University of St. Thomas, Minnesota
St. Catherine University

Social Work Master's Clinical Research Papers   School of Social Work

2014

Better Mental Health Service Provision for Somali Youth: Overcoming the Barriers

Megan Jacobs
University of St. Thomas, Minnesota

Follow this and additional works at: https://ir.stthomas.edu/ssw_mstrp

Part of the Clinical and Medical Social Work Commons, and the Social Work Commons

Better Mental Health Service Provision for Somali Youth:

Overcoming the Barriers

by

Megan Jacobs, BSW

MSW Clinical Research Paper

Presented by the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

Committee Members
Catherine Marrs Fuchsel, Ph.D., LICSW
David McGraw-Schuchman, MSW, LICSW
Eva Solomonson, MSW, LICSW

Abstract

It is estimated that there are over 50,000 Somali refugees currently living in Minnesota, making Minnesota the largest resettlement location for Somalis in the United States (World Relief Minnesota, 2013). Research has shown that refugees, including the Somali community, experience higher rates of mental health concerns and seek less mental health treatment than any group. This phenomenon is even more prominent in refugee youth (Ellis, Lincoln, Charney, Ford-Paz, Benson & Strunin, 2010). There is a gap in the current research on Somali youth mental health and how to overcome the current barriers to treatment. This study examines the data from eight qualitative interviews with human service personnel with experience working with Somali youth. These interviews explored the participants' understanding of Somali youth mental health, the Somali cultural view of mental health and its treatment, current barriers that keep Somali youth out of the mental health service delivery system, and strategies to overcome those barriers in order to provide better mental health services for Somali youth. The themes from the data suggest that it is critical to understand the Somali worldview, as well as the unique stressors Somali youth face, in order to engage in more effective mental health treatment with this population. The data also identifies current barriers, as well as various approaches to overcoming those barriers. The implications of this research may be used to inform micro level practice changes for human service personnel, as well as mezzo and macro level policy changes within our mental health service delivery system.

Keywords: Somali youth, mental health services

Acknowledgements

It is my honor to thank the many individuals who helped support me throughout this

research process and graduate program.

To my committee chair, Catherine Marrs Fuchsel, PhD., LICSW, thank you so much for

your guidance and support throughout this process. You have shared your passion for

research and your gift for writing. Thank you for your dedication to my work!

To my committee members, David McGraw-Schuchman, MSW, LICSW and Eva

Solomonson, MSW, LICSW, thank you both so much for taking the time out of your

busy lives to support my research. I have appreciated greatly how you've challenged me

and engaged in my writing enthusiastically. David, thank you for all of your help

throughout the process, from sending me current research to connecting me with others

who are passionate about serving Somali youth. Thank you both!

To my participants, thank you for taking the time to share your knowledge and

experience with me. Without you there is no research! Thank you for all of the work you

are doing in the Somali community.

Thank you to my family and friends for your unwavering support of me throughout this

process! I could not do any of it without all of you. To my friends, thank you for reading

my work and being interested in my project. To my parents, thank you for instilling the

drive and love for learning in me. And most importantly, to my husband, thank you for

being my biggest fan and greatest support throughout this program. Words cannot

express my gratitude for all of your encouragement and understanding. You inspire and

challenge me everyday. Thank you.

To Daniel, thank you for stretching my heart and teaching me more about what it means

to help people. Thank you for making me a better me.

And finally, to my Heavenly Father, thank you for all that you've laid before me and

behind. Thank you for the opportunity to learn and grow in the passion you've put inside

me. Be glorified!

Somali Youth Mental Health

Table of Contents

Somali Youth Mental Health

Better Mental Health Service Provision for Somali Youth:

Overcoming the Barriers

The need to provide better mental health services for refugees, specifically Somali

youth, is critical. There are currently more than 10 million refugees worldwide (UNHCR,

2013). A refugee is, as defined by the United Nations, "someone who has been forced to

flee his or her country because of persecution, war or violence" (USA for UNHCR,

2013). There are millions of refugees who have psychological symptoms due to the

traumatic events they have experienced, such as war, loss of family members, and

displacement.

Among this group of refugees is the Somali population. Somalia is a country on

the eastern side of the continent of Africa. Not unlike other refugee groups, the Somali

community has undergone significant trauma. Over two million individuals living in

Somalia have been uprooted from their homes due to a civil war, which broke out in 1991

(Refugees International, 2012). Approximately 1.3 million Somalis are currently

displaced within Somalia and another one million have been forced out of the country

(Refugees International, 2012). Over the past 20 years, a Somali community in

Minnesota has developed. It is estimated that there are over 50,000 Somali refugees

currently living in Minnesota (World Relief Minnesota, 2013). This number is significant

because it indicates that Minnesota has the largest Somali population in the United States

(World Relief Minnesota, 2013).

Among the growing Somali population in Minnesota is a generation of young

people greatly affected by their pasts. They are often coping with violence, loss of family

members, and other concerns due to displacement, as well as trying to acculturate in their

new environment. Research has indicated that refugee youth often have "significant

mental health needs" but their level of utilization of mental health services does not meet

the level of use by their non-refugee counterparts (Ellis, Lincoln, Charney, Ford-Paz,

Benson & Strunin, 2010, p. 790).

One can conclude that Somali youth are underserved when it comes to mental

health services, although the need is apparent. There are several likely reasons for this.

The most commonly discussed reasons in the literature include the language barrier and

differing cultural beliefs about mental health (Ellis & Lincoln et al., 2010). Other

barriers, which can prevent refugee youth from utilizing mental health services discussed

in the literature include resettlement stressors, such as housing and other basic needs

(Ellis, Miller, Baldwin, & Abdi, 2011). The obstacles to engaging Somali youth in mental

health treatment are complex and unique to each young person and family, but it is

important to look at the commonalities within the Somali community in order to

determine the best way to provide effective mental health services.

This research project strived to further dissect and articulate the mental health

needs of Somali youth and how to provide the most effective and culturally appropriate

mental health services for them. The researcher defined Somali youth as young people

ages 0-18 who reside within a traditional Somali family. A traditional Somali family

includes families who have one or more members residing in the home that are first

generation migrants to the United States, speak Somali in the home, or adhere to

traditional Somali culture through food, religion, dress, etc. The researcher gathered

knowledge and content expertise from mental health providers and other human service

personnel who have experience working with the Somali community. Some of the

participants were Somali themselves, but not all. The prevailing criterion for participation

in this study was experience working with Somali youth in the context of a professional

helping relationship. Through this project, the researcher added to the current literature

on this topic. It is vitally important that a better understanding about how to overcome the

current barriers for this population is reached because thousands of Somali young people

are in need of quality mental health services. The goal in this research project was to

answer the following research question, how can barriers be overcome so that more

effective mental health services are provided for Somali youth?

Literature Review

Refugees

The number of individuals and families that have left their home countries due to

violence, persecution, poverty, or simply, a hope for a better life is constantly growing.

Estimations have been made that there are currently 12 million refugees and asylum

seekers around the world (Ellis et al., 2011). The United States, just one of many host

countries, has nearly one million refugees living within its borders (Ellis et al., 2011). If

immigrants are included in that number, the United States is a new home to 21 million

individuals (Ellis & Lincoln et al., 2010). Those twenty-one million people have

undergone huge transitions, even experienced trauma, in order to settle in a new place.

The commonality shared by refugees is the circumstances in their home countries.

Whether living in a refugee camp or having resettled decades ago, all refugees fall under

the United Nations definition, which means they have undergone severe persecution, war,

or violence, which has resulted in them involuntarily leaving their home country (USA

for UNHCR, 2013). Due to these risk factors, refugees have an increased susceptibility to mental health concerns (Ellis & Lincoln et al., 2010).

      Mental health. One study found that an "average of more than 50% of refugees present with mental health problems" (Guerin, Guerin, Diiriye & Yates, 2004, p. 59). Post Traumatic Stress Disorder (PTSD) and Depression are among the most common diagnoses for refugees. Depression rates among immigrants and refugees is estimated at 47-72% and PTSD rates between 39%-100%, as compared to the 1% prevalence of PTSD in the general population (Schuchman & McDonald, 2004). Unfortunately, studies have also shown that ethnic minorities use mental health services less than their majority counterparts and that refugees use mental health services even less than ethnic minorities (Ellis & Lincoln et al., 2010). These findings indicate that refugees are grossly underserved by the mental health service delivery system. "An estimated 92% of immigrants and refugees deemed in need of mental health services never receive them" (Ellis et al., 2011, p. 70). It is also important to note that when minorities, including refugees, do seek mental health care it is often "later and at a more critical stage" (Loewenthal, Mohamed, Mukhopadhyay, Ganesh & Thomas, 2012, p. 43).

      Conclusively, refugees are frequently in high need of mental health services due to their backgrounds and exposure to significant risk factors, but they often do not receive services and when they do it is often late in the progression of symptoms. In a seminal article, Gong-Guy, Craven, and Patterson (1991) reported on barriers to accessing mental health services: (a) language, (b) lack of bi-cultural practitioners, (c) lack of understanding about the United States health and mental health care systems, (d) different understanding about the problem and helpful treatments, and (e) a high volume of

somatic complaints brought to providers other than mental health professionals. Although Gong-Guy, Craven, and Patterson's list is not all encompassing it provides a starting point to understanding why refugees' mental health needs are often not addressed. A closer look at barriers to providing mental health services to Somali youth in particular will follow, but it is important to note some of the common barriers amongst all refugees.

Refugee youth mental health. Approximately 50% of refugees in the United States are under 18 years old. This means there is a high percentage of refugee youth, who have undergone immense stress and trauma, living in our communities (Ellis & Lincoln et al., 2010). The stress and trauma that refugee children have endured have, "devastating effects" on them (Center for Victims of Torture, p. 1). The Center for Victims of Torture, a program that provides mental health services for refugees in the Minneapolis, Minnesota area, describe some symptoms refugee children may experience due to the trauma they have experienced including, being, "stunned, numb, unresponsive, mute or hyperaroused, hyperactive or frantic" (p. 1).

Much like their adult counterparts, refugee children experience high rates of depression and PTSD. Studies show that 1/3 of refugee children, who had resettled in North America, met criteria for depression and 63% met criteria for PTSD. These statistics are significant, but not surprising when 60% of the same refugee children reported that they had experienced "death through war or political unrest of family members" (Heptinstall, Sethna & Taylor, 2004, p. 376).

There are millions of refugees around the world at risk for mental health disturbances who are not being treated. Each refugee group has similar experiences in their home countries, but each group has a different history, culture, and belief system

that impacts their mental health and their utilization of mental health services. Taking a

closer look at the Somali community is critical to understanding how mental health

practitioners can better serve Somali youth.

Somali Experience

As previously mentioned, millions of Somali people were displaced from their

homes as a result of the violence that broke out after the start of the civil war in Somalia

in 1991 (Refugees International, 2012). It is estimated that 50,000-75,000 Somalis have

resettled in Minnesota (Schuchman & McDonald, 2004). A study from 2004 showed that

the median age of a Somali refugee, now residing in Minnesota, when they left Somalia

was 15 and the median number of years since they arrived in the United States was 4.2

years (Halcon, Robertson, Savik, Johnson, Spring, Butcher, Westermeyer & Jaranson,

2004). In 2011, it was reported that the median age of the Somali community in

Minnesota was 25 years (Williams, 2011). These statistics show that the Somali

community that has settled in Minnesota is relatively young and relatively new to the

country as a whole.

The Somali community faces much stress in migrating, resettling, and

acculturating. Many Somalis have faced multiple traumas as a result of violence,

persecution, and even torture (Schuchman & McDonald, 2004). They then face additional

stressors upon arrival in the United States. A study done on Somali refugees in the

Minneapolis, Minnesota area depicted some of the obstacles Somali refugees must

endure. For example, 50% of Somali refugees reported difficulty with learning English

and 44.7% of females and 50.8% of males reported that they found "American life hard

to understand" (Halcon et al., 2004, p.22).

