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"We could see our real selves:" The COVID-19 syndemic and the transition to telehealth for a school-based prevention program for newcomer Latinx immigrant youth

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Abstract

Newcomer Latinx immigrant youths in the United States are currently in a syndemic of increased risk of behavioral health concerns, disparities in access to related services, and are disproportionately impacted by the COVID-19 pandemic. This study used qualitative inquiry to examine the impact that the transition to telehealth had on a school-based group prevention program for immigrant youth, *Fuerte*, within the context of this syndemic. Data included semi-structured interviews with group leaders, and focus groups with youth program participants. Themes indicated both positive and negative impacts of the transition to telehealth on program component implementation, youth participant engagement, and youth participant social connectedness. Despite the telehealth model, youth participants reported that they felt socially connected to each other through the program. This study's results provide implications for the potential value and drawbacks of a telehealth prevention model for newcomer immigrant youth, as well as deepening understanding of how virtual behavioral health programs may operate in socially isolating contexts around the world.

KEYWORDS

behavioral health, community-based participatory action research, COVID-19, immigrant youth, Latinx, prevention, syndemic

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1 | INTRODUCTION

Immigrants in the United States, and particularly recent arrivals and the undocumented, may be disproportionately impacted by the coronavirus disease 2019 (COVID-19) pandemic (Clark et al., 2020), creating a synergistic effect with direct consequences. The traumatic experiences of migration, along with the context of reception (e.g., anti-immigrant political climate), deeply intersect with disparities in access to basic needs and human rights (e.g., housing, legal advocacy), thereby contributing to social determinants of mental and physical health (Mccabe & Kinney 2010). Pandemic-related school closures negatively impacted the academic engagement and mental health of children worldwide, particularly newcomer immigrant children who are more likely to have been exposed to violence, and who are also amid acculturation and language learning (Kim, 2020). Therefore, it was imperative that school-based psychological services for immigrant children quickly adapt, using a community psychology lens, to be delivered remotely. Additionally, these services also needed to carefully address challenges with engagement as well as effectively navigate the syndemic of COVID-19, immigration-related traumatic stress, and socioeconomic and health disparities.

Increased migration to the United States (Batalova et al., 2021) has resulted in 44.9 million immigrants or 13.7% of the total population, currently living in the United States (Batalova et al., 2021). Over the last decade, a surge of unaccompanied children, as well as children in family units, from Latin America began migrating across the US–Mexico border (United Nations High Commissioner for Refugees, 2014). In 2019, a record 73,000 unaccompanied youth were apprehended at the border, with approximately 86% originating from El Salvador, Guatemala, and Honduras (US Customs and Border Protection, 2020). While the numbers of unaccompanied minors apprehended at the border fell significantly in 2020 due to the pandemic and stringent immigration laws, the numbers began to rise again with the change in US administration in January 2021, and more favorable travel conditions in the spring season (Morin, 2021). Since then, the number of immigrant children and families entering the US from the Southwest border has increased exponentially, with Central American countries continuing to lead in countries of origin of new minor and family unit arrivals (US Customs and Border Protection, 2022).

When COVID-19 began to spread around the world as a global pandemic, cases in the United States rose to 20 million infections in 2020, with more than 346,000 deaths (American Journal of Managed Care Staff 2021). The COVID-19 pandemic particularly impacted vulnerable populations of children within the educational system. Following shelter-in-place regulations, schools transitioned to remote learning, often without adequate technological knowledge or equipment (Human Rights Watch, 2020). In April of 2021, approximately 23.1 million households with children in the United States received online or virtual teaching (Duffin, 2021). However, over 181,000 households had children who did not attend school at all, even virtually, due to their schools being closed to all educational services (Duffin, 2021). These numbers are likely even higher, given the extremely limited research on the educational impact of pandemic-related school closures. Early evidence also demonstrates that vulnerable immigrant children were disproportionately impacted by COVID-19 (Fredricks et al., 2020). For immigrant children and unaccompanied minors specifically, the pandemic has deeply impacted social, cultural, political, educational, psychological, and interpersonal experiences (Popyk, 2020).

These broad-reaching and at times traumatic experiences may have had a particularly devastating, synergistic impact on vulnerable immigrant families with prior exposure to migration trauma. Immigrant youth leave their countries for a variety of reasons, including to reunite with family members, seek safer living conditions, and escape extreme poverty and violence (United Nations High Commissioner for Refugees, 2014). Before, during, and following migration, immigrants may be exposed to violence, family separation, political and economic uncertainty, barriers to basic needs and human rights, and a difficult context of reception (e.g., anti-immigrant political climate; Birman, 2011; Patel et al., 2016, 2021; Sangalang et al., 2019). This exposure to poverty, violence, political uncertainty, and instability places migrant youth among the most vulnerable to developing psychological distress, traumatic stress reactions, and decreased well-being (Bean et al., 2007; Derulyn et al., 2009; Hodes, 2000; Michelson & Sclare, 2009; Thibeault et al., 2017).

Further compounding trauma exposure, there is a synergistic tie to disparities in terms of behavioral health services (Alegría et al., 2015; Birman, 2011). Already at a disadvantage regarding access to much-needed mental health services, the COVID-19 pandemic has substantially increased barriers to mental health care provision and utilization for vulnerable immigrant youth (Pfefferbaum & North, 2020). Opportunities to offer mental health services during the pandemic were made difficult due to shelter-in-place confinement and the delivery of programs via telemedicine. Unfortunately, there was already a shortage of effective mental healthcare before the pandemic, which only worsened throughout 2020 (Rauch et al., 2020). Vulnerable immigrants have been disproportionately impacted during this time due to a synergetic aggregation of barriers to care. Even before the pandemic, immigrant individuals often were underinsured, may have feared deportation, experienced language, and technology barriers, faced discrimination, and had difficulty navigating complicated health care systems (Galvan et al., 2021; Suárez-Orozco & Yoshikawa, 2013). In addition, immigrant families from Latin America are more likely to access mental health support through community-based programs, schools, and emergency medical services. Many organizations serving immigrant and refugee youth have reported that drastic, rapid changes were needed to continue supporting families, including dissemination of information, active outreach, extensive case management, and creative tele-health communication (Endale et al., 2020).

