely stems from their history, as their journeys prior to resettlement are fraught with adversity, including threats to safety, witnessing of violence, loss of homes and loved ones, socio-economic insecurity, and negative experiences in refugee camps (Hadfield et al., 2017). These experiences undermine refugees' sense of trust, even after they have migrated to safety (Hynes, 2003). Indeed, refugees' mistrust was found to be transferred to their interactions with service providers and interpreters, preventing them from obtaining or fully benefiting from services as they feared the spread of private information in the community (Ahmed et al., 2017; Shannon et al., 2015). As reported by service providers in the current analysis, shifting mental health services to a virtual setting during the COVID-19 pandemic exacerbated mistrust issues. This corroborates Appleton and colleagues' (2021) review of virtual mental health service implementation for the general population during the pandemic, which revealed that practitioners faced significant challenges in establishing rapport and maintaining privacy and confidentiality. Our results suggest that this system-wide issue may be particularly problematic for vulnerable populations, such as refugees, who may already have a predisposition to mistrust. We believe a comprehensive commitment to service quality and cultural safety is necessary to combat mistrust at a deeper systems level, including employing service providers with Middle Eastern backgrounds in long-term positions to lead culturally informed mental health programs and wellness workshops (Im et al., 2021), as well as to act as cultural advisers to non-Middle Eastern service providers.

Understanding Refugee Service Needs and Challenges

One of the system-level challenges identified by service providers was the discontinuity of services, particularly the discontinuity of mental health services once refugees had been resettled for a certain amount of time. Similar challenges have been encountered across Canada, as service providers struggle to assist large influxes of new refugees while falling short of meeting recently resettled refugees' ongoing mental health and integration needs (Rural Development Institute, Brandon University, and Immigration Research West, 2015). These issues negatively impact service continuity and coordination (Braun & Clément, 2019) and contribute to service provider burnout and turnover (Akinsulure-Smith et al., 2018). Continuity of care is also critical for refugees' sustained use of health promotion strategies and social functioning as their resettlement and related mental health challenges tend to persist long after the initial terms of resettlement services (Gray et al., 2018; Puntis et al., 2015). While longevity in care challenges existed prior to COVID-19, they have been exacerbated by increased financial constraints and service disruptions during the pandemic (Im & George, 2022). Refugees' risk of retraumatization may be heightened if they are not provided with appropriate mental health services or are subjected to repetitive or redundant assessments and interventions—experiences that may further compound existing difficulties with refugee service uptake and organizational trust (Miller et al., 2019).

A common recommendation voiced by the participating service providers was to support continuity of care by increasing funding for long-term employees and professionals to meet incoming and ongoing demands for mental health services. This may reduce concerns about long-term efficacy

and retraumatization if refugees can keep using services for longer periods of time and/or continue to work with the same case worker when they are most vulnerable. In addition, the multiple references to trauma that came up in our interviews may reflect the need for trauma-informed training that promotes service providers' capacity to provide appropriate and sustained care in these roles (Wylie et al., 2020). Further, initiatives aimed at supporting service providers' own mental health, especially considering the additional challenges posed by COVID-19, may reduce burnout and turnover in this area.

Another possible solution is to increase strategic coordination and collaboration among relevant service settings and organizations. This can help identify complementary or repetitive services. For example, some have recommended the integration of mental health and physical health services to better address refugee needs, which often span these boundaries (Giacco et al., 2014). Increased coordination of care may also be a solution to underfunding. For example, refugees' short- and long-term needs can be addressed through a communicative process in which first-contact services document refugee clients' service backgrounds and securely share this information with referred agencies to limit risks of retraumatization. Improving mechanisms of communication and coordination among service providers may cultivate the strength and potential of care systems, which in turn may support the strength and potential of refugee children and families seeking services.

Socio-Cultural Considerations and Strengths

Our needs assessment also revealed the importance of taking cultural aspects and strengths of the refugee population into

account. Participants agreed on the importance of understanding the experiences and perspectives of the Syrian refugee population (e.g., family structure, linguistic needs, cultural norms) to ensure an equitable and integrative system that empowers refugees and increases their future participation in services. Indeed, failure to consider refugees' cultural and linguistic diversity has been shown to impede their service access and uptake, particularly for mental health services, because refugees may not understand or trust the nature and/or benefits of services that are not presented in their native language or framed within their culture (Chaze et al., 2015; Riggs et al., 2012; van der Boor & White, 2020).