The Somali community has faced war, death, and violence, which leave them at risk for mental health concerns. There is a "high correlation between trauma/torture and psychological problems" leading to PTSD, depression, and anxiety disorders (Halcon et al., 2004 p. 23). Somali refugees' use of mental health services aligns with the research on refugees' use of mental health services as a whole. One study reported that "60% of those [Somalis who reported emotional problems] had not seen anyone" for their mental health needs (Guerin et al., 2004, p. 59).

Mental health concerns. Somali underutilization of mental health services is not for lack of need. Of the Somali refugees studied in Minnesota, 49.2% of females and 30.6% of males reported, "feeling alone" (Halcon et al., 2004, p. 22). Similarly, a study of Somali women in the United States found that feeling isolated is a common sentiment and they quoted a Somali woman saying, "we [Somalis] have depression" (Pavlish, Noor & Brandt, 2010, p. 355). The most common mental health complaints by Somalis are somatic symptoms, including, "body pain, headaches, sleep problems," fatigue or low energy, "decreased appetite and weight loss or gain," difficulties with memory, concentration or "thinking too much," and, "flashbacks, nightmares and a heightened startle response" (Schuchman & McDonald, p.70). The feelings of isolation often exacerbate these mental health symptoms (Schuchman & McDonald, 2004).

Somali individuals are commonly diagnosed with PTSD, depression, or anxiety (Schuchman & McDonald, 2004). A study on Somali women in Minnesota found that 60% of Somali women had both depression and PTSD, compared to 3.4% of non-Somali women. Additionally, at one clinic in Minnesota, 80% of the Somali men under the age

of thirty presented with psychoses, which was compared with the non-Somali control

group, which had a rate of psychoses of 13.7% (Kroll, Yusuf & Fujiwara, 2011).

      Mental health from a Somali cultural perspective. In order to better serve the

mental health needs of the Somali community, the Somali perspective and understanding

about mental health must be explored and integrated. The primary way in which the

traditional Somali population describes issues or symptoms relating to mental illness is

by using the word *waali,* which means crazy in Somali (Schuchman & McDonald, 2004).

The Somali language lacks the descriptors that differentiate varying degrees of mental

illness, as in the English language (Schuchman & McDonald, 2004; Warfa, Bhui, Craig,

Curtis, Mohamud, Stansfeld, McCrone & Thornicroft, 2006). Therefore, either a person

is *waali* or they are not. For instance, in Somalia someone who is *waali* may, "go around

throwing stones, yelling, hitting, eating from the dumpsters, and walking around naked"

(Guerin et al., 2004, p. 60). These people are, "considered a danger to themselves and

others" and may be put in a hospital or when hospital access is limited, chained up apart

from their community (Guerin et al., 2004, p. 60). More "mild" mental health symptoms,

such as somatic symptoms, difficulty sleeping, or crying are often accepted as a part of

everyday life (Guerin et al., 2004). It makes sense that mental health symptoms

associated with many disorders are not reported for fear of being shamefully labeled

waali in the Somali community (Schuchman & McDonald, 2004). The differences in the

Somali language from English and other western languages, related to mental illness is a

huge piece in understanding the Somali worldview of mental illness.

      Along with understanding the Somali language for mental illness, it is equally

important to understand the Somali belief system behind the causes of mental illness.

Many in the Somali community believe that evil spirits, or *jinn*, cause mental illness (Schuchman & McDonald, 2004). Most Somalis are Muslim and their religion is often central to their belief system about the world, as seen in this core belief about the cause of mental illness (Pavlish et al, 2010). Many times, Somali individuals are seeking help to reunify with their family because they believe that will make their symptoms go away (Guerin et al., 2004). They may also attribute mental health symptoms, like of PTSD for example, as being caused by separation from their family and the adjustments that come with being in a new country, as opposed to the trauma they have endured (Guerin et al., 2004). A third overarching concept that is important to understand is that trials and hardship are often accepted as part of the Islamic god, Allah's will and even sometimes viewed as part of Allah's punishment (Guerin et al., 2004; Pavlish et al., 2010; Schuchman & McDonald, 2004). When considering the common Somali beliefs about the causes of mental health symptoms, it is imperative to note the importance placed on religion and family and community, as opposed to the mainstream Western individualistic, medical approach.

With the language differences and beliefs about etiology of mental illness in mind, the means of treatment many Somalis prefer are more easily understood. For instance, Somali individuals struggling with mental illness may seek out a religious leader or participate in readings from the Quran, the religious text of the Islam religion, or prayer. Alternatively, Somalis may get family counseling from an elder in the community because problems are seen as a family or community issue, which should be dealt with within the Somali community (Guerin et al., 2004; Schuchman & McDonald, 2004). Additionally, Somalis may be drawn to alternative therapies, such as massage

therapy, because their symptoms can be experienced as heavily somatic (Guerin et al., 2004). It is important to note that individual treatment or treatment that focuses on the past can be confusing or seen as not helpful by Somali individuals. One Somali person was quoted as saying that therapy, in its traditional sense, was, "not Somali" and another Somali individual pointed out the differences in views about expressing one's problems by saying, "why would you want to talk about your issues?" (Ellis & Lincoln et al., 2010, p. 801).

It is critical to see that the Somali beliefs about mental health and the appropriate treatments can be vastly different than the Western worldview. With an understanding of what the Somali community has faced, what their mental health concerns are, and how they conceptualize mental illness and its treatment broadly, we are able to look at Somali youth in particular through more of an informed lens.

Somali Youth Mental Health

Research has shown that over 25% of refugee youth have a "significant psychological disturbance," which is three times the national average (Fazel & Stein, 2003, p. 134). There is a substantial number of Somali youth in the Minneapolis, Minnesota community, who are susceptible to the psychological disturbances previously noted. For instance, there are currently, "approximately 5% of school-aged children in Minneapolis speak Somali at home," which means there are many young refugees from Somalia living in this area who may have unmet mental health needs (Kroll et al., 2011, p. 482).

Somali youth are at-risk for mental illness for the same reasons that refugees are broadly, but they also have some unique struggles of their own. Research done on Somali

youth who have resettled in the United States or a similar Western culture has shown that

these children face issues such as lack of language fluency, lack of education/interrupted

schooling, absent family members, poverty, and cultural exposure that their parents lack.

A particular point of difficulty for Somali families can be that children gain English

language skills more quickly than their parents do. This alters the family dynamics by

giving children more power. Somali children are immersed into western culture through

the public education system, which opens their eyes to a vastly different perspective on

family, gender roles, religion, and parenting. Somali youth can often begin to stray from

the Somali language, Islamic beliefs, and cultural practices, such as respecting their

parents and elders, due to this exposure (Guerin, Guerin, Abdi & Diiriye, 2003). One

prime example of a difference in Somalia and the western world is parent involvement in

their child's school, which can create turmoil between youth and their parents. "In

Somalia, parents were not often involved in their children schooling…Indeed, it was

often thought a bad thing for a parent to visit a school since that almost always meant that

their child was in trouble for something" (Guerin et al., 2003, p. 185). This cultural

difference in parenting styles impacts Somali youth because they may begin to feel

disconnected to their parents due to them not parenting the same way that some

mainstream western parents do. This phenomenon can create conflict between youth and

their parents because the young person may not feel as understood or cared about due to

the differing views on parenting.

　　　　Another factor that has been shown to impact the mental health of Somali youth is

perceived discrimination. A strong relationship has been established between one's

personal experience with discrimination and, "poorer mental health outcomes" (Ellis,

MacDonald, Lincoln & Cabral, 2008). Seventy-two percent of Somali adolescents reported that they had experienced one or more discriminatory act (Ellis, MacDonald, Klunk-Gillis, Lincoln, Strunin & Cabral, 2010). Additionally, the research has shown that PTSD and depression correlate with discrimination (Ellis & MacDonald et al., 2010). The adolescents who participated in one particular study voiced feelings that the discrimination was directed at them most for being Muslim (Ellis & MacDonald et al., 2010). It was discussed that Somali girls have a harder time acculturating due to the traditional Muslim headdress, which may result in increased discrimination and therefore higher rates of PTSD and depression (Ellis & MacDonald et al., 2010). These results speak to the impact that life after resettlement, not just before resettlement, has on Somali youths' mental health.

Coping strategies. Somali youth can have many challenges when it comes to their mental health, which they cope with in various ways. Unfortunately, refugee youth utilize mental health services even less than the general refugee population (Ellis, Miller, Baldwin & Abdi, 2011). The refugee population utilizes mental health services less than the minority population, which is less than the majority population (Ellis, Miller, Baldwin & Abdi, 2011). In short, refugee children, including Somali children are getting very little mental health care. In a study on Somali youth, 20% met criteria for PTSD and 3% of those children with PTSD also met criteria for depression (Ellis & Lincoln et al., 2010). Only 12% engaged in any kind of help-seeking behavior, not just from mental health practitioners, but any help (Ellis et al., 2010). Two percent of that 12% sought help through prayer (Ellis et al., 2010). In general, it was concluded that Somali youth do not normally seek out help on their own (Ellis & Lincoln et al., 2010). The Somali youth

interviewed reported that, "hiding problems is central to the Somali culture" and that they did not seek help because they did not want to "burden the parents" (Ellis & Lincoln et al., 2010, p. 800). Somali children suffer silently because of the, "generational breakdown" (Guerin et al., 2003, p. 185) they feel with their parents, as described above, and their sense that they must hold in their concerns (Ellis & Lincoln et al., 2010).

Somali youth have faced, and continue to face, trauma, stress, and hardship around past trauma, migration, and acculturation (Center for Health and Health Care in Schools, 2008). They are unique in the cultural, religious, and generational shifts they are facing. Many Somali youth are in need of mental health services and support, but they are often not receiving it for various reasons. In order to more adequately meet their needs it is important to understand the current barriers preventing adequate mental health service delivery.

Barriers

After reviewing the literature, six main barriers to providing Somali youth with mental health services emerged. This researcher put the barriers in order of perceived impact, from the greatest barrier to the smallest barrier, per the researcher's opinion. These barriers include cultural beliefs, lack of culturally integrated services, resettlement stressors as priority, lack of understanding of the service delivery system, language and interpreters, and transportation.

Cultural beliefs. The first barrier to mental health services for Somali youth is the Somali perspective and understanding of mental illness. Due to the cultural and religious beliefs about mental illness there is a powerful stigma that comes along with receiving mental health services, which is a huge deterrent to seeking help (Ellis et al.,

2011). Also, the discrepancies in Somali and Western beliefs about the problem and its

cause can lead to a disconnect when it comes to treatment planning (Ellis & Lincoln et

al., 2010; Gong-Guy et al., 1991; Guerin et al., 2004). Language differences and beliefs

about the problem and its cause lead to different ideas about who should be sought out for

help (Ellis & Lincoln et al., 2010; Guerin et al., 2004).

Lack of culturally integrated services. The lack of culturally integrated services

is a barrier because Somali youth are forced to either seek services within the Somali

community, including a Muslim religious leader, or with a Western practitioner. Somali

youth are not given very many options that integrate components of Somali culture and

beliefs and Western beliefs (Ellis & Lincoln et al., 2010). This one-or-the-other set up

may contribute to the generation cultural gap that is often experienced by Somali youth.

They can be put in a position where they are expected to pick a culture, when in most

other cases they are encouraged to be bi-cultural. Most often, Somali youth need a parent

to consent to treatment, so it would additionally help involve parents if culturally

integrated services were offered. Similar to this concept is the need for more bi-cultural

mental health providers, which would assist in integrating Somali culture with traditional

Western mental health service provision (Gong-Guy et al., 1991; Schuchman &

McDonald, 2004).

Resettlement stressors as priority. The literature speaks to the fact that Somali

refugees often have many immediate concerns upon resettlement in the United States that

overshadow mental health concerns, such as employment, language, housing, schooling,

transportation, etc. Due to the high priority set on getting settled and acculturated many

families, youth included, will not seek out services simply because of other, often times more immediate, needs (Ellis et al., 2011; Gong-Guy et al., 1991).