In addition to impacting community mental health provision and services, the COVID-19 pandemic significantly altered the experiences of vulnerable immigrant children at school (Kim, 2020). Shelter-in-place policies resulted in increased isolation, difficulty engaging in remote learning, excessive confinement, financial issues from parents' job losses, and increased rates of witnessing domestic violence (Human Rights Watch, 2020; Kim, 2020; Rothman et al., 2020). Those on the front lines have also observed deteriorating mental health, including suicidality and heightened levels of stress. These new realities have had a profound impact on immigrant children, who are particularly reliant on schools to learn the local language, make friends, access free/subsidized lunch, engage in academics, stay active, and culturally adapt to the local cultures (Jaeger & Blaabaek, 2020; Kim, 2020; Popyk, 2020; Rothman et al., 2020). When schools transitioned online, many immigrant children faced difficulty engaging in academics due to language barriers, limited technical and academic support, lower levels of motivation, and peer isolation (Jaeger & Blaabaek, 2020; Popyk, 2020). The prolonged period of online schooling also had a significant impact on immigrant children's opportunities to develop strong mentorship relationships, that might otherwise naturally develop within school settings (Popyk, 2020). To address the syndemic of migration-related psychological trauma, pandemic-related school closures, and the services gap for vulnerable immigrant youth, contextually informed adaptations to school-based mental health services were urgently needed to allow for effective teletherapy administration. A better understanding of the lessons learned during this rapid transition can inform future provision of telehealth services for highly vulnerable populations of immigrant children and families. Community psychology is uniquely positioned through its founding principles to best inform how we use these lessons with social justice frameworks.

One program impacted by the pandemic and school closures was the *Fuerte* program (Martinez et al., 2020), a brief, school-based prevention program delivered in a group modality targeting newcomer Latinx immigrant middle and high school students in a school district in California. *Fuerte* is an evidence-based program, using elements of cognitive-behavioral principles and the Attachment, Self-Regulation, and Competency framework (see Blaustein & Kinniburgh, 2010). The program is delivered in a group format in school settings, with approximately 4–8 youths enrolled in each group, and is relatively brief, consisting of eight sessions to complete the curriculum. *Fuerte*'s goal is to eliminate health disparities within the Latinx newcomer immigrant youth community by targeting three primary outcomes: (1) screening, identification, and linkage of youth at-risk for mental health concerns to specialty mental health services; (2) increasing youth's mental health literacy (Jorm, 2012); and (3) improving youth's social connectedness (Borraccino et al., 2020). Due to pandemic-related school closures beginning in March 2020, and the switch to a remote learning environment, the program had to quickly transition to a telehealth adaptation and implementation.

Data in the present study were collected as part of a hybrid effectiveness-implementation trial (Curran et al. 2012) of the *Fuerte* program. Guided by the core tenants of community psychology, the program's design, implementation, and evaluation utilized community-based participatory methods at each stage (Centers for Disease Control and Prevention

2015), and are described in further detail in Martinez et al. (2020). Following school closures, the *Fuerte* program was delivered via videoconferencing software, a modality that it was not initially designed for. Before the shift to remote learning, recruitment of study participants was done in person, largely through support staff in school-based health centers (SBHC), who also provide medical and behavioral health support services to students and are co-located within each high school in the district. However, all recruitment during remote learning was done telephonically by the *Fuerte* study team, in collaboration with staff at the SBHC. Furthermore, the bandwidth of Wellness Center staff was limited due to the ongoing academic, socioeconomic, and socioemotional needs of students associated with the pandemic, and thus, recruitment was difficult without both the support of Wellness Center staff, as well as eligible participants being able to meet with study team members in person during the school day to learn more about the program. Many eligible participants could not be reached by phone, and of those connected with telephonically, many were apprehensive about strangers contacting them about a program serving newcomer immigrant youth, particularly in the context of a recent wave of anti-immigrant rhetoric within the United States.

Despite these difficulties, the *Fuerte* program was still able to provide support to support to youths during the 2020–2021 school year. The present qualitative study seeks to explore *Fuerte*'s adaptation to telehealth in the context of the syndemic of COVID-19, immigration-related traumatic stress, and behavioral health access disparities. More specifically, the study focused on the perceptions of group leaders and youth participants of how well *Fuerte* was able to meet its intended primary outcomes during the shift to a telehealth model. Informed by community psychology principles, this study exemplifies prevention, social justice, respect for diversity, and active citizen participation.

2 | METHODS

The study was approved by the Institutional Review Board of the first author's home institution, as well as respective research review departments for both the school district and the county public health department where the study took place. The hybrid effectiveness-implementation trial was originally intended to be conducted in person across 8–10 high schools. However, due to the switch to remote learning, and the significant difficulties with recruitment through remote methods, the telehealth adaptation of the *Fuerte* program was offered only for students enrolled in two high schools with large numbers of immigrant youth, and where there were already strong stakeholder ties to our program to facilitate recruitment.

2.1 | Participants

2.1.1 | Youth participants

Youth participants were recruited through high school SBHCs, which provide support for students' physical, mental, and emotional health. Each SBHC has a lead coordinator with access to rosters of students identified as newcomers to the United States. Students were eligible to participate in the program if they had arrived in the United States within the last five years of the group initiating, were from a Latin American country, were high school students, and were predominantly Spanish speaking. The SBHC coordinators assisted *Fuerte* project personnel with identification and outreach for students who met criteria to participate in the *Fuerte* groups.

All youth participating in the *Fuerte* program were eligible to be a part of the present study. For the 2020–2021 academic year, a total of 32 students participated in the *Fuerte* program, across six separate groups, in two different high schools. The high schools predominantly served low-income and diverse communities in the school district, with one high school reporting 89% of students being socioeconomically disadvantaged and the second high school reporting 62% of students. Of the students who participated in the *Fuerte* program, 25 (78.1%) consented to have their data used for research purposes, and among those, a total of 12 (48.0%) participated in focus groups for the

present study. There were no significant differences in age, gender, and country of origin for youths who consented to research and those that did not, nor were there any differences between youths who participated in the focus groups versus those who chose not to participate. Demographic information on participants can be found in Table 1.

2.1.2 | Group leaders

Each *Fuerte* group had two group leaders, and at least one of the group leaders was either a master's or doctoral level licensed behavioral health clinician, or a master's or doctoral level trainee supervised by a licensed clinician. Non-licensed group leaders were typically Wellness Center staff or case managers, who had experience working with immigrant youth populations with behavioral health issues yet were not licensed to practice independently. All group leaders ($N = 9$) delivering *Fuerte* groups during the 2020–2021 academic year were invited to participate in semi-structured interviews at the conclusion of their groups, and eight (88.9%) agreed to participate. Demographic information on group leaders can be found in Table 2.