Building cultural partnerships is one way to increase refugee socio-cultural sensitivity. Service provider teams can include refugee community members with cultural and linguistic skills in service and care settings to foster cultural safety and implement solutions that better fit the refugee community. In support of such approaches, Soto and colleagues (2018) summarized two meta-analyses of 114 mental health treatment approaches adapted for race, culture, and ethnicity. They found that clinical improvement increased in lockstep with services' cultural adaptation efforts. Cultural partnerships can also be supplemented by the hiring of social workers and professionals from the same ethnic background as refugees to improve communication and comfort (Gopalkrishnan, 2018; Wylie et al., 2020).

Refugee family mentoring programs, as many participants in our needs assessment suggested, are another option for increasing cultural sensitivity. These programs are designed to assist incoming refugee families in a variety of areas (e.g., housing, employment, education, health, and well-being) through a supportive, scaffolding environ-

ment in which they are mentored by resettled refugees with similar experiences. Such approaches build on previous research that found mentoring to be an effective tool for refugee resettlement because it promoted trust and a sense of community while allowing refugees to maintain core aspects of their personal and cultural identities (Atkinson, 2018; Paloma et al., 2020; Vickers et al., 2017). Mentoring programs may also reduce refugees' reliance on overburdened service providers. Nonetheless, it should be ensured that the methods and aims of mentoring families are compatible with those of service providers and established organizations.

Finally, it is important to consider refugees' socio-cultural concerns from the lens of integration. **Integration** is commonly defined as acculturation into the culture of a new country while retaining one's heritage and cultural identity (Berry, 2011). In our needs assessment, refugee caregivers stressed the importance of preserving their mother language as a means of fostering their cultural identity and buffering incompatible majority culture influences (see Lindner et al., 2020). Nonetheless, this emphasis on language retention did not undermine refugee caregivers' active role in encouraging their children to learn English, as indicated by their optimistic attitude towards their children's participation in Canadian education and culture. Our needs assessment also highlighted the importance of retaining and celebrating the social aspects of Syrian refugee culture. Indeed, service provider participants admired refugee families' strong support structures, which included extended family, informal networks of support back home, and a vibrant community in Canada (also see UNHCR, 2017). These close-knit communities were especially vital amid the social restrictions and challenges of the COVID-19 pandemic

(also see Bukuluki et al., 2021; Santiago et al., 2021).

Limitations and Conclusions

The current study's findings reflect the needs, challenges, and strengths of Syrian refugees who have been resettled in Canada, as well as those of services for this specific population in particular Canadian regions. As a result, the findings may not be fully generalizable to other international or even national refugee communities of different backgrounds and resettlement experiences. Future needs assessments of refugees from a broader range of cultural backgrounds and resettlement destinations should be conducted to understand the specificities and commonalities of the current findings for refugees, Middle Eastern or otherwise (see Malti & Cheah, 2021).

Furthermore, the current study only included refugee mothers. Future needs assessments should include the perspectives of additional refugee caregivers, including fathers, to better understand the unique needs and challenges that may characterize different caregiving roles. As one of our service providers stated:

We continue to struggle with fathers; they are not that involved in workshops or improving and developing themselves. I would say that the youth and mothers are more active. The father is more concerned about finding a job and being the provider.

Finally, although our community partners, who have an intimate and extensive understanding of the Syrian refugee community, were involved in every stage of the current project, direct member checking was not conducted to assess the validity of our themes. Approaches building on the current study should include refugee community members alongside those who serve them in the member checking process. Notwithstanding, the

current results stand to improve our understanding of the needs and challenges faced by Syrian refugees resettled in a Western country, as well as for the services available to them and how COVID-19 has exacerbated issues around mental health and service access and uptake.

The findings reveal strengths among Syrian refugees and the services provided to them, such as optimism and strong networks of social, cultural, and service support, which may foster refugees' resilience and positive participation in their resettlement country. The findings may also inform mental health intervention programs and services aimed at Syrian and related refugee communities, highlighting the importance of addressing stigma and building on personal and interpersonal strengths. Service providers who work with refugee families may wish to heed our refugee participants' collective recommendations to provide culturally responsive care that is sensitive to refugees' experiences and focused on building trust and a sense of safety in care settings. Many of these conclusions were resoundingly apparent before the pandemic and have become increasingly critical during and beyond COVID-19 as refugee crises continue to emerge.