Lack of understanding of the service delivery system. The lack of understanding of mental health services can be as simple as not knowing what is available. This is a likely barrier for Somali youth and families who have recently arrived in the United States (Christensen, 2010; Gong-Guy et al., 1991). Being unaware of services can lead to the common occurrence of a Somali individual bringing their concerns and symptoms to their family doctor. This can be a barrier because the doctor may or may not refer them to a mental health provider. If they do refer them to a mental health provider, the family might not understand what a referral is or why they were referred, which may result in them not following through with the appointment (Gong-Guy et al., 1991; Guerin et al., 2004).

Language and interpreters. Language and interpreters can be barriers to providing mental health services because of the risk of mistranslation (Guerin et al., 2004) or the client's concerns about using an interpreter for fear that their confidentiality will not be kept (Loewenthal et al., 2012). When these fears are present or mistranslating issues have arisen in the past, it may prevent a Somali youth or their families from seeking or supporting others in seeking services. Full language proficiency can take approximately eight years, so often times an interpreter is needed (Ellis & Lincoln et al., 2010).

Transportation. Transportation is a good example of one of the several likely logistical barriers that prevent Somali youth from engaging in mental health services

(Guerin et al., 2004). Similarly, lack of providers in a rural area may be another example of a logistical barrier to mental health service engagement.

Although each individual has their own unique set of obstacles that may keep them from engaging in mental health services, providers need to be aware of the common barriers in order to best address them. Particularly for Somali youth and their families, barriers such as cultural beliefs about mental health, lack of culturally integrated services, primary needs following resettlement, lack of understanding of the service delivery system, language and interpreters, and logistical concerns should be considered when attempting to engage this population.

Overcoming Barriers

There are several ways that the literature suggests to overcome the barriers to engaging Somali youth in mental health services. The suggestions include engaging the family and community, partnering with "cultural experts" (p. 73), implementing services within an existing, trusted service system, and taking a comprehensive approach (Ellis et al., 2011).

Engaging family and community. When developing a program, and as an on-going best-practice, programs should partner with the Somali community, particularly with the families of the clients being served (Christensen, 2010; Ellis et al., 2011; Ellis & Lincoln et al., 2010; Guerin et al., 2004; Schuchman & McDonald, 2004). This means engaging with the "key stakeholders" (Ellis at el., 2011) and hosting community events where the voices of the recipients can be heard (Christensen, 2010). Along with receiving input, these partnerships can also open a door to provide psychoeducation to the Somali community (Ellis & Lincoln et al., 2010).

Partner with cultural experts. Partnering with cultural experts can include interpreters or cultural brokers (Ellis et al., 2011). More broadly, it means that the program is engaging in integrative services where there is room for religious ceremonies or other culturally appropriate practices (Schuchman & McDonald, 2004). As discussed earlier, this gives the Somali youth the option to be bi-cultural in the treatment of their mental health symptoms and it strives to ensure that Somalis believe in their treatment and its hope for success.

Programs within existing systems. The literature suggests the best placement for a mental health program striving to reach refugees is within an already, "trusted and highly accessed" service system, such as a school (Ellis et al., 2011, p. 73). The belief is that if the family is already comfortable with the system the treatment may be less stigmatized. As a result, students and families may be more open to engaging in services (Ellis et al., 2011; Ellis & Lincoln et al., 2010).

Comprehensive approach. Several authors write about the need for a shift in thinking about mental health service delivery to a model that takes a more holistic-approach (Guerin et al., 2004; Schuchman & McDonald, 2004). This means engaging clients in a multidisciplinary team, which results in their needs being met broadly, rather than solely their mental health needs (Schuchman & McDonald, 2004). The idea is that providing mental health services for the Somali community is not effective when using the "50-minute-hour" approach (Schuchman & McDonald, 2004, p. 73). Serving Somalis can often take more time and flexibility due to their level of need, language differences and cultural considerations (Guerin et al., 2004; Schuchman & McDonald, 2004).

Program example. The program Supporting the Health of Immigrant Families and Adolescents (SHIFA) is an example of a newly launched school-based mental health program for Somali youth in Boston, Massachusetts, that has utilized and tested these strategies for overcoming existing barriers. The program "addresses the diverse and multiple problems that are faced by post-conflict communities" (Ellis, Miller, Abdi & Barrett, 2013, p. 130). It is set up so varying levels of mental health needs can be accommodated by using a four-tier approach. The first tier is the engagement of the community, which is lead by Somali individuals in hopes of providing psychoeducation and outreach to the Somali community in the area. The second tier is school-based groups, where Somali students in the English Language Learner classrooms are all invited to attend a mental health support group during the school day. The third tier is one-on-one therapy, which students are recommended to engage in as the practitioners see the need and after the family has come to know and trust the program. The last tier is intensive home-based services that can be implemented for families of the students in individual therapy if the need is there. The whole program is co-led by Somali and non-Somali practitioners, with the goal that families will develop trust over time and students will receive mental health services in a non-stigmatizing way (Ellis et al., 2011).

After the first year, SHIFA reported that 100% of the families gave consent for their child to attend the school-based group. Sixty-seven percent of the Somali students who were invited attended the group throughout the school year, and 100% of the youth recommended for individual therapy were given parent consent for individual treatment (Ellis et al., 2011). Additionally, the program saw a decrease overall in mental health symptoms (Ellis et al., 2013).

This program is a current example of an innovative approach, which addresses the common obstacles that keep Somali youth from receiving mental health care. The four approaches recommended in the literature to overcome the current barriers were put in to practice through this program; engage the families and community, partner with "cultural experts" (p. 73), implement services within an existing, trusted service system, and take a comprehensive approach (Ellis et al., 2011). It is concluded that this research-based approach was effective in meeting Somali youths' mental health needs.

The current literature on the needs of refugees, particularly Somali youth and their families, makes a compelling case for the need of mental health services, depicts a complex picture of the barriers mental health providers are currently facing in engaging Somali youth in services, and concludes with a research-based approach for overcoming the barriers. This is the foundation on which this research project stands and will inform the research to come. The goal of this research project was to capture the qualitative voice of mental health providers and other human service personnel in the Minneapolis, Minnesota area in regard to the topic of providing effective mental health services for Somali youth.

Conceptual Framework

This research was approached through the lens of the ecosystems theory. This theory melds two foundational social work theories: systems theory and ecological theory. In general, the ecosystems theory perspective is holistic in nature. It views individuals in the context of their environment (Lehmann & Coady, 2001). To better understand the lens through which this research was conceptualized, a closer look at the roots of ecosystems theory, systems theory and ecological theory will be explored.

Systems Theory

Systems theory has been a theory of social work for decades. It is what sets social work apart because of how it takes in to consideration the impact of environment on individuals. Systems theory accounts for all of the multiple systems involved in each individual's life. Most people are a part of several systems such as, peers, family, neighborhood/geographical community, education system, religious group, social/recreational groups, culture groups, political groups, and more. The systems theory states that these external factors need to be taken in to consideration when striving to understand and help someone (Lehmann & Coady, 2001).

Ecological Theory

Ecological theory is similar to systems theory in that it takes into consideration a person's involvement in systems outside of the individual. Ecological theory builds upon systems theory by discussing the interactions between an individual and the systems they are involved with. Ecological theory is focused on how a person's environment (or systems) impacts them and how an individual impacts their environment. In general, the ecological theory includes the impact of external environmental factors on a person (Lehmann & Coady, 2001).

Together, ecological theory and systems theory make a theoretical framework (i.e. ecosystems theory). Through the lens of ecosystems theory an individual is assessed in all of their complexities, including the impact of the internal and external factors.

This framework was appropriate for this research project because of its attention to the powerful impact that systems and social groups have on people. Particularly when studying refugees, it is important to address how being a part of specific culture and

religious group impacts the client. For the Somali community, it would not make sense if a practitioner discussed and addressed their concerns only on an individual basis, as they have a communal world view and often see their problems as rooted in the system they are involved in, such as the family. It is critical that the impact of culture, religion, and family be taken in to consideration when addressing issues of Somali youth engagement in the mental health system.

It is clear that the Somali worldview aligns adequately with the ecosystems theory, which is a critical starting point. With that, ecosystems theory as a research framework was appropriate because this research looked at how Somali youth interact with the mental health service system. The ecosystems theory addresses the role of institutionalized systems, such as the mental health service delivery system, which this research strived to better understand. This research project examined Somali youths' mental health needs and their interaction with mental health services. Through the ecosystems lens, mental health service provision for Somali youth was analyzed.

<div align="center">**Methods**</div>

Research Design

This research project has a qualitative research design. Qualitative research seeks to gain a better understanding of the realities of individuals and their perceptions of the world around them. A qualitative way of researching is often through interviewing participants and gathering information about their life experience (Merriam, 2002). A qualitative research design was appropriate for this research project because this project strived to better understand Somali youths' mental health needs and how mental health services can meet those needs more effectively. By conducting qualitative interviews, this

researcher was able to get insiders' narratives about their experiences related to this topic (Merriam, 2002).

This researcher conducted eight semi-structured interviews. The interviews each lasted approximately one hour. The interview questions (see Appendix A) began by gathering information about the interviewees' experience with and knowledge about the Somali community, specifically Somali youth. The later portion of the interview consisted of questions related to potential barriers to mental health treatment and how the interviewee had seen those barriers overcome or new approaches to providing services to Somali youth they thought might be effective. The interviews helped this researcher gain a better understanding of how to better serve Somali youth.

Sample

There were eight participants in this study. The participants were mental health providers and other human service personnel who were currently working with or had worked with Somali youth in the past. This researcher recruited individuals who were interested in sharing their experiences with and knowledge about Somali youth and their mental health needs.

The recruitment of participants was through key members of the Somali mental health service delivery system. This sampling technique is called snowball sampling. Snowball sampling was appropriate for this project because it allowed the researcher to gain access to participants who were experts in the field through the recommendation of key professionals who work with the Somali community (Marshall, 1996). These identified key stakeholders in the human service community were given an email (see Appendix B) that they distributed to potential participants. This email gave the potential

participants a brief idea about what the research study was about and gave them the

researcher's contact information so that they could request more information if they were

interested in participating. When potential participants contacted the researcher, in

response to the initial email, they were sent an information sheet (see Appendix C). The

information sheet provided potential participants with detailed information about the

research project, such as the purpose, the types of questions that would be asked, and that

the interview would be audiotaped. Information about confidentiality and risks and

benefits were also provided through the information sheet. Mental health providers and

other human service personnel that received this information sheet were expected to

contact the researcher to get any questions answered and set up an interview.

The interviews were conducted at a location where the interviewee was

comfortable. A closed room was suggested, as confidentiality is better kept if in a private

space. If the interviewee did not have a preference, this researcher suggested a closed

room at the University of St. Thomas or St. Catherine University.

Protection of Human Subjects

The St. Catherine University Institutional Review Board (IRB) reviewed this

research study before data collection began. The researcher worked to ensure that the

participants of this study were protected throughout the process. The interviews were

conducted in a location of the interviewees choosing. Before the interview, the researcher

offered to read the consent form (see Appendix D) aloud to the participants. The

researcher reiterated that their participation was voluntary and they could end the

interview at any time. The participants were asked to sign the consent form before the

interview began. Each interviewee received a $5.00 gift card to Starbucks upon signing

the consent form. The participants kept the provided compensation regardless if the interview was completed or not.

Steps were taken to ensure that the confidentiality of each participant was maintained. The audiotapes were only accessed by the researcher and were destroyed after they were transcribed. The transcribed interviews were kept on a password-protected computer and were destroyed upon the completion of this project. The participants were notified that the latest date confidential information would be destroyed was May 30th, 2014. No identifying information was used throughout the research project report.