2.2 | Procedure

2.2.1 | Youth participant focus groups

A youth participant focus group was held for each of the six *Fuerte* groups that were conducted during the 2020–2021 academic year. The six focus groups were held via Zoom videoconferencing software within two weeks of the last session of the *Fuerte* program. All efforts were made to hold focus groups on the same day and time that the group was held to increase participation, but a few focus groups were rescheduled following low participant

TABLE 1 Youth focus group participant characteristics ($N = 12$)

Demographic characteristics	*n*	(%)
Gender		
Female	8	(66.7)
Male	4	(33.3)
Country of birth		
Honduras	3	(25.0)
El Salvador	2	(16.7)
Guatemala	7	(58.3)
Race or Ethnicity		
Latinx	9	(75.0)
Mayan	1	(8.3)
Other	1	(8.3)
Don't know	1	(8.3)
Age, years, mean (*SD*)	17.4	(1.2)

Abbreviation: *SD*, standard deviation.

TABLE 2 Group facilitator characteristics ($N = 8$)

Demographic characteristics	*n*	(%)
Gender		
Female	7	(87.5)
Male	1	(12.5)
Country of birth		
United States	7	(87.5)
Mexico	1	(12.5)
Race or ethnicity		
Latinx	5	(62.5)
Mixed race	1	(12.5)
White	2	(25.0)
Highest level of education		
Bachelor's degree	2	(25.0)
Post-graduate degree	6	(75.0)
Education status		
Professional	4	(50.0)
Trainee	4	(50.0)
Discipline		
Social work	2	(25.0)
Psychology	6	(75.0)
Age, years, mean (*SD*)	30.1	(6.9)

Abbreviation: *SD*, standard deviation.

show rates. All focus groups were conducted in Spanish by the third and fourth authors, who are certified to provide bilingual healthcare services through an institutional bilingual certification program. Both focus group facilitators are bicultural female project members, one is a Latin American immigrant to the United States, with one holding a terminal master's degree and the other a doctoral student in clinical psychology. The two group interviewers were trained by the first author in qualitative data collection methods, and a subset of focus groups was reviewed by the first author (also certified to provide services in Spanish) for quality assurance. All recordings of focus groups were transcribed by an undergraduate research assistant who is fluent in Spanish, and an immigrant from Central America.

Focus groups averaged 38.2 min ($SD = 6.6$ min). Student participants were consented approximately 2–3 weeks before the initiation of the *Fuerte* groups as part of the overarching hybrid effectiveness-implementation trial, which including consenting and agreeing to be contacted to participate in a focus group within two weeks of the last session of the *Fuerte* program. Informed consent was gathered from all youth participants using Zoom videoconferencing software. Digital signatures were gathered through REDCap (Harris et al., 2019), a HIPAA-compliant survey and database management software. Youth participants received a $20 gift card for participating in the focus group.

2.2.2 | Group leader interviews

All group leader interviews were conducted through individual interviews using Zoom videoconferencing software. Interviews were held within 3 weeks of the last group session. Interviews were conducted in English by a master's level clinical research coordinator. All interviews were recorded and then transcribed by undergraduate research assistants. A subset of transcriptions was reviewed by the first author for quality assurance. Group leader interviews averaged 35.0 min in length (*SD* = 9.0 min). Informed consent was gathered from all group leaders before the start of their semi-structured interviews using similar procedures to those of youth participants, and each group leader received a $40 gift card for their participation.

2.3 | Measures

2.3.1 | Demographics

Demographic data from youth participants were collected via surveys using HIPAA-compliant REDCap data management and survey software hosted at the first author's institution. Surveys were administered using Zoom videoconferencing software, and items were read aloud to participants, while the RedCap survey screen was shared with them. Youth participant demographic questions were completed within 2 weeks to the onset of the *Fuerte* groups, and were part of a larger survey completed for the planned hybrid effectiveness-implementation trial. Demographic data from group leaders were collected by project personnel following their interviews. Relevant demographic data collected for the present study included year of arrival in the United States, country of origin, gender, age, and race or ethnicity.

2.3.2 | Youth focus group guide

The youth focus group guide was developed by the first and fourth author to assess what went well during the *Fuerte* program, what needed improvement, and what kinds of things helped or impeded their engagement in the program. Questions started broadly (e.g., W*hat did you like best about the groups?*), and more specific probes were included to facilitate discussion including probes focused on engagement (e.g., *Are there things in your life that made it difficult to participate in Fuerte?*), the use of technology (e.g., *How did Zoom help make the Fuerte groups more convenient for you?*), as well as suggestions for future improvements to the program (e.g., *Are there things you wished Fuerte had that it currently does not?).* Items on the focus group guide were developed as part of the hybrid effectiveness-implementation trial to gather qualitative data on groups following each group's administration, and to allow for iterative changes to take place in the program based on youth participants and group leader feedback. Items were developed in partnership with various stakeholders including school and county personnel, as well as previous participants in the *Fuerte* program. For the present study focused on the adaptation to the telehealth model of *Fuerte*, items in the focus group guide were adapted slightly to account for remote service delivery. For example, questions about the use of Zoom and access to technology were included.

2.3.3 | Group leader interview guide

The group leader interview guide was similarly structured to the youth participant guide and developed with input from relevant stakeholders, including former group leaders. For the present study, questions were adapted to include items specifically focusing on the delivery of *Fuerte* through a telehealth model, and how the telehealth

model may have facilitated or created barriers for *Fuerte* group leaders. Questions started out broadly (e.g., *Tell us about things that didn't go as well with the groups*) and more specific probes were used as needed to facilitate discussion (e.g., *Was Zoom an engaging way to deliver the Fuerte groups? Why or why not?).*

2.4 | Data analysis

Semantic thematic analysis (Braun & Clarke, 2006) was used to code data for overarching themes and subthemes. The coding system was developed by the first, third, and fourth authors using an initial subsample of three group leader interviews and three group participant interviews, and developed using themes from the literature, as well as outcomes for the program evaluation. Once the codebook was developed, the first author coded one group leader interview and one youth participant focus group, which served as an example for coding. Data were independently coded by the first, third, and fourth authors, and an undergraduate research assistant, all trained by the first author in qualitative data analysis methods. Data for group leader interviews and focus groups were coded and analyzed separately. Data were aggregated according to participant type, allowing us to see unique patterns that emerged in responses between youth participants and group leaders.