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APPENDIX A

INTERVIEW QUESTIONS

Interview section	Prompts	
	Caregiver	Service provider
Refugee strengths	<p>What do you think are the greatest strengths, resources, and capacities within your community?</p> <p>What are your strengths as a parent?</p> <p>What are the strengths of your child?</p> <p>How do you manage these stressors or challenges? What do you find helpful?</p>	<p>What do you think are the greatest strengths, resources, and capacities within refugee children, families, and communities you work with?</p>
Refugee needs	<p>What do you think are the greatest needs and challenges experienced by children and families in your community?</p> <p>What are your greatest stresses and challenges you experience as a parent?</p> <p>Do you have any worries about your own well-being (eating, sleeping, mood)?</p> <p>What, if any, worries do you have about your child(ren)'s well-being (mental health/development/behaviour, eating, sleeping, mood)?</p> <p>At home? With siblings? With other family members? At school? With peers?</p> <p>Have you spoken to anyone about these worries? If so, who? If not, why not?</p> <p>Are you worried about the well-being of other children in your community? Why or why not?</p> <p>How do you think the needs of children in your community are or are not being met?</p>	<p>What do you think are the greatest needs and challenges experienced by newcomer refugee children and families in meeting their own children's well-being and development (mental health/behaviour)?</p> <p>At home? With family? At school? With peers? In the community?</p> <p>What are the mental health, developmental, and/or behavioural needs or challenges that you see in children and families in the community?</p> <p>Are these needs being met by the community? Your organization? Gaps? If no, why not? If yes, how?</p>

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Interview section	Prompts	
	Caregiver	Service provider
Service strengths	<p>How do you manage these stressors or challenges? What do you find helpful?</p> <p>What supports do you find most helpful for you, your children, and your family?</p> <p>What services or supports have you (or other members of your community) used?</p> <p>How did you find out about these supports?</p> <p>If you found these services helpful, please explain why.</p>	<p>What is your role within your organization with respect to working with newcomer refugee children and their families?</p> <p>What services are provided? Resettlement? Educational? Children's mental health?</p> <p>How do you and your organization leverage these strengths?</p> <p>How do you or your organization assist with these needs and challenges?</p> <p>How is the community addressing and/or supporting the mental health and well-being of children and their caregivers/families?</p> <p>Are these needs being met by the community? Your organization? Gaps? If no, why not? If yes, how?</p> <p>Who accesses these services (e.g., child, mother, the family as a whole)?</p> <p>How effective is your organization in supporting the development and well-being of children and their caregivers/families?</p> <p>What services, supports, and/or policies help promote the healthy development and well-being of children at home, at school, and in the community?</p> <p>What is in place?</p> <p>What services, supports, and/or policies do you think are most helpful for newcomer families struggling with mental health concerns and/or positive child development?</p> <p>What is in place?</p>

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Interview section	Prompts	
	Caregiver	Service provider
Service needs	<p>What services or supports have you (or other members of your community) used?</p> <p>If these services were not helpful, please explain why.</p> <p>If no services or supports have been sought by you, please explain why.</p>	<p>Are these needs being met by the community? Your organization? Gaps? If no, why not? If yes, how?</p> <p>What are the barriers? Who are the important community members who play a key role in connecting families to your organization/services?</p> <p>What are the barriers? What would help your organization or others in the community?</p>
Recommendations	<p>What supports could be helpful in dealing with your stressors/challenges (i.e., informal and formal)?</p> <p>What services and supports would be most helpful in supporting the well-being and the development of your child and that of children and families in your community?</p> <p>Why are these supports a priority?</p> <p>Are these services/supports available/accessible in your community? Why or why not?</p> <p>Would the services/supports needed be similar to or different from those for children who are not from your community?</p> <p>What would help you and other families access supports needed? Barriers?</p> <p>What, if any, resources, strengths, and capacities within your community are not being fully used to promote the well-being of children and families in your community?</p> <p>What recommendations do you have for service providers and policy-makers for supporting the well-being of children and families in your community?</p>	<p>What are some missed opportunities?</p> <p>Are there missed opportunities to mitigate these challenges by your organization / by others in the community?</p> <p>What should be in place?</p> <p>What sectors or systems?</p> <p>What recommendations do you have for supporting the well-being and development of children and families in newcomer refugee communities?</p> <p>(At multiple levels and contexts [e.g., home, family, school, policy.])</p>