Data Collection and Data Analysis

Eight individual interviews were conducted for the data collection for this project. A semi-structured interview guide (see Appendix A) informed the interviews. Each of the eight interviews were audio recorded. The interviews were transcribed in full following the interview. The audio recordings and transcriptions were used as data for this project. Content analysis was the method through which the data was analyzed. This approach consisted of following the subsequent steps (Schreier, 2012). The researcher studied each interview critically in order to analyze the data. First, each interview was read and re-read. The researcher looked for important concepts. Once the key concepts of each interview were determined, then a comparison of the key concepts was done to determine the themes across the data. A word count of language associated with emerging themes was done to quantify the significance of each theme (Schreier, 2012).

Strengths and Limitations

There are several strengths and limitations of this study. Adding human service personnel perspectives to the current research on Somali youth mental health qualitatively is a strength of this study. The majority of the current research is quantitative and symptom focused. This study adds a personalized voice to Somali youth mental health services. Another strength of this study is the level of expertise of the participants. Many of the professionals working with the Somali community have practiced with the Somali population for an extended period of time. Their expertise informed this project. Also, this researcher interviewed several Somali providers, which adds to the level of expertise of the participants, as they have a first hand perspective on the culture. Lastly, this study encourages professionals to consider how to better serve the mental health needs of Somali youth. This is an area of research that is just beginning to take shape. This study contributes to the current body of knowledge and empowers mental health professionals to develop new ways of engaging and serving Somali youth.

The limitations of this study include the second-hand nature of the information gathered from the participants and the size of the study. This study did not gather data from Somali youth themselves. This is a limitation because a first-hand perspective on what would make mental health services work better for Somali youth would potentially be seen as more credible. Second, the small size of this study is limiting because it would be potentially more meaningful to gather many professionals' perspectives. The data could be more generalizable if the size of the study was larger.

Conclusion

This is a qualitative research project, which included eight semi-structured interviews with mental health providers and other human service personnel who had experience working with Somali youth. Participants were recruited through key human service community members who distributed an initial email. The researcher distributed information sheets to those who indicated interest in participating in the study. One-hour interviews were conducted and were audiotaped with the interviewees' permission. Interviews were transcribed and studied in order to develop themes in the data.

Findings

This research project explored Somali youth mental health, including the Somali cultural view of mental health, barriers to mental health treatment, and ways to overcome the current barriers. Individual qualitative interviews were conducted with various community members who had experience working with Somali youth. The interview questions (see Appendix A) were intended to gather information about the interviewees' experience with and knowledge about the Somali community, specifically Somali youth. The questions also addressed potential barriers to mental health treatment of Somali youth and how the interviewee has seen those barriers overcome. The purpose of the interviews was to gain a better understanding of how to serve the mental health needs of Somali youth more effectively.

Demographics

This portion of the research is intended to give context to the data obtained from this study. The demographic information is important in order to understand the participants' life experiences and perspectives informed by their work with Somali youth.

Eight participants were interviewed for this research. Five of the participants were Somali females, two participants were Caucasian females, and one participant was a Caucasian male. The participants had varying experiences working with Somali youth. A few of the participants identified as a Somali youth or young adult and spoke from their personal experience. Most participants had experience working with Somali youth in the context of a school setting. One participant was a school social worker, two others provided psychotherapy services in the school setting, a few others tutored Somali youth, and two participants had experience working with Somali college students. Other experiences the participants brought to this research included working in a Somali daycare and working with Somali youth with Autism and ADHD.

Qualitative Data

The remainder of the findings section will explore the content obtained from the qualitative data that was gathered through one on one interviews. The data collected from the eight qualitative interviews was transcribed and a content analysis was done to extract themes. Through this process the researcher developed four main themes, each with various sub themes. The four main themes included a) Somali youth mental health, b) Somali cultural view of mental health, c) barriers, and d) overcoming barriers. These four main themes and the various sub themes will be explored.

Somali Youth Mental Health

One of the first questions participants were asked in the qualitative interview was what their experience taught them about the mental health needs of Somali youth. This researcher found that there were two predominant perspectives on the mental health needs of Somali youth. Several participants expressed feeling like Somali youth have

similar mental health needs to other communities. It was also quite common for

participants to highlight the unique mental health needs of Somali youth, or how their

experience brought challenges that differed from other populations.

Similarities. The participants in this research reported that Somali youth face

mental illnesses, such as depression, anxiety, bipolar disorder, autism, schizophrenia, and

borderline personality disorder. Two participants explicitly stated that they view the

mental health needs of Somali youth as similar or the same as other groups or cultures.

Several other participants expressed feeling like there were not any mental illnesses

overrepresented in Somali youth.

Differences. On the other hand, many of the participants reported that although

the rate of mental illness in Somali youth may seem similar to other communities, there

are several unique aspects that make the mental health needs of Somali youth different

from those in other communities. Some of the differences that were discussed included

family dynamics, intensity of symptoms before help is sought, and the trauma history in

the Somali community.

More than half of the participants talked about how family dynamics uniquely

impact Somali youth. A common theme was discussion about how greatly the family

dynamics shift for Somali refugee families after resettlement. They reported that children

can be put into roles that are not congruent with the Somali culture, which causes

heightened stress within the family system. Participants reported that youth are put in

positions of power due to their more advanced language acquisition and their greater

level of exposure to western culture, often through public education. Parents often

become dependent on their children, which works against the ideal that children should

respect their elders. Additionally, youth are caught between two cultures, which depending on the family's approach to acculturation can have a highly negative impact on the mental health of Somali youth. One participant described this phenomenon by stating, "I think just being stuck in between two cultures creates this isolation. Youth may feel like they're pretty isolated."

In addition to family dynamics, participants often brought up that the mental health symptoms that Somali youth experience can reach a much more acute stage before help is sought out. Although there are many factors that contribute to this pattern, the qualitative data collected consistently showed this as an important aspect in understanding the mental health needs of Somali youth. One participant talked about how Somali youth are not referred for mental health treatment until it is "really bad." Another spoke from the perspective of a Somali youth by stating, "you're in your head because no one understands you, what do you do? Just explode." This image of exploding is powerful when considering the degree of suffering of some Somali youth with mental illness who aren't receiving treatment.

Lastly, one participant of this research highlighted how the trauma history of the Somali community impacts the mental health needs of Somali youth. This participant spoke about how the civil war in Somalia led to a heightened need for mental health intervention for the community as a whole. The following quote depicts the impact this has on Somali youth:

> The way your parents talk about it, the way siblings, those who were affected by it, talk about it, I guess kind of pass down some health problems. Especially, ya

know, if your parents went through that and then they had you, you're probably

going to have that.

Many participants in this study discussed how the mental health needs of Somali

youth are similar to other cultures. They used examples from their experience to highlight

common diagnoses, such as depression and anxiety. Many participants also added that

there are elements that make the mental health needs of Somali youth unique, such as

shifting family dynamics, a delay in seeking treatment, and the Somali community's

trauma history.

Somali Cultural View of Mental Health

The way in which the Somali community views mental health was one of the

major themes of this study. Understanding how the Somali community views mental

health, generally, is critical to understanding how to better serve the mental health needs

of Somali youth. The participants in this research study spoke in great detail on this topic.

They spoke most consistently about three facets of the Somali view of mental health

including, the stigma, the conceptualization of mental health, and the conceptualization of

mental health treatment. Through the discussion of these three areas, a greater

understanding of how mental health is viewed by many in the Somali community can be

gained.

Stigma. All eight participants of this research study discussed the concept of

mental health being stigmatized in the Somali community. The word stigma was utilized

thirteen times throughout the eight interviews and the concept was discussed implicitly

on far more occasions. Other words and phrases that were used to depict how the Somali

culture often approaches mental health were: "suspicious," "not comfortable with it,"

"don't embrace it," and "not real open." One participant depicted the stigma of mental

health in the Somali community by stating, "mental health is something that is frowned

upon." The consequences of this stigma was often highlighted by participants by way of

stating that mental health is not openly talked about in the Somali community. One

participant spoke about Somali youth when saying:

> I feel like they don't know a lot about mental health or even if they do they
>
> usually just keep it to themselves cause if adults are not talking about it there is no
>
> reason you should be talking about it.

> In addition to many in the Somali community feeling like they cannot talk about

mental illness due to the stigma, there are also other consequences of mental health being

stigmatized, such as symptoms being minimized or blame being placed on the individual.

For instance, one participant talked about how a Somali youth displaying mental illness

may be approached by stating:

> So these certain youth members or individuals are displaying characteristics of
>
> mental illness, it's not acknowledged as mental illness. It's more acknowledged as
>
> behavioral. Ya know, like 'oh this person needs to get their act together' versus
>
> 'this person really needs to be medicated…or they need to go see someone.' No
>
> one says that, its more behavioral. Like they just need to just stop doing this. So
>
> it's like 'knock it off.'

> Finally, a couple of participants made the connection between the stigma of

mental illness in the Somali community and the differences in how the Somali

community understands the nature of mental illness, compared to mainstream Western

views. One participant stated that mental health, from a Western perspective, was "not

well understood" in the Somali community. Additionally, other participants raised

notions such as Somali individuals believing that mental illness is contagious or that

mental illness is not something that Somali people experience.

The stigma of mental illness within the Somali community is a complicated topic.

The participants of this study linked this stigma with decreased discussions of mental

illness and decreased understanding of mental illness, as conceptualized by mainstream

Western society, which can result in misplaced blame and a decrease in openness to

Western mental health treatment.

Conceptualization of Mental Health. Most of the participants of this research

study spoke about how mental health is conceptualized in the Somali community. The

two most common themes found in the data about how mental health is commonly

conceptualized in the Somali community were: the dichotomous view, that either a

person is sane or crazy, and that spiritual forces cause mental illness. One participant

summarized the most common conceptualization of mental illness in the Somali

community by saying, "they categorize it in to two sections. It's really limited. Either that

person is crazy or some how it has something to do with religious, some sort of religious

things in it."

Several respondents introduced the dichotomy of: you either have mental illness

or you don't; you're either sane or crazy. One interviewee reported that, "mental illness is

kind of seen as an on-going thing, like life long. If you say the word mental health it

almost equates to like Schizophrenia, something that is persistent, long term and really

effects functioning." Many participants described this polarized view as quite different

from the Western view, which views mental health on a continuum.

The other important piece to understanding how the Somali community generally conceptualizes mental health is the religious component. Several interviewees talked about the role religion plays in how the Somali community views mental illness. One respondent said, "many Somali individuals would view mental illness, and its viewed in Somalia, as a sign of evil, not a medical disorder and you either have it or you don't and if you have it you may be possessed."

In summary, the participants of this study supported the two most important concepts relating to how the Somali community conceptualizes mental illness, which are viewing mental illness in a dichotomous fashion, it is either present or it is not, and how religious views influence the ideas behind the cause of mental illness. Understanding how mental health is conceptualized commonly in this community allows for a greater understanding about how mental health treatment is conceptualized from this worldview.

Conceptualization of Mental Health Treatment. When participants were asked how their experience has shaped their understanding of how individuals in the Somali community view mental health treatment two main ideas emerged. Respondents talked about how individuals in the Somali community go about treating, or not treating, their mental illness and how Somali individuals may view mainstream Western mental health treatment.

Many participants talked about Somali individuals seek religious treatment, mainly through having the holy Quran read over them, and through talking to family and friends. One participant illustrated the importance of spiritual intervention by saying, "so, if you don't have that religious part of the practice done for the person within our community it doesn't look like it's working, I believe in it highly." Another respondent

talked about the confusion some Somali people may have about Western mental health treatment by reporting, "I can just talk my heart out with anyone in the house, why do I need to pay for someone to listen to me?" Spiritual intervention and seeking support from family and friends were two common ways participants described how Somali people treat their mental health symptoms.

In addition to these two approaches, a few participants talked about how Somali people do not seek mental health treatment at all. One interviewee said that mental illness is "usually brushed off or you deal with it in your own way." The same respondent later expressed that, "we don't end up doing anything about it until maybe its gotten really out of control and it's too late then."