All coders were bilingual in Spanish, bicultural (Latinx), and two coders were immigrants to the United States. Coding of focus groups data was completed in the original Spanish language of the group interview, as per best practices for cultural and linguistic accuracy in qualitative (Squires, 2009) and intervention research (Griner & Smith, 2006). For the present manuscript, all quotes in Spanish were translated to English through consensus by the first, third, and fourth authors. To establish inter-rater agreement, all interview transcripts were double-coded, and any coding discrepancies were discussed and resolved through group consensus (Lincoln & Guba, 1985).

3 | RESULTS

Analysis of interview and focus group data resulted in three overarching themes: (1) Telehealth modifications, (2) program engagement, and (3) social connectedness. Within each theme, both positive and negative factors were reported, which emerged as subthemes and are described below.

3.1 | Telehealth modifications

The Telehealth Modifications theme focused on the specific impact that the delivery of *Fuerte* over Zoom teleconferencing software had on programmatic elements. Participants described both benefits and drawbacks of these modifications. It should be noted that several group leaders ($n = 3$) had administered the *Fuerte* program in person before the pandemic, and thus had the ability to compare the telehealth version to the in-person model. However, all group leaders, in one way or another, made comparisons between the telehealth model and in-person services. This contrasted with the youth participants, who all participated in *Fuerte* for the first time during the pandemic, and so were only exposed to the telehealth model. Regardless, findings suggested that, for the most part, group leaders and youth participants were aligned in describing both positive and negative aspects of telehealth modifications.

3.1.1 | Positive factors

Both youth participants and group leaders reported several positive factors of delivering the *Fuerte* program through a telehealth model, particularly providing comparisons between the benefits of doing the groups over

Zoom teleconferencing software versus in person in the school setting. Several group leaders reported that adapting the *Fuerte* program for delivery over telehealth made it easier to deliver the program within a school-based (remote) setting, by eliminating the need for group leaders to travel to school sites, as well as reducing some of the complexities of delivering programming in physical school environments, for example, having to find a space big enough to conduct the group. For example, one group leader reported, "In term of accessibility, we didn't have the layers of school environment and travel [time], so for me as a [group leader] it made it easier, it cuts that out…and time [is] a valuable resource."

Several group leaders also reported that a telehealth model provided opportunities for different kinds of creativity in delivering the program, compared to what might otherwise be used during in-person sessions. For example, all group leaders mentioned that the use of digital tools through the Zoom interface, such as digital whiteboards and various websites (e.g., videos to demonstrate coping skills), helped them find creative ways to deliver the intervention to youth participants, who, as "digital natives," may be more familiar with technological advances than the group leaders. Several group leaders suggested that this perhaps provided an advantage over doing the groups in person. For example, one group leader noted, "I really feel as though…Zoom offers some opportunities…[using] the whiteboard feature and [since] kids are very tech savvy now… it's kind of meeting them where they are at, in a sense…"

Additionally, both group leaders and youth participants explained that the telehealth model allowed youth participants to share things about themselves, their interests, and their home environments in ways that in-person sessions at school might not allow. Some youth participants and group leaders provided examples of them sharing elements of the youth's home environments, for example, family pictures, using the Zoom screening sharing function. One group leader noted, "…having the flexibility of sharing in the moment instead of 'I'll bring it next week' it just kept the flow [of the session]."

Both youth participants and group leaders reported that doing groups over telehealth allowed youth participants to communicate more flexibly than what would be possible for groups conducted in person. Youth participants also reported enjoying the flexibility that Zoom allowed them, particularly for youth who had more difficulty expressing difficult emotions in a group setting. For example, some youth participants explained that to communicate in a group, they had the option of "texting" using the chat function, could communicate verbally via a microphone, and make the decision to turn on their camera or leave it off. These options may have allowed youth to communicate in a more developmentally attuned manner, as they communicate with their peers outside of school over text or video calls. One group participant summed up these expressions by stating, "I see it being better like this over Zoom, talking to people…"

3.1.2 | Negative factors

Many youth focus group participants and group leaders reported that the greatest barrier for the telehealth administration of the *Fuerte* program was a lack of stable internet connection. Several youth participants reported being dropped from sessions due to poor internet connections, not being able to sign on to Zoom or if signed on, their internet connection was not strong enough to hear or see participants well. Similarly, several youth participants reported audio and video quality issues due to their unstable or slow internet connections. A few youth participants and group leaders also reported that some students in the groups lacked adequate speakers, microphones, or cameras for engaging in videoconferencing. For example, a youth participant explained, "…the worst session I had was not the fault of the group leaders but rather the fault of technology because I would be kicked off and then [have to] sign on, so it was difficult…"

Similarly, a group leader described feeling that, although youth were still able to share their thoughts and feelings in the group, it seemed as though this would have been better facilitated in an in-person group setting:

> I wonder if in-person, people might just more readily share their thoughts…I think the format was just another barrier to being able to share…often when kids would turn on their camera and turn on their sound there was a lot of other stuff going on in the room with them, we noticed a lot of music or other people…even with those barriers I was impressed with how much they were willing and able to share. But it felt more structured, like [we would say] 'ok your turn now, then your turn" not just a more organic conversation, which maybe would've happened in-person.

Several youth participants conveyed their discomfort with how activities were adapted over telehealth, particularly their discomfort with engaging in group activities remotely over Zoom rather than in an in-person setting. One youth participant noted, "…because when we engaged in creative activities, like when we danced, we were all separated [from one another], and you did not feel the same energy, so that is something that I did not like."

3.2 | Program engagement

The Program Engagement theme emerged from youth participants and group leaders reporting how the delivery of groups over telehealth helped or hindered youth participants from attending and participating in the *Fuerte* program.