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Interview section	Prompts	
	Caregiver	Service provider
COVID-19 impacts (probed across interview sections)	What, if anything, has changed as a result of the COVID-19 pandemic?	<p>What, if anything, has changed with respect to services as a result of the COVID-19 pandemic?</p> <p>What services, supports, and/or policies help promote the healthy development and well-being of children at home, at school, and in the community? What, if anything, has changed / needs to change as a result of the COVID-19 pandemic?</p> <p>What services, supports and/or policies do you think are most helpful for refugee/newcomer families struggling with mental health concerns and/or positive child development in the current context of COVID-19?</p> <p>What recommendations do you have for supporting the well-being and development of children and families in newcomer refugee communities in the current context of COVID-19?</p>

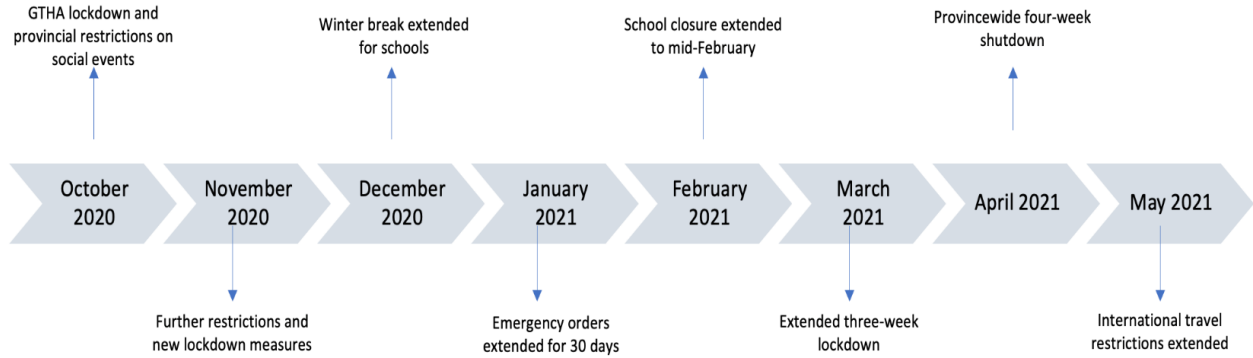
APPENDIX B

CODED THEMES

Theme	Description	Examples
Language	Anything related to language and language barriers	Lack of interpretation services; language barriers; language assessment services
Learning	Anything related to learning, including schooling, academics, and the acquisition of other professional and life skills (besides language)	Resettlement workshops; financial literacy; adult schooling; homework assistance; service provider training; caregivers' awareness of services; parenting workshops
Health	Anything referencing physical, mental, and behavioural health or otherwise health related	Anger/aggression regulation; general health concerns; substance dependence
Social and interpersonal	Anything involving interactions between individuals/groups that does not fall into any of the other themes	Peer influences; domestic violence; strong community ties; lack of family support; sports and recreational programs
Religion and culture	Anything related to religion and/or culture, including mental health stigma	Religious coping; preserving culture and religion; children learning religion at the mosque/Islamic school, mental health stigma
Financial	Monetary-, employment-, and funding-related factors	Money for basic needs; unemployment; service funding cuts
Parenting	Anything related to parenting, including parenting practices/strategies and services but excluding parenting knowledge/skills acquisition (see Learning)	Maintaining routines; positive parental involvement; setting positive examples for children; childcare supports
Resilience factors	Individual- and community-level characteristics that promote well-being and do not fall into any of the other themes	Industriousness; enterprising; altruism; resilience
Service quality	Specific characteristics of services that affect their quality (positively or negatively), excluding factors related to funding	Service synergy; communication between services; standardization of programs across different locations; long waitlists
Other	Anything noteworthy that does not fall into any of the other themes	N/A

APPENDIX C

Figure 1 COVID-19 Restrictions at the Time of Data Collection.



Note. GTHA = Greater Toronto and Hamilton Area.

Figure 2 Refugee Needs.