Several of the interviewees talked about how the Somali community commonly views Western mental health treatment. One interviewee put it simply, "well, the treatment part would be mostly a mystery for those who don't have familiarity with it." This concept is consistent with what other participants expressed. Others talked about the Somali community not understanding Western mental health treatment, as well as mistrusting it, fearing it, and not believing in it. One respondent voiced some of the common concerns Somali individuals have about Western mental health treatment, from her perspective by stating, "people don't really want to become guinea pigs and be overmedicated."

The qualitative data gathered in this study explored ideas about the Somali community's conceptualization of mental health treatment, which commonly includes the belief in religious treatment, seeking help from family or friends, or not seeking treatment

at all. Additionally, the data suggested that many in the Somali community have reservations about engaging with the mainstream Western mental health system.

The Somali cultural view of mental health was a prominent theme in this study. The participants focused on the stigma of mental illness and the conceptualization of mental health and its treatment when asked about the traditional Somali cultural view of mental health. Through these common themes a fundamental understanding of the traditional Somali worldview, as it relates to mental health, is established. This necessary understanding allows for a broader perspective on the current barriers to Somali youth mental health treatment.

Barriers

The participants of this research study were asked to identify any barriers they thought keep Somali youth out of the mental health services delivery system. The respondents came up with several barriers, which this researcher put into five overarching categories: a) Somali cultural view of mental health, b) communication, c) family, d) trust, and e) lack of provider education. These five overarching themes will be discussed as they relate to barriers to mental health treatment of Somali youth.

Somali Cultural View of Mental Health. Two common components of the Somali cultural view of mental health that the participants of this study conceptualized as barriers were the stigma of mental health and the lack of education about Western views of mental illness.

The stigma within the Somali community related to mental health and its treatment is a significant barrier. One respondent put it simply, "I think there's a big stigma about seeking mental help, being mentally ill, things like that." Along with the

stigma comes fear. This fear is powerful, as one respondent describes, "even if you tell them or the sheikh tells them 'well you need to go to this mental institution.' They're not going to do it because they're just, they're fearful."

The other part of how the Somali culture views mental health, that the participants identified as a barrier was the lack of education in the Somali community about Western views of mental health. This point was spoken about extensively. Nearly every respondent spoke about this being a barrier. One interviewee spoke about the lack of education as a barrier by saying, "education…Not only categorizing into two sections is really not helpful because they don't know what they have. So they're not willing to seek the help, ya know, that they needed." This relates to another participant's response who stated, "it's partially not being educated that this can happen to you, this is what it looks like if you see it in yourself and someone around you, this is what you do." These respondents are exposing various aspects of the lack of education about Western views of mental health in the Somali community that can be barriers including, thinking they cannot get mental illness, not seeing a need to identify symptoms of mental illness, and not knowing potential treatment options for it.

In addition to highlighting differences in education and understanding about mental illness, a few participants in this study brought up the lack of understanding the mental health service delivery system as an additional barrier. It was said that, "with a lot of the Somali community there's just this lack of understanding of what the mental health system is, so why would you want to be a part of something you don't understand." Another respondent highlighted the complexity of the system by stating, "the confusion of the many stages of the mental health institute has is overwhelming to understand

because you have therapists, psychiatrists, you have a doctor, you have a social worker,

you have five different people."

The stigma associated with the traditional Somali worldview of mental health was

a large barrier identified in this data. Related to that, the differences in education and

understanding of mental health and the Western mental health service delivery system

were also significant barriers proposed by the participants in this study.

Communication. The second theme related to barriers found in this study was

communication. The majority of the participants expressed viewing communication as a

barrier to effective mental health service provision for Somali youth. There were three

major ways communication presented as a barrier, as described in the data, which were

communication through an interpreter, communication between youth and their elders,

and communication between providers and Somali clients.

Various respondents reported barriers associated with the use of interpreter

services. The four main concerns interviewees brought up about using interpreters was

the availability of interpreters, Somali clients willingness to use an interpreter, concerns

about interpreters adding content to the conversation, and concern that providers who rely

too much on interpreters hinder the therapeutic relationship. A few quotes that depict how

interpreters can become barriers to mental health treatment of Somali youth are as

follows:

> Many immigrants are not yet fluent English speakers so they need help from an
>
> interpreter and may or may not have that available or may or may not be willing
>
> to enlist an interpreter. So, language itself is a potential barrier. And
>
> communicating through an interpreter has some hazards.

They're just very worried that they're going to know this interpreter, that they're

going to be hearing their business, that its going to be someone they know and

I've also had a hard time finding an interpreter who does direct interpretation

without adding information.

In addition to barriers associated with utilizing an interpreter, many interviewees

reported communication barriers related to translating topics associated with mental

illness into the Somali language. Most respondents reported feeling like this was a barrier

largely experienced by youth trying to talk to their parents about mental illness in the

Somali language. One respondent described the difficulty for youth to communicate with

their parents due to translation issues by stating:

I think the youth in the Somali community, well the majority that I know, their

English is pretty good. And therefore maybe they don't know how to

communicate that back into Somali because a lot of the words are not the

same…But ya, it's that language deficit between kids and their parents or even

with each other, they're losing touch [with the] Somali [language].

Another participant stated, "they don't even know how to say it out loud cause sometimes

the words are not…you can't really translate to their own language and they don't know

how, to like, communicate with their parents about it." This communication barrier

between youth and their parents can be profound. It can contribute to youth staying silent

and not receiving the treatment that they need.

Lastly, communication can also be a barrier between non-Somali providers and

Somali youth and their families because of the differences in vocabulary particularly

related to mental health. A couple of participants discussed the differences in the Somali

language and the English language when it comes to mental health symptoms and diagnoses. One interviewee said:

> Depression, the word itself I don't think you can translate in Somali, but you can say like I'm very sad, I don't want to do anything around the house, then she'll get the hint that you may be depressed, but she won't exactly know exactly that, that's what depression is.

Another respondent exposed the barrier further by stating:

> We don't really have words, like a word for depression or anxiety, but we have words like someone being stressed out, worrying a lot…but those are just temporary states though, it's not like over a long period of time. So its like I'm stressed out or she's stressed out lately, but something continuing for a long period of time, we don't have anything like that.

These participants are pointing out how communication across languages can be challenging because it is not easy to relay the same idea when words and concepts cannot be directly translated. This can be a hindrance to the effectiveness of mental health treatment.

The data from this study emphasized communication as a barrier in Somali youth receiving Western mental health treatment. Particularly communication as it relates to using interpreter services, communication between Somali youth and their parents, and communication between non-Somali speaking providers and Somali youth and their families. This barrier of communication closely relates to another barrier identified in the data, which is family.

Family. The participants in this study reported that parent opposition to treatment, lack of partnership with the parents, and family stress can all be contributing factors that keep Somali youth out of the mental health service delivery system. This theme was commonly brought up amongst participants as a potential barrier.

Respondents expressed that parents are often either in denial of their child's mental illness, want to believe their child is perfect, or aren't open to talking about mental health generally. Each of these common responses from parents can be a potential barrier to treatment. One participant described it as, "generally a lot of parents might not be open to it because they don't want to think really bad of their children, ya know like they'll always think of them as innocent." Yet another interviewee said, "they're at that denial stage where it doesn't exist, 'my child's perfect', like any other parent." It is important to note that this barrier is not exclusive to the Somali community. A few respondents pointed out that this is common amongst parents of all ethnicities. It was stated, "I think it's a human thing to not really want to acknowledge something. It's just threatening."

In addition to family opposition as a potential barrier, lack of partnership with a Somali youth's parents or family can also be detrimental. Two respondents in particular discussed difficulties making contact with Somali families and their on-going struggle with creating a partnership. In these two cases lack of communication and partnership with the families prevented Somali youth from getting treatment. Other respondents also agreed that lack of partnership with the family was potentially a major barrier to treatment; "I said family not being on board as one barrier."

Lastly, family stress was also brought up as a potential barrier. A few participants highlighted the extensive adjustments Somali families go through upon resettlement and how more immediate needs can take precedence over mental health symptoms. One respondent talked about one family's struggles, "he's trying to support a family, he's trying to run a business…in an alien culture, from a trauma history. It's like well he's dealing with some things too."

Families can be great supports for youth seeking mental health treatment, but they can also present as barriers to the process. The qualitative data from this study showed three major ways families could potentially be barriers to mental health treatment, which were parent opposition, lack of partnership with the parents, and family stress. Another identified barrier that relates to parent-provider relationships is the barrier of lack of trust.

Trust. The complex issue of building trust was a common theme throughout this research study. Many respondents stated that building trust with Somali youth and their families is difficult and can be a barrier to mental health treatment if it is not established. Another aspect of trust that respondents identified as a barrier was mistrust of the mental health system and the recommended treatments. Additionally, not having enough Somali providers was brought up multiple times as a part of Somali clients having difficulty trusting their provider, the treatment, and the system.

Various respondents reported that lack of trust between a Somali client and their mental health provider is a barrier to treatment. Particularly, participants highlighted the length of time it can take to develop the needed trust for treatment to be successful. One interviewee put it this way:

I think in general trust has been a barrier…it has taken a long time to build that

trust and it's really hard to do when you're coming in saying you're in mental

health, to be able to start to build that one on one relationship.

Another concern respondents brought up in relation to trust was Somali youth and

their families' potential mistrust of the system and the treatment being offered. This

barrier can be great because parents are not going to consent to treatment if they do not

believe in or trust the Western mental health treatment system. One participant spoke

about this barrier by stating:

If your family first of all doesn't trust the school system, as with the healthcare

system, ya know and doesn't feel like the school is really there to support their

kids…I don't think they're going to be open to getting some kind of support. So I

think that may be mistrust of the system. Also, maybe just not believing in this

treatment.

Lastly, a few of the participants in this research brought up a lack of Somali

mental health professionals as a barrier. These interviewees appeared to associate this

issue with trust by stating that a Somali client would likely be more comfortable and

more trusting of a Somali provider, as opposed to a non-Somali provider. One

interviewee complicated this belief by reporting feeling like this could be a barrier for

some Somali clients, but is not necessarily a barrier for all by stating, "for some people it

could be, it depends on them."

One of the main themes extracted from the qualitative data obtained in this study

related to barriers to Somali youth mental health treatment was trust. Participants spoke

about how difficult it can be to build trust, how some Somalis may mistrust the mental

health treatment system, and that a lack of Somali mental health providers could contribute to the lack of trust. The final theme related to barriers to mental health treatment of Somali youth is the lack of provider education.

Lack of Provider Education. Although most of the participants in this study put the responsibility on the Somali community for many of the barriers, a couple respondents talked about the barriers the mainstream Western mental health system create that keep Somali youth out, such as the lack of provider education. One participant expressed her own insecurities about working with the Somali community by saying things like, "I'm walking into this almost blind," "I just feel so not knowledgeable," "I just feel lost," and "I feel like I'm lacking so much information." These words expose how many providers may feel when they begin working with a new community, in this case the Somali community, which could potentially be a barrier.

Along with the lack of education about the Somali community itself, two participants talked about their concerns with how the system treats Somali youth, as well as other minority youth. One quote that summarizes this point is:

I think America just invests in this whole school to prison pipeline in kids that

have behavioral issues [or] mental health issues. [They] aren't really directed to

get the services that they need, but instead get into the juvenile justice system.

These interviewees talked about how this phenomenon is perpetuated by helping professionals not being aware and intentional about adjusting this pattern. Another respondent said it well:

I think therapists, people treat kids differently based on the neighborhood the kid

lives in, that sort of thing and I think as more, as a demographic in the state is

changing I think people that choose to go into the helping field should make more

of an intentional effort, and a genuine effort in getting to know the different

communities that make up the communities that they're serving.

It is from this perspective that the lack of provider education about the Somali culture

itself and the lack of awareness of the discrimination within the system are seen as

barriers to mental health treatment for Somali youth.