3.2.1 | Positive factors

Several youths reported that the telehealth model facilitated comfort engaging with others in the *Fuerte* program. A few participants even reported more engagement with *Fuerte* than with both remote learning and in-person interactions with classmates. For example, one youth participant shared that participating in *Fuerte* helped him feel more comfortable speaking publicly over Zoom as opposed to when he had to do so in remote learning settings:

> I liked joining [the *Fuerte*] group through Zoom as it helped me take away my fear. You know, I'm a little fearful, I'm someone who is, how should I say, timid to speak around other people, but since school was online, I didn't talk very much, but the meeting of this program helped me…to speak more, especially using a microphone.

In addition, some participants mentioned that the ability to turn off their cameras allowed them to engage with the group on a deeper level over time. One youth participant specifically mentioned that allowing youth to have their cameras off at first until they were comfortable to turn them on, if ever, helped foster a system of trust:

> I also think that for some who are not very confident to socialize, I think it was very beautiful. At the beginning, I also liked it, and it helped me a lot to socialize…with people. First with the camera turned off [enthusiastic voice] and later [when I was] a little more at ease with turning on the camera. I do think that this helped me a lot personally. I do think it helped a lot. It helped to create a more trustworthy system.

Several group leaders and youth participants reported that telehealth allowed participants with competing responsibilities to join with more flexibility. Some participants joined from their lunch break at work, from a bus, from a car, or while caring for their siblings. The following participant reported joining regularly at times when he would have otherwise not been able to join, "I have to drop-off my sister and afterward I could join [Zoom] and I could also drop-off her off at the same time while listening to the topics we discuss [in our group meetings]."

In addition, both the youth participants and the group leaders reported that when youth participants found their surroundings distracting or loud, as the following group leader describes, participants quickly found alternative ways to engage virtually when they lacked privacy:

> They didn't always show their faces, but I think that's more to do because they were sharing space, so I noticed they'd type in their answers [in the chat function] like 'I'm sorry but there's someone here' or 'I had to move' or things like that … that was another plus, students that maybe wouldn't have been able to attend were [able to do so]… and they seemed really comfortable, especially with the chat option.

3.2.2 | Negative factors

While the telehealth model allowed youth participants to attend from anywhere that they could log onto an internet connection, several participants reported struggling to find access to private spaces to speak comfortably. Several youth participants also noted having difficulty engaging due to the noise level of their surroundings. Therefore, the context of youths' home environments appeared to have an impact on whether they perceived positive or negative impacts on engagement through the telehealth model. For example, one youth participant described feeling uncomfortable when they lacked privacy, "We have to share bedrooms or people come to visit or our siblings are here…sometimes it's difficult to talk about how you are feeling [when you don't have privacy]."

> Finally, group leaders often found it challenging to re-engage students who they might have otherwise been able to reach at school in-person. For example, a group leader explained:
>
> We had like six or seven kids originally signed up, so I wonder what happened to those other kids … I think that's probably one of the downsides of being online … When we did it at the middle school last year … my co-facilitator was a school personnel person and she had rapport already with kids. [So she] would go track them down and find them [laughs]…so we had every kid every time that we were there in person.

3.3 | Social connectedness

The impact of telehealth on one of *Fuerte's* primary outcomes, social connectedness, was examined in both youth and facilitator focus groups, to explore whether the telehealth model was successful at facilitating youths' social connections and belonging. Thematic analysis revealed that the telehealth modality consistently functioned as a facilitator to establishing social connections among youth participants, although some youth participants noted barriers as well.

3.3.1 | Positive factors

Both group leaders and youth participants reported that the delivery of *Fuerte* over telehealth was conducive to establishing and maintaining a sense of social connectedness. Collectively, youth participants described the telehealth adaptation of *Fuerte* as facilitating the opportunity to discover a new way to socialize with peers, a platform

to build friendships, and a safe venue to express themselves authentically without judgment. During the pandemic, many youths were socially isolated due to regional stay-at-home orders, and within this context, the *Fuerte* groups provided a venue for these youths to connect with other students. One participant described their experience of having to modify the way they socialize and get to know other students who attend their school, given the distance learning during the COVID-19 pandemic, "…getting to know new people even though we are in the same school, but perhaps we didn't know each other and we didn't speak, but we could [now] communicate through the [*Fuerte*] group."

Focus group participants experienced the delivery of *Fuerte* over telehealth as a platform to build new friendships. Students stated their favorite *Fuerte* modules consisted of reciprocal dialog of their personal interests, future plans, hopes and worries, and experiences as immigrants, culminating in a sense of social connectedness amongst participants. For example, one youth participant described how *Fuerte* created a sense of belonging and shared experience:

> *Fuerte* is a great group because we share our ideas and dreams for our future, and other things about ourselves, and we share these with the group…I learned a lot of things about [other youth participants], and they learned about me too.

Another youth participant compared the group's sense of social connectedness to that of family unity, "…we had a [session] where we had to communicate like family members that hardly speak, and it allows us to not only connect with our family but also with [other *Fuerte* participants]." Similarly, a group leader reported the impact on youth participants:

> …I again was in some ways surprised [by] how much they at the end seemed to really appreciate it… one of [the youth participants] said, 'you know this feels like a family and I'm gonna miss you'…to only be connected six times online and to whatever degree those sentiments were true [laughs]…it just felt like [the *Fuerte* program]really filled [a] need for them.

Group leaders indicated that the delivery of *Fuerte* through telehealth led to several positive outcomes such as building a sense of relatability to others, as well as a sense of unity between group leaders and youth participants, affirming group leaders' enthusiasm in participating in the program. The following group leader shared how she created a sense of social connectedness to the participants and shared their strategies to create a virtual space that students found motivating, positive, and meaningful:

> I do remember how important and valuable it was to me when participants shared their experiences and opened up to us and were able to get on that deeper level… so that made me feel that [the group leaders] were very supportive and we were able to provide a safe space for them. So that was really neat to watch and to experience, and I do remember going back [to] the voices of the participants… towards the end they didn't want [the program] to end. They did share that 'oh it's ending so soon, is there future sessions?' So they voiced that they were really interested in [the *Fuerte* program] and wanted to continue in the future.

Many youth participants endorsed feeling happy, valued, and part of a community because of participating in the *Fuerte* program. Youth participants expressed virtual participation in *Fuerte* facilitated safe and confidential space to express themselves authentically without judgment. For example, one participant expressed how the last session was her favorite, as it allowed her to share her poetry with others and feel connected to a community, "So it was very encouraging for me to hear other people who tell me, 'Hey, I love what you do.' Therefore without a

doubt, the last session was my favorite." Similarly, another student indicated that feeling connected to participants and group leaders allowed her to engage in self-reflection and self-expression:

> …it was a space where we could express ourselves, a space where we could see our real selves. See in what we are weaker in and in what gives us strength…where I was working with my classmates and I would say 'Today you are going to do something you like, and today you are going to do something you don't like to do.' Therefore, it is very nice to see the equilibrium between negative and positive things, that was my favorite part of the group.