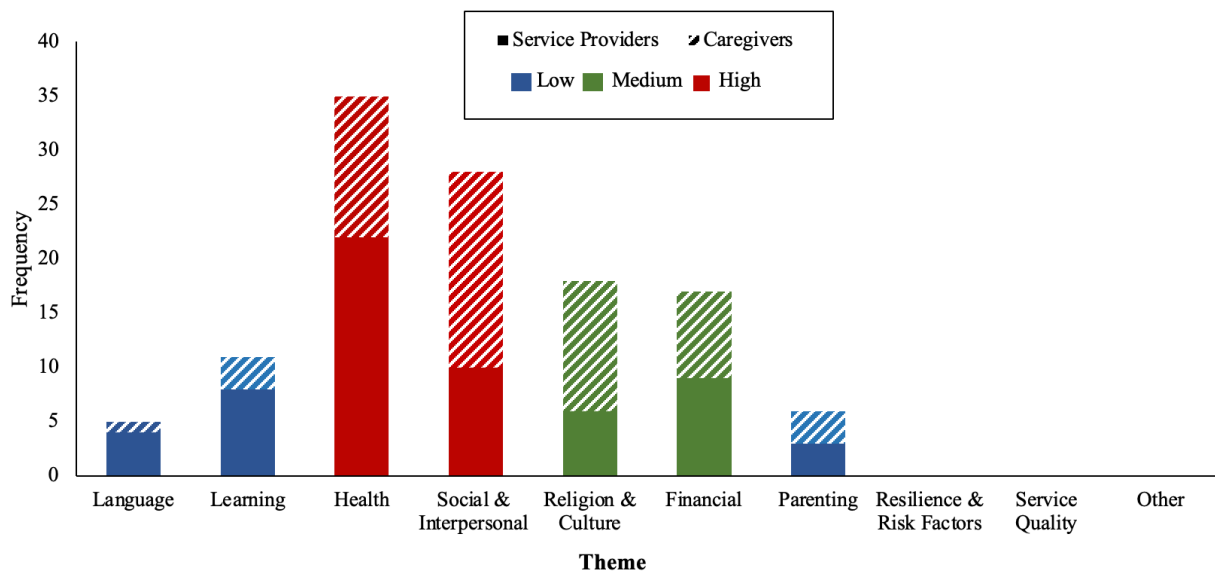


Figure 3 Service Needs.

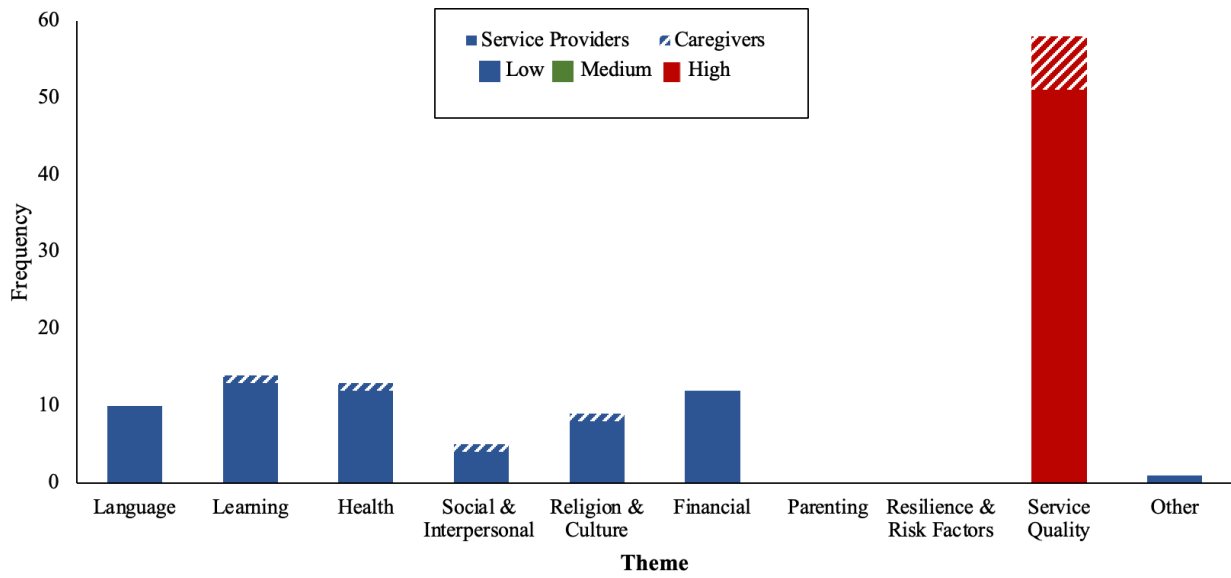


Figure 4 Refugee Strengths.