Through the qualitative data gathered in this research study five main barriers to

Somali youth mental health treatment were supported. These barriers included Somali

cultural view of mental health, communication, family, trust, and lack of provider

education. It is important to understand all of the contributing factors associated with

these current barriers. One participant pointed out that it is how the Somali community

and the current mental health system interact that has been problematic, not necessarily

that just one party is to blame; "There may very well be a need, but with our current

system it's not I guess set up in a way that is working for the Somali families to be

receptive to it." Understanding these complex dynamics is critical to overcoming these

barriers.

Overcoming Barriers

All of the qualitative data explored thus far has laid the groundwork for

understanding the strategies for providing better mental health services for Somali youth.

The participants of this research study offered approaches to overcoming the current

barriers, which stemmed from their personal, professional, and educational experiences.

There were six common themes within the data, including a) Somali psychoeducation, b)

communication, c) relationship, d) increase comfort through cultural sensitivity, e) provider education, and f) a holistic approach.

      Somali Psychoeducation. The most commonly discussed way to overcome the barriers for Somali youth seeking mental health treatment was education. Every participant in this study stated that educating the Somali community about mental health would reduce the current barriers. There were four groups of Somalis, in addition to the Somali community at large, that were routinely discussed as needing this education: the elders, spiritual leaders, the youth, and their parents. One interviewee explained this approach by stating:

> Community education…really not targeting any one age level, but so for example elders are respected in the Somali community and elders may be influential in helping families make good decisions about seeking help, so some of the education should probably happen with the spiritual leaders and elders, not just with parents and youth.

One participant reported that someone of a similar age and status would be most effective in educating Somali elders.

      In addition to educating Somali elders and spiritual leaders, the data also supported educating Somali parents and youth. Educating Somali parents was discussed frequently by various participants. A few quotes that highlighted the importance and potentially beneficial strategies for educating Somali parents and youth are: "I think like talking to the parents is really one way to do it because if you have barriers at home the chances of you seeking outside help are very limited" and:

First of all talking about mental health in general, maybe in terms of how parents

might be impacted, like depression or something they got from an experience or

something from the civil war. That's really like a good place because that would

show parents that it starts with you, if you're not healthy and you don't have the

knowledge about it, your kids are more likely to be in the same, ya know, area or

place or whatever as you are.

Other participants pointed out the benefits of educating Somali youth themselves. They

stated that the youth are the next generation and some families are open to learning from

their children. Many reported educational groups in schools would be a good way to

empower Somali youth.

Lastly, a majority of the interviewees spoke about educating the community as a

whole and they raised general ideas about how to do that most effectively. One

respondent said, "I guess like going to densely Somali communities and talking to them.

Just giving them small information and just repeating it would be really helpful." The two

main recommended approaches were having testimonials from individuals from the

Somali community about mental health and having Somali people educate the elders,

spiritual leaders, parents, youth, and the community at large. "I feel like having…people

who went through stuff that are very prominent in the community giving them lectures,

telling them their stories could be really helpful." Also, the thought behind having Somali

people educate the community was explained as follows: "having Somali health

professionals talk to those communities will also help out because I feel like if you see a

person from your culture you can easily relate to them and you don't feel as shamed or

something."

Generally, the most frequently discussed approach to overcoming current barriers for Somali youth in the mental health system was through educating the Somali community about mental health. One interviewee said, "education is very, very, very important." This study identified four specific groups to target that would be critical to changing mental health treatment for Somali youth, which were elders, spiritual leaders, parents, and youth. It was discussed that psychoeducation by respected Somali individuals in a group setting would be most effective. Additionally, community wide psychoeducation would also raise awareness and alter the commonly held stigmatized beliefs about mental illness.

Communication. The second approach to overcoming current barriers for Somali youth is through communication. Most of the respondents in this research study talked about the significance of communication in engaging Somali youth and their families in mental health treatment. The two important aspects of communication emphasized in the data were the practical, initial approaches to communicating about mental health and the on-going best practice techniques for communicating about mental health treatment.

The first important aspect of communication is understanding the initial approaches that are most effective when engaging with the Somali population. For instance, a couple of interviewees advised not using words like mental health or therapist initially. Instead, some stated using behavioral health as a substitute and describing the role of a therapist, as opposed to using the term. Similarly, many advised to not use diagnostic labels, but instead talk about psychosomatic symptoms. It seems that these initial communication strategies are highly critical to engaging youth and families in the beginning. One respondent said:

The term mental health is not one to be used if you want to open dialogue about

making changes and like working through problems. I've kind of learned that if

you're going to talk about mental health you talk about specific symptoms…I

don't introduce myself initially as a mental health therapist…I kind of explain

what I do before I put any labels on anything.

The second part of communication is the on-going approaches that can reduce

barriers. Several of the respondents highlighted important pieces, such as providing

information, explaining things thoroughly, answering questions, listening, normalizing,

and creating an understanding. One participant described providers' role in

communication by saying, "providing information, responding to questions, and helping

people see evidence that treatment can be helpful." Another respondent depicted the

importance of normalizing and creating an understanding with the client by stating:

To point out culturally this is how we [Somalis] see it and I know where you're

coming from. I think that just does wonders because its like 'wait, okay so you

see where I'm coming from. You see that I'm not resistant, I just don't get it or I

just don't see it how you see it.' So just saying it's okay for you to have this view,

but this is what [Western] people do when they are in this situation, ya know,

these are your options.

Additionally, it was noted that taking the time to build that understanding and providing

information in the Somali language verbally is important to being as inclusive as

possible, as not all Somalis are literate in the Somali language.

One main theme extracted from this research study, related to overcoming barriers

to mental health treatment for Somali youth, was communication. The participants of this

study expressed that initial communication, as practical as which words to use and which ones not to use, and on-going communication best practices, including thorough explanations and taking the time to develop an understanding, are vital to engaging Somali youth and their families in successful mental health treatment. The overarching idea of how to best communicate with Somali youth was described well in this quote: "youth are receptive when they learn that there is hope." These strategies are closely linked to the next identified approach to overcoming barriers, which is focused on building relationship.

Relationship. The following way in which the respondents in this study reported that barriers to mental health treatment for Somali youth can be overcome is through relationship. This theme is very closely related to the last theme, communication, because they go hand in hand; it is difficult to have one without the other. The participants almost unanimously talked about relationships being key in treating mental illness in Somali youth. One participant noted the significance of this by stating, "it's hard for someone who is not Somali to get in and work with the Somali unless you have a profound relationship with them."

This profound relationship is critical to the mental health treatment process. It was said that, "there is a trust building process and I think that the understanding and confidence can only be built through building a trusting relationship." The importance of relationship was also described as follows: "[treatment] needs to be explained and trust needs to be built so that treatment as we know it might be an approachable and desirable solution over time."

There were a few approaches presented in the data that talked about how this trusting relationship is built. The first approach was just being available and being patient. One interviewee said, "just being there, being around and starting to build the trust to be able to make some changes." Similarly, another respondent made a suggestion to, "invest time in building rapport and relationships with the family." Another point that was highlighted on more than one occasion was the need to engage the entire family system, not just the youth. Two participants made this point by saying, "to me one of the most critical things in being successful in working with any client, family system is fully engaging the parent, parents or caregivers and the child or children who are involved" and "it comes back to the therapist and how they develop that relationship and how they explain things to the family and to the kid."

Finally, the importance of genuine relationship was poignantly described by one participant who said:

> I think the person's [provider's] intentions can always be sensed, ya know, and if this person is really here to support you and really there to help and kind of understanding where you come from and is open to learn where you're coming from, I don't think it matters what you look like, ya know, or what religion you practice. It's just I think people can see that.

It was also powerfully stated that, "just having one good experience with a social worker or therapist or someone kind of sets you up for getting support in the future."

The significance of relationship building to providing better mental health services to Somali youth cannot be overstated. Respondents suggest taking the time to form the alliance, focus on building trust, and remaining genuine as three ways to ensure

a solid working relationship is built with the client and their family. One way of

providing an environment conducive to building quality relationships is by increasing the

comfort of Somali individuals through cultural sensitivity, which will be explored next.

       Increase Comfort Through Cultural Sensitivity. There were several ways the

participants in this study thought that the comfort of Somali individuals could be

increased within the mental health system. A few examples are: having Somali

employees, using consistent, quality interpreters, and making the space more inviting.

One participant noted the importance of creating this comfort and warmth by stating, "if

we become known as a place where Somali folks are comfortable seeking help and are

treated respectfully and are given results that word of mouth is hugely important in the

community."

       Many respondents noted the importance of employing Somali staff. One

interviewee said, "Somali kids and other kids, minority kids, can see people that look like

them as part of the staff of these different facilities and they're more likely to feel like

they can come there." Additionally, making the environment inviting was also raised as

an important part of making Somali clients comfortable. One participant relayed this

point by saying, "change how the place actually looks, more homey, friendly," as

opposed to the hospital-like environment.

       The data gathered in this study exposed ways that the mainstream Western mental

health system could change so that Somali clients might feel more comfortable. A few of

the main approaches explored in the qualitative interviews employing Somali individuals,

using consistent, quality interpreters, and making the space more inviting. Another

important piece of overcoming the current barriers is through provider education.

Provider Education. Another significant piece in overcoming the barriers that keep Somali youth out of the mental health service delivery system is through education within the Western mental health system. A few respondents in this study noted the importance of providers being educated about Somali youth and the Somali community as a whole. One respondent expressed feeling like cultural trainings could be effective by stating, "educating the people about the community, the psychiatrists, the therapists, because they're looking, they're not in the community…so to develop workshops of historical context, just kind of trainings that are sensitive towards the culture." Another participant suggested the following to providers, "education about the culture, listening, learning, involving ourselves in community organizations that respect and teach about those other cultures." It was also suggested that providers, "demonstrate that knowledge and ask for feedback." The final piece of provider education that was identified was increased research on mental health treatment within the Somali community. One respondent said:

> Research is really needed because I feel like if you can have like a research and you've actually done studies, you get to share with the parents. It's really effective because its not just some person talking there is some sort of a back up to it.

One way the mental health service delivery system can grow and develop to better serve Somali youth is by becoming more educated. The data gathered in this study, included ways for providers to increase their understanding of the Somali community and strategies to more informed as a system, such as attending workshops, engaging in community cultural groups, and doing further research.

Holistic Approach. The final theme related to overcoming barriers was taking a holistic approach. Many individuals who participated in this study talked about how mental health treatment may be more effective for Somali youth if it was viewed from a holistic perspective. One participant shared a vision of what it might be like to merge traditional Somali spiritual treatment with mainstream Western treatment; "spiritual is how we seek [treatment] and it helps, that does help, but there needs to be an environment that is structured towards gaining with the Western medicine, I guess kind of bringing it together." Another respondent spoke of a holistic approach across disciplines when stating, "I think if there is a concerted effort to look at partnering with and helping individuals from the Somali community be healthy and successful, stigma may be overcome as an overall approach, rather than just signaling out one issue." Yet another participant talked about how the agencies within our mental health system could honor a more holistic orientation by creating some latitude for providers to meet the unique needs of their clients and take the extra time to build relationship when needed.

Overall, several interviewees concurred that approaching mental health treatment with Somali youth from a holistic point of view is best, whether that means including spiritual practices in treatment, collaborating more closely with other providers, or advocating for greater leeway within the treatment setting.

There are several ways in which barriers to mental health treatment of Somali youth can be overcome. This study highlights six strategies, including Somali psychoeducation, communication, relationship, increased comfort through cultural sensitivity, provider education, and a holistic approach. These themes are related and

interconnected in many ways. Together they make up a vision of how better mental

health service provision for Somali youth can be achieved.

The findings of this research study covered several areas related to Somali youth

mental health, including the mental health needs of Somali youth, the Somali cultural

view of mental health, the barriers to Somali youth seeking Western mental health

treatment, and strategies to overcome those barriers. These findings foster a broad

understanding of Somali youth and their interaction with the Western mental health

treatment system. It is through this understanding that implications for the human

services field, as well as recommendations will be made.