3.3.2 | Negative factors

While almost all youth participants reported that the telehealth delivery of *Fuerte* helped facilitate social connectedness a few group leaders reported barriers in establishing and maintaining social connectedness amongst *Fuerte* participants and leaders. For example, one group leader attributed a lack of rapport with students due to not all students turning on their cameras during group. One youth participant, unlike most other youth participants, reported that she never felt close enough to other youth participants to share her personal feelings, "I think that it is difficult to talk about your feelings and it is hard for many, and it is also difficult for me because sometimes you just don't feel comfortable discussing this with others."

4 | DISCUSSION

The COVID-19 pandemic served to further exacerbate the pre-existing syndemic of high risk for trauma-related mental health concerns and lack of access to healthcare for newcomer immigrant youth (Alegria et al., 2015; Birman, 2011; Thibeault et al., 2017). In particular, low-income newcomer immigrant youth and unaccompanied minors from the Central American countries of El Salvador, Guatemala, and Honduras are highly vulnerable. Minimal research has examined mental health prevention programming on this population. Furthermore, we could find no studies examining newcomer immigrant youth's perceptions of adapting an in-person program to a remote, telehealth model.

The present study provides one such example, using a community psychology framework and qualitative inquiry to examine the *Fuerte* program, a school-based prevention program for newcomer immigrant youth, after the program transitioned to a telehealth model following shelter-in-place county guidelines in March 2020. Results indicate that delivering a prevention modality over telehealth can potentially foster social connectedness in the context of an isolating pandemic, suggesting an important way to support such a highly vulnerable population.

The main focus of this study was the feasibility of implementing the components of *Fuerte* via telehealth. The *Fuerte* program focuses on improving three primary outcomes among newcomer immigrant high school youth: (1) screening and linkage to specialty mental health services; (2) mental health literacy; and (3) social connectedness. While we found that conducting groups via telehealth created several barriers to program implementation, there were important and novel ways in which implementation was facilitated by the online format. Results were particularly promising in this regard with respect to social connectedness.

The study did not specifically address issues in screening and linkage to mental health services. This is not done in the group with participants, but primarily administratively through screening participants out who are at risk for mental health concerns and then referring them to Wellness Center coordinators for linkages to specialty mental health community-based organizations. During the pandemic, many of the local community-based organizations were either closed or operating at reduced capacity through telehealth, leading to large waitlists across the city, particularly for youths who required bilingual clinical services. Therefore, as these are aspects of the program that

are done administratively through the schools, the first outcome was not a theme that came up during any of our focus groups or interviews, as this was largely handled "behind-the-scenes." However, the present study did provide some preliminary qualitative data suggesting that a telehealth model may be helpful for youths to improve the other two program outcomes – their mental health literacy, and their social connectedness.

Our findings suggest that the adapted telehealth model may be especially important for this highly vulnerable population who remained further socially isolated throughout the pandemic. In the context of COVID-19, the remote aspects of the groups were reported by youth participants to facilitate social connectedness to others, during a time when many youths spent little time outside the home due to regional stay-at-home orders, and thus lacked the physical spaces, such as those in school, to interact and socially connect with peers. It is possible that telehealth methods are beneficial for other groups of youth that remain socially isolated regardless of the pandemic, such as those living in more rural areas with smaller numbers of newcomer immigrant families (Goodridge & Marciniuk, 2016; Martyr et al., 2019; Stewart et al., 2020). The importance of social connectedness for the mental wellbeing of immigrants has been well documented in the literature (e.g., Gray et al., 2015; Rogers-Sirin et al., 2013), and this study's results indicate that a telehealth model may be helpful in facilitating social connections, particularly for those in the most socially-isolated contexts.

While our findings offer insights into issues to consider when structuring a group via telehealth, it is important to note that we found that often the same issues were both a barrier and a facilitator. For example, group leaders noted that students' ability to turn their cameras off was a barrier in building rapport with the group. However, for youth participants, communicating without a camera was a positive way to participate in the group while preserving their privacy, giving them the ability gradually increase their engagement as they grew more comfortable with the group. Similarly, digital technology-facilitated communication and participation using chat and digital whiteboards, tools that were not available in non-telehealth program administration. These tools allowed group leaders to help improve participants' mental health literacy through novel ways to deliver the *Fuerte* curriculum on psychoeducation. However, the lack of stable internet connection to use the technology was a barrier. Similarly, being unable to join the group at the school was a barrier for some who joined from home, and noise and distractions made it more difficult to participate. At the same time, not having to be in school also made it easier for some to participate, given the flexibility to join from other locations while also meeting their work and family obligations. Therefore, others developing school-based groups for immigrant youth should consider their particular circumstances to determine how our findings might transfer to another setting.

Regardless, it would be beneficial to address or better understand the negative factors or barriers to implementing *Fuerte*. Further understanding of these factors will allow us to design a stronger telehealth model of the program, and further test its feasibility with this and other newcomer populations. More specifically, engagement appears to be an issue that is more difficult to address with the telehealth model for some youth. And for some youths, without the necessary resources, in terms of both technology and private space, a telehealth model is anything but feasible. It will be important to fully understand the needs of the population that is proposed to be served by telehealth adaptations, to account for these, and other, potential barriers.

5 | LIMITATIONS

Some limitations of this study include that results may not be generalizable to all newcomer immigrant youths, particularly those not from Central American countries. Additionally, the sample only included slightly less than half of all students who participated in the *Fuerte* program during the 2020–2021 school year, and it is possible that the students who did not participate in the focus groups may have had a unique perspective to share. However, the possibility of this is low, as difficulties with recruitment for the focus groups largely stemmed from scheduling complexities and finding a time that worked for most group members. Additionally, the study took place within two (remote) high schools that had strong partnerships with the research team, and thus, it is possible that if the program were to be delivered in schools where academic-community partnerships were weaker, the results may

differ. Finally, recruitment of participants during the pandemic was much more difficult than when the program was held in person. Many youths were difficult to reach and thus, the youths who participated in the telehealth model of *Fuerte* may not be representative of all those who typically participate in the in-person *Fuerte* program.