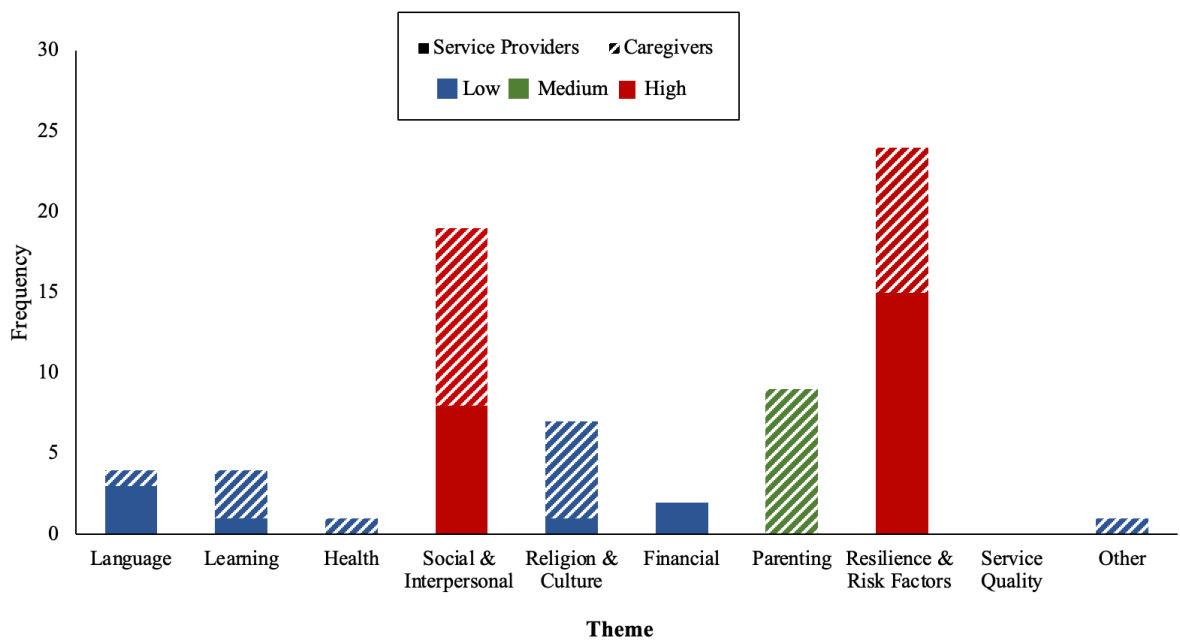


Figure 5 Service Strengths.

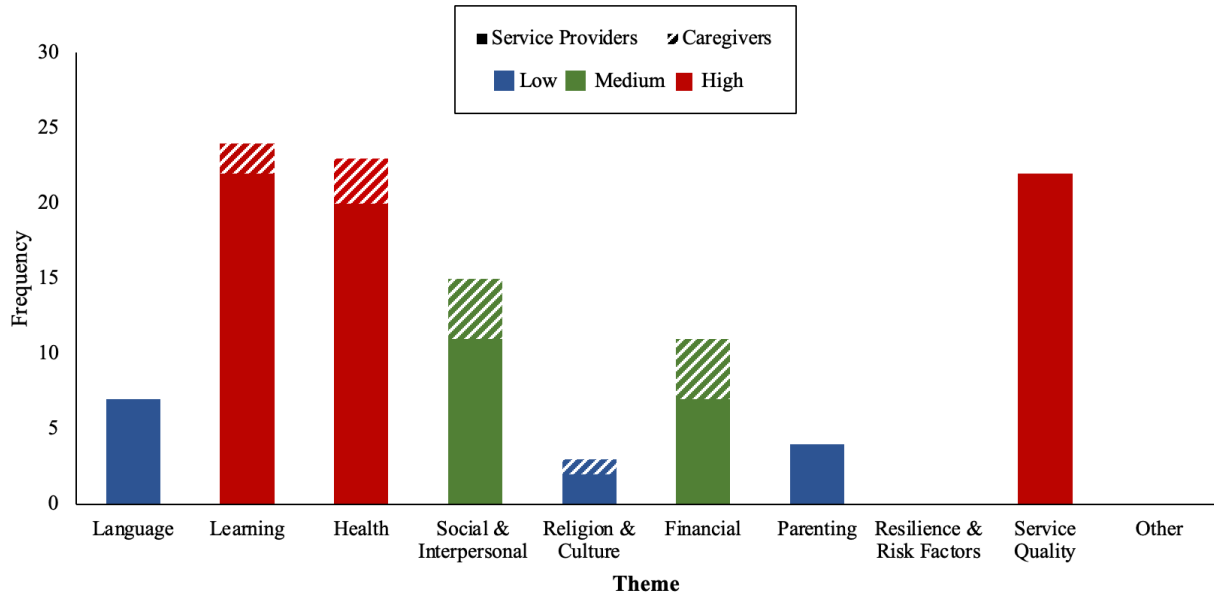


Figure 6 Recommendations.