Discussion

The similarities and differences between the current literature and this research

study will be explored in depth. This will lead to a discussion about the strengths and

limitations of this research study and lastly, the implications for social work practice,

policy, and future research.

When comparing this research study to studies in the review of the literature,

similarities are found related to the Somali cultural view of mental health and its

treatment, Somali youth mental health, the current barriers to mental health treatment,

and best approaches to overcome those barriers. There are a few areas in which the

findings in this research add greater context and detail, but overall the findings in this

study are consistent with the studies in the review of the literature.

Somali Cultural View of Mental Health. The first area in which the findings in

this study reiterate the findings in the existing literature is in the Somali cultural view of

mental health. One study in the current literature talks about how the Somali community

traditionally labels those with mental illness as crazy (Schuchman & McDonald, 2004).

The qualitative data in this study exposed a similar idea: that mental illness is viewed as

something you either have or you don't; you're either sane or crazy. In the same study,

the authors describe how evil spirits are traditionally seen as the cause of mental illness

(Schuchman & McDonald, 2004). A few of the participants of this study reported just

that, that spiritual discord is often deemed responsible for mental health symptoms.

In addition, the findings in this research study coincide with the review of the

literature regarding traditional Somali approaches to mental health treatment. Findings in

two studies suggest that spiritual treatment, such as praying or having the Quran read

over you is the most common type of treatment in the Somali community (Guerin et al.,

2004; Schuchman & McDonald, 2004). This idea was supported in the data gathered in

this research. Additionally, the notion that friends, family, and others within the Somali

community are sufficient outlets for treating mental illness was also frequently discussed

in this study, as well as in the current literature. On the other hand, the findings of this

study did not include alternative therapies as a common treatment option in the Somali

community, as suggested in one study in the review of the literature (Guerin et al., 2004).

Somali Youth Mental Health. There were many similarities found between the

review of the literature and the findings in this research study in regard to Somali youth

mental health. One study discussed family dynamics as being a significant mental health

stressor for Somali youth (Guerin, Guerin, Abdi, Diiriye, 2003). This idea was similarly

discussed in this research, as participants often noted the shifts in family dynamics due to

the youth's higher degree of English language acquisition and cultural knowledge.

Additionally, another research study highlighted that Somali youth often don't seek

mental health treatment and that they often hold their concerns in (Ellis & Lincoln et al., 2010). The findings in this study support these ideas fully, as there was extensive discussion about the lack of mental health treatment sought and the powerful stigma that keeps Somali youth from discussing their mental health symptoms.

Barriers. There were six primary barriers to Somali youth receiving mental health treatment that were identified by this researcher in the review of the literature. Similarities were found related to the barriers identified in this study, but there were also differences. The similarities in barriers found between this study and other studies are the Somali cultural beliefs about mental health (Ellis et al., 2011), the concerns with the use of interpreters (Guerin et al., 2004; Loewenthal et al., 2012), and resettlement stressors (Ellis et al., 2011; Gong-Guy et al., 1991). Each of these barriers was noted in both the review of the current literature and in this study.

There were a few barriers acknowledged in this study that closely relate to the other barriers identified in the review of the literature. For example, two studies reported that difficulties understanding the Western service delivery system can be a barrier to the mental health treatment of Somali youth (Gong-Guy et al., 1991; Guerin et al., 2004). This research exposed lack of trust as a current barrier, which includes potential mistrust of the treatment system. These concepts are related because a lack of understanding can lead to a stance of mistrust. Similarly, a lack of culturally integrated services is a potential barrier, as noted in the review of the literature (Ellis & Lincoln et al., 2010). The idea being that it would be more beneficial for there to be treatments available that include both Somali and Western approaches to treatment. The findings in this study

included the idea that more culturally competent providers could provide a greater degree of cultural integrated services.

Within the theme of barriers, there were also points of distinction between the findings in this study and the findings of other studies found in the literature. Overall, the findings in this study seemed to explore more relational barriers. For instance, communication was a frequently discussed barrier in this study, including communication between the youth and their parents and communication between the provider and the youth and their family. These concepts add a greater depth of understanding to the barriers of language and use of interpreters discussed in the review of the literature (Guerin et al., 2004; Loewenthal et al., 2004). Also, this study discussed family opposition as a common barrier, which was not explored in the literature. Additionally, the data gathered in this research study did not highlight logistical barriers to treatment, such as transportation, which was noted in one article cited in the review of the literature (Guerin et al., 2004).

Overcoming Barriers. The last point of comparison between this study and studies found in the review of the literature is in the suggested approaches to overcome the current barriers to treating Somali youth. The overarching concepts in this area seem to be quite similar, but there are a few important points of difference. First, findings from current literature emphasize engaging Somali families and the Somali community, at large, in program development and modification, which includes a component of psychoeducation for the Somali community (Christensen, 2010; Ellis et al., 2011; Ellis & Lincoln et al., 2010; Guerin et al., 2004; Schuchman & McDonald, 2004). This study confirmed these ideas by suggesting psychoeducation in the Somali community as an

effective approach to overcoming barriers. Also, partnerships formed with individuals from the Somali community can inform more culturally sensitive practices within mental health agencies. Two articles also talked about a holistic approach as being important to overcoming the current barriers (Guerin et al., 2004; Schuchman & McDonald, 2004). This concept was described explicitly in this study, as well.

A few of the differences between the review of the literature and the findings in this study were the themes of communication, relationship, and provider education, which were not explicitly discussed in the literature. Themes in the findings provided a detailed perspective on what providers can do to overcome barriers at the micro level, as opposed to the literature's solutions that were mainly on the mezzo or macro level. Also, the review of the literature discussed developing programs within trusted systems, such as schools, which was not a commonly discussed approach to overcoming barriers in this study (Ellis et al., 2011).

Overall, the findings in this study adds to the existing literature. The qualitative data collected mirrored much of the previous research broadly. It also added some varying perspectives. There is not a lot of current research specifically looking at how to provide better mental health services for Somali youth, so this study also fills a gap in the research.

Strengths and Limitations

There are several strengths and limitations of this study. Adding human service personnel perspectives to the current research on Somali youth mental health qualitatively is a strength of this study. The majority of the current research is quantitative and symptom focused. This study adds a personalized voice to Somali youth

mental health services. Another strength of this study is the level of expertise of the participants. Many of the professionals working with the Somali community have practiced with the Somali population for an extended period of time. Their expertise informed this project. Also, this researcher interviewed several Somali providers, which adds to the level of expertise of the participants, as they have a first hand perspective on the culture. Lastly, this study encourages professionals to consider how to better serve the mental health needs of Somali youth. This is an area of research that is just beginning to take shape. This study contributes to the current body of knowledge and empowers mental health professionals to develop new ways of engaging and serving Somali youth.

The limitations of this study include the second-hand nature of the information gathered from the participants and the size of the study. This study did not gather data from Somali youth themselves. This is a limitation because a first-hand perspective on what would make mental health services work better for Somali youth would potentially add credibility. Second, the small size of this study is limiting because it would be potentially more meaningful to gather many professionals' perspectives. The data could be more generalizable if the size of the study was larger.

Implications for Practice

This study has several implications for social work practice, as well as other human services fields. This research allows human service professionals to gain a better understanding of the Somali community broadly. It also fosters a deeper understanding of Somali youth and the unique stressors they are facing. With this knowledge base, one can engage in a more informed practice with this population. The specific implications for practice can be drawn from the suggested approaches to overcoming the current barriers.

Specifically, engaging in effective communication and relationship building practices with all clients, but particularly with those from the Somali community. Also, seeking out educational opportunities, formally and informally to gain a better understanding about the Somali community and how to best serve them. Lastly, being more open to a holistic approach, which includes merging traditional Somali practices with mainstream Western mental health treatment. There are many implications for practice on a micro level that can be drawn from this research, including strategies to best engage Somali youth and their families, the importance of seeking cultural sensitive educational opportunities, and the benefits of taking a more holistic approach with Somali clients.

In addition to the micro level implications for practice, this research suggests mezzo level implications, such as the need for intervention on the community level. An important finding in this study is that psychoeducation within the Somali community is critical to ensuring that Somali youth are receiving adequate mental health services. Psychoeducation within the Somali community should include engaging Somali elders, spiritual leaders, parents, and youth. A couple potentially beneficial strategies are having Somali individuals lead the discussion and having Somali community members give their testimonial of their experience with mental illness and Western mental health treatment.

Social workers, and other human service professionals, can provide more effective mental health services to Somali youth on a micro level based on the previous recommendations. Additionally, on the mezzo level much can be done within the Somali community to foster a positive connection and understanding of the Western mental health service delivery system. It is important to note that these recommendations and skills are potentially transferable to other ethnic groups. The approaches suggested in this

research are a part of a broader understanding of how to best engage in culturally sensitive practice.

Implications for Policy

There are implications for policy on the mezzo and macro levels drawn from this study. On the mezzo level, this research offers several implications for agency policy. Agencies that provide mental health services can incorporate the findings from this research by building in more latitude to ensure that the unique needs of the Somali community are accommodated, providing more culturally sensitive training, intentionally hiring individuals from culturally diverse backgrounds, and by making necessary adjustments to allow varying cultural and spiritual practices to be accessible in their setting.

In addition to agency policy implications, there are also implications for public policy. These implications include creating policies to address the pipeline between the education system and the juvenile justice system. It is vital that racial discrimination be addressed and that children are given access to the appropriate treatments. Additionally, public policies are needed to create more opportunities for Somali individuals, and other minorities, to engage in higher education. The participants in this study reported that more Somali professionals in the human services field would increase effectiveness in treating Somali youth mental health. These implications for policy are critical in making the mezzo and macro adjustments needed in our mental health service delivery system to better serve Somali youth.

Implications for Research

Further research is needed in this area to explore and reinforce the topics discussed in this study. As noted in this study, it is important that research continues to be done on Somali mental health, as it is an important tool in engaging and educating the community. It is also necessary that this topic be explored on an on-going basis, as the needs of Somali youth change. The best approaches to treating Somali youth will need to adjust with each generation. It also appears that more research on specific programs that have been proven effective in engaging and treating Somali youth would be beneficial. Qualitative research conducted with Somali youth and their families would be helpful in gaining a better understanding of how to best serve Somali youth's mental health needs.

Conclusion

This research explored how the mental health needs of Somali youth can be better served. The data in this study was gathered through eight qualitative interviews with mental health providers and human service personnel with experience working with Somali youth. This researcher found that understanding the traditional Somali community's views on mental health and its treatment, as well as the unique mental health needs of Somali youth, are critical to understanding how to provide better mental health services for Somali youth. When a broad understanding of these topics is obtained then the topic of current barriers and strategies for overcoming those barriers can be effectively engaged.

This study identified several potential barriers to Somali youth receiving mental health treatment, including the Somali cultural view of mental health, communication, family opposition and stress, mistrust, and a lack of provider education about the culture.

To address these barriers, the data offered six approaches as solutions, including Somali psychoeducation, effective communication and relationship building, increased cultural sensitivity, increased provider education, and a more holistic approach overall. The implications of this research are substantial and highly imperative to for those in the Somali community. One participant expressed her concern about what the future may look like if these issues are not addressed by stating:

> The thing is like, I know that my kids are going to be born here so should they be discluded out of the system? What's going to happen? Should I prepare to be going because the system is not serving me? Is that it?

It is critical that we more effectively address the mental health needs of Somali youth in our communities.

References

Center for Health and Health Care in Schools. (2008). *Screening and assessing immigrant and refugee youth in school-based mental health programs*. Washington, DC: Birman, D., & Chan, W. Y.

Center for Victims of Torture. *General findings on the effects that war, violence, and trauma have on Children*. St. Paul, Minnesota.