6 | CONCLUSIONS

In sum, this study provides promising preliminary evidence in support of telehealth adaptation of prevention programs for immigrant youth, in particular as a method for fostering social connectedness in the context of isolation. COVID-19 has had an immense, syndemic impact on underserved and high-risk populations like newcomer youth from Central America, much of which be yet to be seen, in terms of the longer-term effects on academic achievement and socioemotional health. School-based mental health services that rapidly adapted to telehealth administration during the school closures in 2020 played a critical role in keeping these youth connected to each other and to their schools. This study's analysis of barriers and facilitators to telehealth adaptation holds important lessons for future telehealth adaptations of prevention programs, as well as clues about novel ways to reduce mental health access barriers for other communities facing social isolation.

Finally, the lessons learned in the present study have implications for understanding the delivery of prevention programming to newcomer youth globally. Specifically, lower-income countries may want to consider whether telehealth delivery of behavioral health services for newcomers may be a less resource-intense service in these greatly stressed regions of the world. Even in higher-income countries, newcomer migrant populations present many difficulties for finding trained personnel able to deliver services in the language of newcomer populations. Telehealth allows for the recruitment of these personnel from anywhere in the world and provides yet another tool for behavioral health experts, nongovernmental organizations, and other human rights activists to use to improve the behavioral health of newcomer immigrant youth.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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REFERENCES

Alegría, M., Green, J. G., McLaughlin, K. A., & Loder, S. (2015). *Disparities in child and adolescent mental health and mental health services in the U.S.* William T. Grant Foundation. https://wtgrantfoundation.org/library/uploads/2015/09/Disparities-in-Child-and-Adolescent-Mental-Health.pdf

American Journal of Managed Care Staff. (2021). *A timeline of COVID-19 developments in 2020*. https://www.ajmc.com/view/a-timeline-of-covid19-developments-in-2020

Batalova, J., Hanna, M., & Levesque, C. (2021). *Frequently requested statistics on immigrants and immigration in the United States*. The Online Journal of the Migration Policy Institute. https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states-2020#demographic-educational-linguistic

Bean, T., Derluyn, I., Eurelings-Bontekoe, E., Broekaert, E., & Spinhoven, P. (2007). Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents. *Journal of Nervous and Mental Disease*, *195*(4), 288–297. https://doi.org/10.1097/01.nmd.0000243751.49499.93

Birman, D. (2011). Migration and well-being: Beyond the macrosystem. *Psychosocial Intervention*, *20*(3), 339–342. https://doi.org/10.5093/in2011v20n3a11

Blaustein, M. E., & Kinniburgh, K. M. (2010). *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency*. Guilford Press.

Borraccino, A., Berchialla, P., Dalmasso, P., Sciannameo, V., Vieno, A., Lazzeri, G., Charrier, L., & Lemma, P. (2020). Connectedness as a protective factor in immigrant youth: Results from the Health Behaviours in School-aged Children (HBSC) Italian study. *International Journal of Public Health*, *65*(3), 303–312. https://doi.org/10.1007/s00038-020-01355-w

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Centers for Disease Control and Prevention. (2015). *Principles of community engagement* (2nd ed.). Agency for Toxic Substances and Disease Registry. https://www.atsdr.cdc.gov/communityengagement

Clark, E., Fredricks, K., Woc-Colburn, L., Bottazzi, M., & Weatherhead, J. (2020). Disproportionate impact of the COVID-19 pandemic on immigrant communities in the United States. *PLoS Neglected Tropical Diseases*, *14*(7), 1–9. https://doi.org/10.1371/journal.pntd.0008484

Curran, G. M., Bauer, M., Mittman, B., Pyne, J. M., & Stetler, C. (2012). Effectiveness-implementation hybrid designs: Combining elements of clinical effectiveness and implementation research to enhance public health impact. *Medical Care*, *50*(3), 217–226. https://doi.org/10.1097/MLR.0b013e3182408812

Derulyn, I., Meis, C., & Broekaert, E. (2009). Mental health problems in separated refugee adolescents. *Journal of Adolescent Health*, *44*(3), 291–297. https://doi.org/10.1016/j.jadohealth.2008.07.016

Duffin, E. (2021). Impact of COVID-19 on children's education, by number of households U.S. 2021. Statista. https://www.statista.com/statistics/1197154/covid-19-impact-childrens-education-number-of-households-us

Endale, T., Jean, N. S., & Birman, D. (2020). COVID-19 and refugee and immigrant youth: A community-based mental health perspective. *Psychological Trauma: Theory, Research Practice, and Policy*, *12*, 225–227. https://doi.org/10.1037/tra0000875

Fredricks, K., Woc-Colburn, L., Bottazi, M. e, & Weatherhead, J. (2020). Disproportionate impact of the COVID-19 pandemic on immigrant communities in the United States. *PLoS Neglected Tropical Diseases*, *14*(7), 0008484. https://doi.org/10.1371/journal.pntd.0008484

Galvan, T., Lill, S., & Garcini, L. M. (2021). Another brick in the wall: Healthcare access difficulties and their implications for undocumented Latino/a immigrants. *Journal of Immigrant and Minority Health*, *23*(10), 885–894. https://doi.org/10.1007/s10903-021-01187-7

Goodridge, D., & Marciniuk, D. (2016). Rural and remote care: Overcoming the challenges of distance. *Chronic Respiratory Disease*, *13*(2), 192–203. https://doi.org/10.1177/1479972316633414

Gray, N. N., Mendlesohn, D. M., & Omoto, A. M. (2015). Community connectedness, challenges, and resilience among gay Latino immigrants. *American Journal of Community Psychology*, *55*, 202–214. https://doi.org/10.1007/s10464-014-9697-4

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice & Training*, *43*, 531–548.

Harris, P. A., Taylor, R., Minor, B. L., Elliott, V., Fernandez, M., O'neal, L., Mcleod, L., Delacqua, G., Delacqua, F., Kirby, J., Duda, S. N., & REDCap, C. (2019). The REDCap consortium: Building an international community of software platform partners. *Journal of Biomedical Informatics*, *95*, 103208. https://doi.org/10.1016/j.jbi.2019.103208

Hodes, M. (2000). Psychological distressed refugee children in the United Kingdom. *Child Psychology & Psychiatry Review*, *5*(2), 57–68. https://doi.org/10.1017/S136064170000215X

Human Rights Watch. (2020). COVID-19's devastating impact on children. https://www.hrw.org/news/2020/04/09/covid-19s-devastating-impact-children

Jaeger, M. M., & Blaabaek, E. H. (2020). Inequality in learning opportunities during COVID-19. *Research in Social Stratification and Mobility*, *68*, 100524. https://doi.org/10.1016/j.4ssm.2020.100524

Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist*, *67*(3), 231–243. https://doi.org/10.1037/a0025957

Kim, J. (2020). With remote learning, a 12-year-old knows her English is slipping away. https://www.nytimes.com/2020/12/29/nyregion/coronavirus-english-language-students.html

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage. https://doi.org/10.4135/97814129862681.n232

Martinez, W., Chhabra, D., Cooch, P., Oo, H., Vo, H., Romano, A., Farahmand, F., Rocha, M., San Miguel, R., Romero, M., Quintanilla, A., & Matlow, R. (2020). Patient and Community engagement for mental health disparities in Latinx youth immigrant populations: The Fuerte program. In A. Breland-Noble (Ed.), *Community mental health engagement with racially diverse populations*. Academic Press. https://doi.org/10.1016/B978-0-12-818012-9.00008-3

Martyr, M. A., & Kivlighan, D. M., III, Ali, S. R. (2019). The role of telepsychology training clinics in addressing health disparities with rural Latinx immigrant communities. *Translational Issues in Psychological Science*, *5*(4), 346–354. https://doi.org/10.1037/tps0000208

Mccabe, H. A., & Kinney, E. D. (2010). Medical legal partnerships: A key strategy for addressing social determinants of health. *Journal of General Internal Medicine*, *25*, 200–201. https://doi.org/10.1007/s11606-010-1298-9

Michelson, D., & Sclare, I. (2009). Psychological needs, service utilization and provision of care in a specialist mental health clinic for young refugees: A comparative study. *Clinical Child Psychology and Psychiatry*, *14*(2), 273–296. https://doi.org/10.1177/1359104508100889

Morin, R. (2021). 'We get the brunt': How the influx of migrants at the US-Mexico border is playing out in Texas border towns. https://www.msn.com/en-us/news/us/we-get-the-brunt-in-texas-border-towns-in-the-rio-grande-valley-life-intertwines-with-migrant-surge/ar-AAKF2EA

Patel, S. G., Bouche, V., Martinez, W., Barajas, K., Garcia, A., Sztainer, M., & Hawkins, H. (2021). "Se extraña todo:" Family separation and reunification experiences among unaccompanied adolescent migrants from Central America. *New Directions for Child and Adolescent Development*, *176*, 227–244. https://doi.org/10.1002/cad.20404

Patel, S. G., Clarke, A. V., Eltareb, F., Macciomei, E. E., & Wickham, R. E. (2016). Newcomer immigrant adolescents: A mixed-methods examination of family stressors and school outcomes. *School Psychology Quarterly*, *31*(2), 163–180. https://doi.org/10.1037/spq0000140

Pfefferbaum, B., & North, C. S. (2020). Mental health and the COVID-19 pandemic. *The New England Journal of Medicine*, *383*(6), 510–512. https://doi.org/10.1056/NEJMp2008017

Popyk, A. (2020). The impact of distance learning on the social practices of schoolchildren during the COVID-19 pandemic: Reconstructing values of migrant children in Poland. *European Societies*, *23*(5), 530–544. https://doi.org/10.1080/14616696.2020.1831038

Rauch, S. A. M., Simon, N. M., & Rothbaum, B. O. (2020). Rising tide: Responding to the mental health impact of the COVID-19 pandemic. *Depression and Anxiety*, *37*(6), 505–509. https://doi.org/10.1002/da.23058

Rogers-Sirin, L., Ryce, P., & Sirin, S. (2013). Acculturation, acculturative stress, and cultural mismatch and their influences on immigrant children and adolescents' well-being. In R. Dimitrova, M. Bender, & F. van de Vijver (Eds.), *Global perspectives on well-being in immigrant families*. Springer. https://doi.org/10.1007/978-1-4614-9129-3_2

Rothman, S., Gunturu, S., & Korenis, P. (2020). The mental health impact of the COVID-19 epidemic on immigrants and racial and ethnic minorities. *QJM: Monthly Journal of the Association of Physicians*, *113*(11), 779–782. https://doi.org/10.1093/qjmed/hcaa203

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

Stewart, R. W., Orengo-Aguayo, R., Young, J., Wallace, M. M., Cohen, J. A., Mannarino, A. P., & de Arellano, M. A. (2020). Feasibility and effectiveness of a telehealth service delivery model for treating childhood posttraumatic stress: A community-based, open pilot trial of trauma-focused cognitive–behavioral therapy. *Journal of Psychotherapy Integration*, *30*(2), 274–289. https://doi.org/10.1037/int0000225

Squires, A. (2009). Methodological challenges in cross-language qualitative research: A research review. *International Journal of Nursing Studies*, *46*(2), 277–287. https://doi.org/10.1016/j.ijnurstu.2008.08.006

Suárez-Orozco, C., & Yoshikawa, H. (2013). Undocumented status: Implications for child development, policy, and ethical research. *New Directions for Child and Adolescent Development*, *141*, 61–78. https://doi.org/10.1002/cad.20043

Thibeault, M. A., Mendez, J. L., Nelson-Gray, R. O., & Stein, G. L. (2017). Impact of trauma exposure and acculturative stress on internalizing symptoms for recently arrived migrant-origin youth: Results from a community-based partnership. *Journal of Community Psychology*, *45*(2), 800. https://doi.org/10.1002/jcop.21905

United Nations High Commissioner for Refugees. (2014). Children on the run: Unaccompanied children leaving Central America and Mexico and the need for international protection. https://www.unhcr.org/56fc266f4.html

US Customs and Border Protection. (2020). US border patrol Southwest Border apprehensions by sector fiscal year 2020. https://www.cbp.gov/newsroom/stats/sw-border-migration/usbp-sw-border-apprehensions-fy2020

US Customs and Border Protection. (2022). Southwest land border encounters (by component). https://www.cbp.gov/newsroom/stats/southwest-land-border-encounters-by-component

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