Christensen, E. (2010). *Caafimadka maskaxda: A community perspective of mental health needs in the Twin Cities*. Augsburg College, Minneapolis.

Ellis, B. H., Lincoln, A. K., Charney, M. E., Ford-Paz, R., Benson, M., & Strunin, L. (2010). Mental health service utilization of Somali adolescents: Religion, community, and school as gateways to healing. *Transcultural Psychiatry, 47*(5), 789-811. doi:10.1177/1363461510379933

Ellis, B. H., MacDonald, H. Z., Klunk-Gillis, J., Lincoln, A., Strunin, L., & Cabral, H. J. (2010). Discrimination and mental health among Somali refugee adolescents: The role of acculturation and gender. *American Journal of Orthopsychiatry, 80*(4), 564-575. doi:10.1111/j.1939-0025.2010.01061.x

Ellis, B. H., MacDonald, H. Z., Lincoln, A. K., & Cabral, H. J. (2008). Mental health of Somali adolescent refugees: The role of trauma, stress, and perceived discrimination. *Journal of Consulting and Clinical Psychology, 76*(2), 184-193. doi:10.1037/0022-006X.76.2.184

Ellis, B. H., Miller, A. B., Abdi, S., Barrett, C., & Blood, E. A. (2013). Multi-tier mental health program for refugee youth. *Journal of Consulting and Clinical Psychology, 81*(1), 129-140. doi:10.1037/a0029844

Ellis, B. H., Miller, A. B., Baldwin, H., & Abdi, S. (2011). New directions in refugee

   youth mental health services: Overcoming barriers to engagement. *Journal of*

   Child and Adolescent Trauma, 4(1), 69-85. doi:10.1080/19361521.2011.545047.

Fazel, M., & Stein, A. (2003). Mental health of refugee children: Comparative study.

   British Medical Journal, 327, 134. doi:10.1136/bmj.327.7407.134.

Gong-Guy, E., Cravens, R. B., & Patterson, T. E. (1991). Clinical issues in mental

   health service delivery to refugees. *American Psychologist, 46*(6), 642-648.

Guerin, B., Guerin, P., Abdi, A., & Diiriye, R. O. (2003). Proceedings from the 22nd New

   Zealand Geographical Society Conference. *Identity and community: Somali*

   children's adjustments to life in the western world, 184-187.

Guerin, B., Guerin, P., Diiriye, R. O., & Yates, S. (2004). Somali conceptions and

   expectations concerning mental health: Some guidelines for mental health

   professionals. *New Zealand Journal of Psychology, 33*(2), 59-67.

Halcon, L. L., Robertson, C. L., Savik, K., Johnson, D. R., Spring, M. A., Butcher, J. N.,

   Westermeyer, J. J., & Jaranson, J. M. (2004). Trauma and coping in Somali and

   Oromo refugee youth. *Journal of Adolescent Health, 35*(1), 17-25.

   doi:10.1016/j.jadohealth.2003.08.005

Heptinstall, E., Sethna, V., & Taylor, E. (2004). PTSD and depression in refugee

   children: Associations with pre-migration trauma and post-migration stress.

   European Child & Adolescent Psychiatry, 13(6), 373-380. doi:10.1007/s00787-

   004-0422-y

Kroll, J., Yusuf, A. I., & Fujiwara, K. (2011). Psychoses, PTSD, and depression in

Somali refugees in Minnesota. *Soc Psychiatry Psychiatr Epidemiol, 46*, 481-493.

doi:10.1007/s00127-010-0216-0

Lehmann, P. & Coady, N. (Eds.) 2001. *Theoretical perspectives for direct social work*

practice: An eclectic approach (2nd ed.). New York, NY: Springer Publishing

Company, Inc.

Loewenthal, D., Mohamed, A., Mukhopadhyay, S., Ganesh, K., & Thomas, R. (2012).

Reducing the barriers to accessing psychological therapies for Bengali, Urdu,

Tamil and Somali communities in the UK: Some implications for training, policy

and practice. *British Journal of Guidance & Counseling, 40*(1), 43-66.

doi:10.1080/03069885.2011.621519

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice, 13*(6),

522-525. doi:10.1093/fampra/13.6.522

Merriam, S. B. (Ed.). (2002). *Qualitative research in practice: Examples for discussion*

and analysis. San Francisco, CA: John Wiley & Sons, Inc.

Pavlish, C. L., Noor, S., & Brandt, J. (2010). Somali immigrant women and the

American health care system: Discordant beliefs, divergent expectations, and

silent worries. *Social Science & Medicine, 71*, 353-361.

doi:10.1016/j.socscimed.2010.04.010

Refugees International. (2012). Somalia. Retrieved from

http://refugeesinternational.org/where-we-work/africa/somalia.

Schreier, M. (2012). *Qualitative content analysis in practice*. London: SAGE

Publications.

Schuchman, D. M., & McDonald, C. (2004). Somali mental health. *Bildhaan, 4,* 65-77.

UNHCR. (2013). Refugee figures. Retrieved from

http://www.unhcr.org/pages/49c3646c1d.html.

USA for UNHCR. (2013). What is a refugee? Retrieved from

http://www.unrefugees.org/site/c.lfIQKSOwFqG/b.4950731/.

Warfa, N., Bhui, K., Craig, T., Curtis, S., Mohamud, S., Stansfeld, S., McCrone, P., &

Thornicroft, G. (2006). Post-migration geographical mobility, mental health and

health service utilisation among Somali refugees in the UK: A qualitative study.

Health & Place, 12, 503-515. doi:10.1016/j.healthplace.2005.08.016

Williams, C. (2011, October 27). Census raises estimate of Somalis in Minn. *MPR News*,

Retrieved from http://minnesota.publicradio.org/display/web/2011/10/27/census-

raises-estimate-of-somalis-in-minn.

World Relief Minnesota. (2013). Somalis in Minnesota. Retrieved from

http://www.worldreliefmn.org/about-refugees/refugee-populations-in-

minnesota/somalis/.

APPENDIX A

SEMI-STRUCTURED INTERVIEW QUESTIONS

1. What experience do you have working with Somali youth?

2. What has your experience taught you about the mental health needs of Somali youth?

3. What is your understanding about how the Somali community views mental health generally and how it should be treated?

4. Do you think there are barriers that keep Somali youth out of the mental health service delivery system? If so, what are they?

5. What have you seen that works well in meeting the mental health needs of Somali youth?

   a. How were the youth and their families engaged?

   b. How was trust built and maintained over time?

   c. Was there anything unique to the Somali community done differently than would be done with other ethnic groups?

   d. Why do you think this worked?

6. Do you have any other ideas about how the mental health needs of Somali youth could be better served? Please explain.

APPENDIX B

INITIAL EMAIL CORRESPONDENCE

Do you work in the human service field? Do you have experience working with Somali youth??

Do you want to participate in a research project focused on how the mental health needs of Somali youth can be better served??

Do you have one hour of time to give? Would you enjoy a $5 Starbucks gift card?

Please contact Megan Jacobs at XXXX@stthomas.edu by January 31st, 2014 for more information on participating in this research study!

APPENDIX C

INFORMATION SHEET FOR THE STUDY

Thank you for your interest in participating in this research study. My name is Megan Jacobs and I am a Master's of Clinical Social Work student under the direction of Professor Catherine Marrs Fuchsel, PhD in the School of Social Work at St. Catherine University and the University of St. Thomas. I am conducting a research study to explore how the mental health needs of Somali youth can be better served. I am interested in learning how human service personnel view the current barriers to services and how those barriers can be overcome. I hope that what I learn from this study will help social workers and mental health providers better understand the mental health needs of Somali youth and effective approaches to meeting those needs.

I am inviting the participation of mental health providers and human service personnel with experience working with Somali youth to participate in an interview for approximately 1 hour. I will be conducting the interview in a private room in a public setting of the interviewee's choosing and on a date and time that is best for the interviewee. If you agree to participate, I will ask you on audiotape if you understand the consent form we will go over, if you have any questions and if you agree to take part in the interview. This study is voluntary and you may choose to stop participating at any time. If you choose not to participate in this study, it will not affect your standing with St. Catherine University or the University of St. Thomas in any way. You may also choose not to answer any questions.

In the interview, I will ask you about your experience working with Somali youth. I will ask you what you think the mental health needs of Somali youth are and how mental health is viewed from the Somali community's perspective. I will ask you about current barriers to providing mental health services to Somali youth and how you think those barriers are best overcome. I will encourage you to think of an example of a program or specific case where you felt barriers were overcome and how mental health services improved because of that.

There is one direct benefit to you for being in this study. You will receive a $5.00 gift card to Starbucks for your time and commitment. This study may have indirect benefits, such as it may help other people understand the mental health needs of Somali youth. The information from this study will be available online through St. Catherine University. Your name will not be used to identify you and information will be recorded anonymously.

The interviews will be tape-recorded, with your permission. You will have the right to ask for the recording to be stopped at any time. The audiotapes will be kept confidential and only I will have access to them. The data will be kept until May 30th, 2014. All notes will be shredded at that time. The audiotape will be destroyed and discarded immediately after the interview has been transcribed.

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Institutional Review Board, through St. Catherine University, John Schmitt, at (651) 690-7739.

IF YOU ARE INTERESTED IN PARTICIPATING IN THIS STUDY PLEASE CONTACT ME TO SET UP AN INTERVIEW BY JANUARY 31th, 2014: Megan Jacobs, (XXX) XXX-XXXX, XXXXX@stthomas.edu

APPENDIX D

Better Mental Health Service Provision for Somali Youth: Overcoming the Barriers
RESEARCH INFORMATION AND CONSENT FORM

Introduction:
You are invited to participate in a research study investigating how to better serve the mental health needs of Somali youth. This study is being conducted by Megan Jacobs under the supervision of Catherine Marrs Fuchsel, PhD in the Master of Social Work Program at St. Catherine University and the University of St. Thomas. You were selected as a possible participant in this research because you have experience working with Somali youth. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:
The purpose of this study is to explore more effective ways of providing mental health services for Somali youth. Approximately eight people are expected to participate in this research.

Procedures:
If you decide to participate, you will be asked to set a date, time and location with the researcher for a one-hour interview in a private room in a public setting. Upon meeting the researcher you will be asked if you have any questions about the information sheet you have received and this consent form will be reviewed. If you decide to participate in the interview, you will be asked 6-10 questions about your experience with and knowledge about Somali youth mental health.

Risks and Benefits:
The study has minimal risks. First, participants will be asked about Somali culture and common views Somalis have on mental health. The participant many feel some discomfort talking about mental illness and varying cultural views on mental health and its treatment. Second, participants will be asked about their ideas about how to better serve the mental health needs of Somali youth. This may be challenging for some participants and lead to some discomfort about not knowing how to respond.

There are no direct benefits of participating in this study, other than the minimal compensation provided.

Compensation:
If you choose to participate, you will receive a $5.00 gift card to Starbucks before beginning the interview, as an expression of gratitude for your time.

Confidentiality:
Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

I will keep the research results in a password-protected computer in my home and only I and my faculty advisor, Catherine Marrs Fuchsel, will have access to the records while I work on this project. All confidential materials will be destroyed as soon as possible. I will finish this project by May 30th, 2014. I will then ensure that all original reports and identifying information that can be linked back to you are destroyed.

Voluntary nature of the study:
Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University or the University of St. Thomas in any way. You may decline to answer any questions throughout the interview. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected. You will receive the $5.00 gift card regardless if the interview is completed or not.

Contacts and questions:
If you have any questions, please feel free to contact me, Megan Jacobs, at XXX-XXX-XXXX. You may ask questions now, or if you have any additional questions later, the faculty advisor, Catherine Marrs Fuchsel, 651-690-6146, will also be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact John Schmitt, PhD, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

You may keep a copy of this form for your records.

Statement of Consent:
You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

_____

I consent to participate in the study. I agree to be audio-taped.

_____
Signature of Participant   Date

_____
Signature of Researcher   Date